2020-2021 Region 3

PRIORITY REPORT

SERAC

Date: June 25th 2021

www.seracct.org

Executive Summary: SERAC Region 3 Priority Report 2020-2021

Goal

The goal of the bi-annual priority process in collaboration with the CT Department of Mental Health and addiction Services is to provide a thorough description of substance use problems, problem gambling, and mental health issues including suicide over various populations and subpopulations in the region. This report provides data and information on the current incidence rates and trends over time. The goal of this information is to assist in prevention needs assessments and gap analyses. This report defines the region 3 priorities, resources, assets, and subpopulations at increased risk for behavioral health issues as well recommendations on addressing these regional gaps and needs and health disparities.

Process

During the first half of 2021, SERAC (in partnership with DMHAS and CPES) collected and reviewed regional and state data sources to create epidemiological profiles and data summary reports for community stakeholders. Key stakeholders were identified through voluntary processes and active involvement in both regional and local initiatives across prevention, treatment, and recovery in behavioral health. Eight focus groups were conducted, and a key stakeholder survey was administered

Regional Priorities & Key Findings

The 2021 regional priority report demonstrates the clear need to prioritize co-occurring mental health and substance abuse issues for future regional and local planning purposes in conjunction with a strong emphasis on addressing disparate and at-risk subpopulations such as veterans/military, LGBTQIA+, elderly, transient families, ethnic groups, and those who have experienced trauma. Findings indicate that prevention, treatment and recovery systems should prioritize targeted strategies to increase cultural inclusivity and intelligence through regional technical assistance. In Region 3, a particular emphasis needs to be placed on resources for small rural communities. Priorities were ranked as the following:

1. Suicide
2. Depression, Anxiety, Alcohol, Heroin/Fentanyl, and Trauma
3. Prescription Drugs, Electronic Nicotine Delivery Systems/Vaping
4. Post-traumatic Stress Disorder, Serious Mental Illness
5. Marijuana, Early Serious Mental Illness, Serious Emotional Disturbance
6. Tobacco, Problem Gambling
7. Cocaine

Strategies and Recommendations

Several strategies and recommendations were made for Region 3 and are included in the full report.

Top recommendations in Substance Abuse/Misuse include:

- Prevention: Regional education and community awareness plan on new policies on adult cannabis use.
- Treatment: Increasing detox, treatment, long term care, and sober living homes in the northeastern corner.
- Recovery: Increasing support groups for children who have lost parents/family/guardian to overdose or current substance use.

Top recommendations in Mental Health include:

- Providing 6 no cost/sliding scale sessions for subclinical services to provide secondary prevention and intervention through education, training, and culturally appropriate engagement.
- Increasing intensive outpatient mental health services in Eastern CT for children.
- Increasing targeted support groups for individuals experiencing loss, trauma, and grief from the pandemic based on the identified populations in the priority report.

Top recommendations for Problem Gambling include:

- Increasing data collection through a regional study on risk factors for problem gambling disorders.

- Expanding treatment services to include youth gaming and online addiction disorders as possible co-occurring disorders.
- Implement youth support groups and alternative activities for gaming, internet, and gambling addiction.

Regional Behavioral Health Action Organization Staff Contributors:

Michele Devine, MA: Executive Director
Angela Rae Duhaime, MA: Associate Director
Jennifer Buckley, BA: Regional Prevention Manager
Deborah Walker: Program Assistant
Jennika Jenkins, MA: Data Coordinator

Community Needs Assessment Workgroup Members/Key Stakeholder Survey Respondents:

Kate Alves
James Baker
Scott Barton
Ann Bastien
Allison Behnke
Katie Bell
Rayallen Bergman
Lori Bergstrom
Romeo Blackmar
Kaitlin Brown
Melinda Bryan
Patricia Buell
Jackie Cook
Jennifer Croce
John Duca
Tina Duvall
Vince Edwards
Paige Fanolis
Fred Fetta
Michael Finkelstein
Missy Garvin
Lisa Girard
Diana Goode
Ana Gopoian
Kim Grant
Ann Gueutal
Ada Haines
Tracey Hanson
Ann Irr Dagle
Brenna Jaskiewicz
Michael Johnson
Barbara Kalpin
Ellen Kleckner
Lindsey Kyle
Andrew Lavalle
Kelly Leppard
Noreen Long
Peter Lusa
Miranda Mahoney
Frances Massy
Julia McGrath
Emily Morse
Diane Nadeau
William Nagel
Thomas Nelson
Haylee Olsen
Janet Pusczynski
Karen Ravenelle-Bloom
Martha Reynolds
Susan Rickards
Kathryn Runquist
Christopher Sandford
John Schwartz
Mary Seidner
Kate Sikorski
Melinda Smith
Matthew Solak
Jennifer Stanton
Philip Steffens
Jodi Stevens
Suzanne Talbot
Brittany Valentine
Lisa Wasel
Lynne Weeks
Carolyn Wilson
Maggie Wood

Abbreviations:

ALICE	Asset Limited Income Constrained Employed
ACEs	Adverse Childhood Experiences
CBD	Cannabidiol
CDC	Centers for Disease Control
CNAW	Community Needs Assessment Workgroup
CT	Connecticut
CTSHS	Connecticut School Health Survey
CRS	Community Readiness Survey
DHHS	Department of Health and Human Services
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DPS	Department of Public Safety
DUI	Driving Under the Influence
ENDS	Electronic Nicotine Delivery System
HIV	Human Immunodeficiency Virus
LPC	Local Prevention Council
MVA	Motor Vehicle Accident
NHTSA	National Highway Transportation Safety Administration
NIDA	National Institute on Drug Abuse
NSDUH	National Survey of Drug Use and Health
PSA	Public Service Announcement
RBHAO	Regional Behavioral Health Action Organization
SAMHSA	Substance Abuse and Mental Health Service Administration
SDE	State Department of Education
SEOW	State Epidemiologic and Outcomes Workgroup
SPF	Strategic Prevention Framework
THC	Tetrahydrocannabinol
US	United States
YRBSS	Youth Risk Behavior Surveillance System

Table of Contents

Introduction

Background:

SERAC is one of five Regional Behavioral Health Action Organizations (RBHAO) that support the promotion of mental health and the prevention of suicide, substance abuse and problem gambling in Connecticut. SERAC serves CT DMHAS Region 3 which includes the following 39 communities located in Eastern Connecticut: Ashford, Bozrah, Brooklyn, Canterbury, Chaplin, Colchester, Columbia, Coventry, East Lyme, Eastford, Franklin, Griswold, Groton, Hampton, Killingly, Lebanon, Ledyard, Lisbon, Mansfield, Montville, New London, North Stonington, Norwich, Plainfield, Pomfret, Preston, Putnam, Salem, Scotland, Sprague, Sterling, Stonington, Thompson, Union, Voluntown, Waterford, Willington, Windham and Woodstock.

Since 2004, DMHAS has utilized the United States Substance Abuse and Mental Health Service Administration's (SAMHSA) Strategic Prevention Framework (SPF) at the State, regional, and community levels. The SPF is a five-step, data-driven process known to promote youth development and prevent problem behaviors across the life span. SERAC has completed this Priority Report with assistance from community members in support of the DMHAS SPF process and to facilitate a data driven analysis of the magnitude, impact, changeability, capacity, and consequence of inaction of several priority issues of concern in Connecticut and in Region 3. The issues related to substance abuse and addiction are: alcohol, tobacco/electronic nicotine delivery system (ENDS) use, prescription drug misuse, marijuana use, heroin and other illicit opioid use, cocaine use, and problem gambling. The issues related to mental health are anxiety, depression, posttraumatic stress disorder, trauma, serious emotional disturbance, early serious mental illness, serious mental illness, and suicide.

Data Sources:

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

- CT SEOW Prevention Data Portal
- DMHAS Community Readiness Survey 2020

- OCME Data
- CT Violent Death Reporting System
- SERAC Regional Youth Summary 2018-2019
- SERAC Community Survey 2020
- SERAC Key Stakeholder Survey 2020
- National & State Surveys: Including National Survey of Drug Use and Health (NSDUH)
- Youth Risk Behavior Surveillance System (YRBSS)
- Connecticut School Health Survey (CTSHS)
- DMHAS Treatment and Admission Reports
- United Way ALICE Report 2020
- Regional focus groups

Strengths and Limitations:

This profile attempts to summarize data collected at the National, State and regional level. A major strength in the region is the availability of local data (specifically youth reported surveys) over the course of more than a decade. Although the data are believed to be reliable, valid and relevant, due to space limitations, it is neither practical nor possible to include all available data. Specific full reports can be found on the seracct.org website and upon request. Also, for some relevant indicators current data in 2020 are not available. Due to the barriers related to the covid-19 pandemic, many youth surveys were postponed until fall of 2021. Local data is also very limited in the northeast corner of the eastern region of CT. In cases when data sources were 5 or more years old, they were omitted for ranking. Approximately 70 individuals participated in the prioritization process and it should be noted that they are not exclusively representative of all the populations and residents in Region 3.

Ranking Process and Report Development:

Development of this profile was a multi-step process. First, the available data relevant to the statewide priorities were compiled, tabulated and summarized. Next, a Community Needs Assessment Workgroup (CNAW) was convened with the purpose of reviewing data for

each of the statewide priorities and for ranking their importance within the Region. Members for the CNAW were self-selected through voluntary attendance at scheduled meetings. Eight focus groups were conducted, and members included local prevention council and catchment area council members. Key sectors representatives from the community ranged from business, law enforcement, school, treatment providers, youth serving organizations, parents, and individuals with lived experience. In developing their rankings, CNAW members were asked to consider not only the sheer magnitude of individual issues but also the impact or consequences associated with that issue, as well and the changeability, community readiness, and consequence of inaction regarding each issue. All responses were collected, and mean scores were compiled for all the issues across substance abuse, problem gambling, mental health, and suicide. Focus group questions were designed to obtain further information on risk factors, at risk sub-populations, strengths and assets, gaps and needs, and recommendations for the region or state. A key stakeholder survey was conducted via survey monkey to reach individuals who may have not had the availability to attend a focus group. The key stakeholder survey, summary report is included as appendices as well as the focus group question list. Results from both the survey and focus groups are included in this report. Overall, approximately 70 individuals across the region participated in the priority report process through surveys, focus groups, and key stakeholder interviews.

Region 3 Priority Report

Description of the Region

According to the American Community Survey 5-year estimate (2019) the total population in the towns served by SERAC is approximately 426,124 residents. In Region 3, 78.4% of the population self-identify as White non-Hispanic, 4.1% as Black non-Hispanic, 3.7% as Asian non-Hispanic, 10.2%, self-identify as Hispanic or Latino of any race. Towns with the highest proportion of Hispanic population are Windham (41.5%), New London (34.7%), Norwich (14.3%), Groton (13.4%), and Columbia (8.3%). The share of Black non-Hispanic population is highest in New London (13.2), Norwich (10.5), Groton (7), and Montville (5.1); Asian non- Hispanic— in Mansfield (10.7%), Norwich (8.6%), Willington (6.2%), and Montville (5.8%).

Approximately 19% of the population are youth aged 0–17 and 15.9% are the elderly (aged 65+). Towns with the highest share of young people are Sterling (23.6%), Colchester (23.5%), Griswold (23.5%), and Killingly (22.3%). In region 3, Union (30%), Stonington (24.2%), East Lyme (22.7%), and Waterford (22.7%) have the highest proportion of the elderly (those aged 65 and above) population.

Median household income in region 3 varies from $39,675 in New London to $113,000 in Salem. Some of richest towns are Columbia ($106,604), Colchester ($103,380), Lebanon ($95,757), and Franklin ($94,000). Towns with the lowest median household income are New London ($39,675), Windham ($44,091), and Norwich ($55,391). According to the most recent ALICE Report (2020) six communities are experiencing a 30%-54% population struggle to afford basic needs in northeastern CT. In southeastern CT four communities are experiencing a 35%-57% rate. The ALICE Threshold assesses the percent of households that earn more than the Federal Poverty Level but less than the basic cost of living. In southeastern CT, 67% of household are above the ALICE threshold and 65% within the northeast subregion.

According to the CT Office of Rural Health (2014) 25 towns out of 39 are considered rural. Resources vary across the region and are often shared among small towns. The southern subregion has more resources available for behavioral health including treatment providers, law enforcement, and youth serving organizations. The current infrastructure across the regionvaries from fully organized local prevention councils and coalitions that have been in existence for 10 or more years to newly organizing and developing advisory groups. There are also regional efforts to address substance abuse and mental health issues coordinated by local hospitals and health districts.

2020 Region 3 Epidemiological Profile: Alcohol

Problem Statement

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

Magnitude (prevalence)

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

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

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

NSDUH Substate Estimates:

Percent Reporting Past Month Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	59.9	61.8	60.7	58.1	60.9	57.5
2016-2018	60.6	61.5	59.4	58.3	63.0	59.0

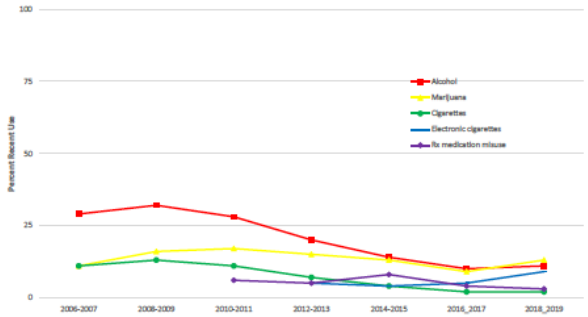
Percent Reporting Past Month Binge Drinking, ages 12+

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

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

SERAC Youth Survey Regional Summary 2018-2019 Estimates:

Regional Trends in Recent Use Among High School Youth:



Alcohol Use Rates 2018-2019

- Lifetime Use
  - 25% of youth report ever having used alcohol in their lifetime.
- Recent Use
  - 9% of youth report having used alcohol in the past 30 days.

While alcohol trends have shown a decrease over the past 15 years and marijuana has shown a slight increase in recent years, this dataset is limited to the southeast region. Data is extremely limited in the northeast corner. The pandemic-related barriers to data collection in 2020 create a gap year where it is difficult to determine trend over point in time data. Focus group information indicated that alcohol use was a greater concern for future planning in the region due to the

[1] NSDUH (2017-2018)

[2] DPH, 2019 Connecticut School Health Survey

excess promotion and favorable community norms that occurred during the pandemic.

Risk Factors and Subpopulations at Risk

- Young people who drink are more likely than adults to report being binge drinkers.[3]
- Men are more likely than women to be heavy drinkers.[3]
- Women are more likely than men to develop alcoholic hepatitis and cirrhosis, and are at increased risk for damage to the heart muscle and brain with excessive alcohol use.[4]
- Individuals with mental health disorders are about four times more likely to be heavy alcohol users.[5]
- Native Americans are at especially high risk of alcohol-related traffic accidents, DUI and premature deaths associated with alcohol misuse.[6]
- While Hispanics or Blacks have higher rates of abstinence from alcohol, those who do drink often have higher rates of binge drinking.[7]
- In 2019, 68.2% of alcohol admissions were male, and 59.6% were non-Hispanic White.[7]
- Among youth, risk factors include:
    - Academic and/or other behavioral health problems in school;
    - Alcohol-using peers;
    - Lack of parental supervision;
    - Poor parent-child communication;
    - Parental modeling of alcohol use;
    - Anxiety or depression;
    - Child abuse or neglect;
    - Poverty;
    - Social norms that encourage or tolerate underage drinking[8]

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

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

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

SERAC Youth Survey Regional Summary 2018-2019

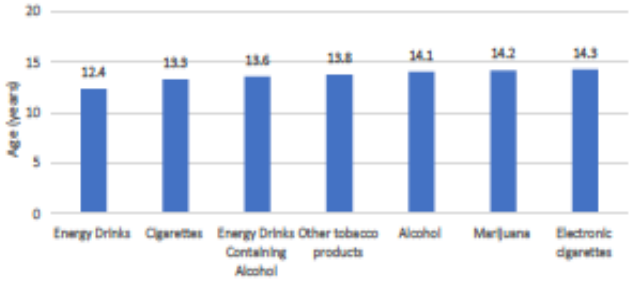
- About 60% of youth report that it is **definitely true** that their family has clear rules discouraging their use of alcohol.

- Only about 40% of youth feel that their friends think it would be ***very wrong*** for them to drink alcohol nearly every day.

Among youth who do report having used alcohol in their lifetime:

- The most common source of alcohol is from **friends**.
- 51% report **ever** having consumed 4 or more drinks in a single occasion in their **lifetime.**
- 18% report having had 4 or more drinks in a single occasion in the **past 30 days**.
- 71.6% report consumption at the homes of other people.
- 7.4% reported that they had been under the influence of alcohol while at school.

Estimates of Mean Age of Initiation of Various Substances Grades 7-12



[3] CDC (2016), Excessive alcohol use and risks to men's health
[4] CDC (2016), Alcohol and public health
[5] NIDA (2014), Severe mental illness tied to higher rates of substance use
[6] NIAAA, Minority Health and Health Disparities
[7] CT DMHAS 2019 Treatment Admissions
[8] National Research Council and Institute of Medicine

2020 Region 3 Epidemiological Profile: Alcohol

Burden (consequences)

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

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

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

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

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

Treatment Admissions where Alcohol is the primary drug at admission[7]:

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2019	24,985	2,698	5,450	5,464	6,546	4,827
FY2020	19,916	2,128	5,014	4,403	4,801	3,570

*Excluding 741 admissions where residence was unknown

Community Wellbeing Survey: Percent Reporting Past Month Binge Drinking

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

SERAC Community Survey 2020 Estimates:

- More than 80% of parents reported that someone in the household uses alcohol (household with youth in grade school).
- Approximately 75% of nonparents reported that an adult in the household uses alcohol.
- Approximately 40% of parents reported that alcohol is not secured in their homes.

Capacity and Service System Strengths

[9] NIAAA, Alcohol Facts and Statistics
[10] NHTSA (2018), Alcohol-Impaired Driving
[11] WHO (2018), Global status report on alcohol and health—2018
[12] NIAAA (2008), Older Adults
[13] NIAAA (2006), Alcohol Alert No. 67, Underage drinking

CPES Center for Prevention Evaluation and Statistics

2020 Region 3 Epidemiological Profile: Alcohol

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

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

According to the region 3 CRS report, the highest age groups of concern for alcohol use are age 66 and older followed by 16-65 years of age. Results on community attitudes show that the majority of respondents disprove of underage drinking. Approximately 30% of respondents felt that financial resources to address alcohol prevention was a great barrier in the region followed by a lack of trained staff to serve appropriate populations, as well as low community buy-in and low willingness to volunteer.

2020 Region 3 Epidemiological Profile: Cocaine

Problem Statement

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

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

Magnitude (prevalence)

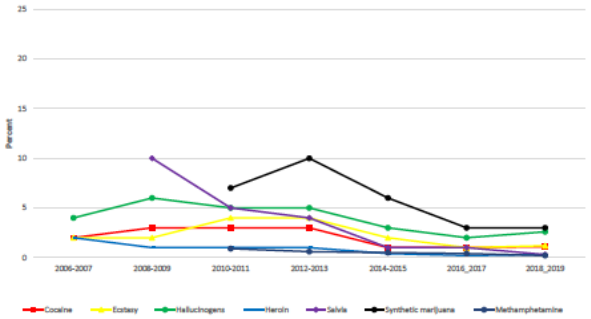
According to data from the 2019 Connecticut School Health Survey (CT YRBSS), 2.6% of Connecticut high school students reported using some form of cocaine in their lifetime.[1] This is consistent with a decreasing trend since 2007, when the prevalence was 8.3%.

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

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

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

SERAC Youth Survey Regional Summary 2018-2019 Estimates:



- Approximately 2.4% of 12th graders report that they have used cocaine in their lifetime.
- 99.1% of all youth report that they have never used cocaine in their lifetime.
- 12% of youth report that it would be ***easy or sort of easy*** to get an illicit drug if they wanted too.
- 5% of 12th graders reported that they have sold an illicit drug in the past year.

Risk Factors and Subpopulations at Risk

Risk factors include:

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

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

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

- Young adults ages 18 to 25 have a higher rate of current use than any other age group[2]
- Males are more likely to use cocaine than females

[1] Connecticut School Health Survey, 2019 (CT YRBSS)

[2] NSDUH 2018-2019

CPES Center for Prevention Evaluation and Statistics

2020 Region 3 Epidemiological Profile: Cocaine

- Those with current or previous misuse of other illicit substances, such as marijuana and heroin/fentanyl
- Individuals with mental health challenges[3]

According to data from the 2019 Connecticut School Health Survey (CT YRBSS), males reported higher rates (3.6%) than females (2.5%). The prevalence of lifetime cocaine use was highest among 12th graders (2.9%). Black students reported higher rates (4.8%) than Hispanic (2.7%) or White (2.1%) students, though the difference was not statistically significant.

Burden (consequences)

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

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

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

- Tolerance, requiring higher and more frequent doses
- Sensitization, where less cocaine is needed to produce anxiety, convulsions, or other toxic effects (increasing risk of overdose)
- Loss of appetite leading to malnourishment
- Increased risk of stroke and inflammation of the heart muscle
- Movement disorders such as Parkinson's disease
- Impairment of cognitive function

- Cocaine users are also at risk for contracting blood-borne diseases such as HIV and hepatitis C via needle sharing and other risky behavior[3]
- Users are at risk of accidental overdose, especially in the presence of alcohol or other drugs.[3]
- In 2019, cocaine was the primary drug in 7.7% of all Connecticut substance use treatment admissions. This represents 5,904 admissions. [4]

Treatment Admissions: Cocaine[2]

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

- Region 3 has the lowest treatment admissions for cocaine use.
- 8.7% of all clients in Region 3 report crack/cocaine as the primary drug for admissions.
- 6.1% report crack/cocaine as the primary drug among 18-25 year old adults.

Cocaine-Involved Fatal Overdoses in 2019[3]
***Rate per 100,000 population**

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

- Overdose deaths involving cocaine increased about 34% in Connecticut, from 345 in 2018 to 463 in 2019.[5]
- More than 7 in 10 (72%) overdose deaths involving cocaine in 2019 occurred in urban core or urban periphery communities.
- Cocaine-involved deaths have been linked to fentanyl-contaminated cocaine in Connecticut.[6] In 2019, almost 9 in 10 (85%) cocaine-involved deaths in Connecticut (n=463) also involved fentanyl.
  - Crack/Cocaine is reported as a drug of use in all cases in region 3 at 28.9%

Capacity and Service System Strengths

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

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

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

CPES Center for Prevention Evaluation and Statistics

2020 Region 3 Epidemiological Profile: Cocaine

According to the Region 3 CRS report, the highest age groups of concern for crack/cocaine use are adults age 18-65 years of age. Results on community attitudes show that the majority of respondents believe the community are concerned about preventing substance misuse and that it is a good investment in the community. Approximately 30% of respondents felt that financial resources to address substance abuse prevention was a great barrier in the region followed by a lack of trained staff to serve appropriate populations, as well as low community buy-in and low willingness to volunteer.

2020 Region 3 Epidemiological Profile: Heroin & Other Illicit Opioids

Problem Statement

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

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

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

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

Magnitude (prevalence)

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

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

Risk Factors and Subpopulations at Risk

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

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

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

SERAC Youth Survey Regional Summary Report 2018-2019 Estimates:

- 99% of all youth (grades 7- 12) report that they have never used heroin in their lifetime.

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

CPES Center for Prevention Evaluation and Statistics

- 0.4% of 11th graders report that they have used heroin in their lifetime.
- 12% of youth report that it would be ***easy or sort of easy*** to get an illicit drug if they wanted too.
- 5% of 12th graders reported that they have sold an illicit drug in the past year.

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

Burden (consequences)

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

Opioid-Involved Non-Fatal Overdoses (DPH)

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

***Numbers are approximate due to suppression**

Heroin-Involved Fatal Overdoses in 2019[3]

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

***Rate per 100,000 population**

Opioid-Involved Fatal Overdoses in 2019[3]

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

***Rate per 100,000 population**

Fentanyl-Involved Fatal Overdoses in 2019[3]

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

***Rate per 100,000 population**

- In 2019 there were 15,226 treatment admissions where heroin was the primary substance. Region 3 accounts for 25% of substance use treatment admissions where the primary substance was heroin or illicit opioids (CT DMHAS 2020).

Treatment Admissions: Heroin* as the Primary Drug

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

*This includes heroin and non-prescriptive methadone

The rate of Opioid Involved Deaths (32.67 per 100,00) in Region 3 is the second highest region in the state. There were approximately 1,223 non-fatal suspected overdoses in the region (CT DPH 2019-2020). The communities that have seen an increase in non-fatal suspected overdoses are rural communities. Of the 6 communities that have seen an increase, 5 of them are located in the northeast area of the region.

Overall, the data treatment has not significantly changed in the past 4 years. Efforts to expand naloxone and medicated assisted treatment programs in the region have a primary goal for the past 4 years. The region also has many safe disposal sites at local police departments and many local prevention councils participated in Drug Take Back Events. Qualitative information from focus groups indicated that the impact of heroin and illicit opioid use is a high concern alongside the consequences of inaction. Anecdotal information suggests that most deaths occur alone and in a residence location. Issues related to the access of treatment and recovery support, particularly in 2020 with the barrier presented by the pandemic are top issues related to heroin and illicit opioid use. This is largely due to gaps of service providers in the northeast region, disadvantages in the use of technology for telehealth services, loss of income, lack of health insurance coverage, and transportation.

Capacity and Service System Strengths

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

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

According to the Region 3 CRS report, the highest age groups of concern for heroin use are adults age 26-65 followed by ages 18-25. Results on community attitudes show that the majority of respondents believe the community are concerned about preventing substance misuse and that it is a good investment in the community. Approximately 30% of respondents felt that financial resources to address substance abuse prevention was a great barrier in the region followed by a lack of trained staff to serve appropriate populations, as well as low community buy-in and low willingness to volunteer.

2020 Region 3 Epidemiological Profile: Marijuana

Problem Statement

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

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

Magnitude (prevalence)

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

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

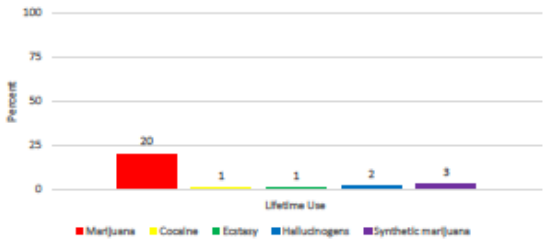
	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	9.3	8.5	9.7	10.6	9.3	8.6
2016-2018	10.9	9.6	11.0	11.4	11.8	10.4

SERAC Youth Survey Regional Summary Report 2018-2019:

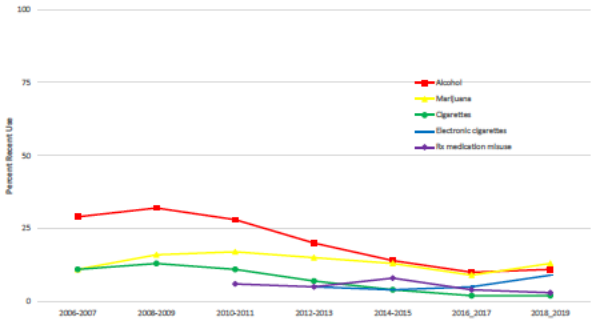
Marijuana Use:

- Lifetime Use
  - 20% of youth report ever having used marijuana in their lifetime.
- Recent Use
  - 11% of youth report having used marijuana in the past 30 days.
- 7% of youth report that their parent use marijuana.

Lifetime Youth Use of Illicit Drugs in Region 3 (2018-2019)



Trends in Recent Youth Use of Core Substances



Marijuana use has shown a slight increase in recent years among youth in the region and have marginally risen above alcohol use as a potential top substance of use. However, this is indicated by preliminary data in recent school surveys and more data is needed to determine if this is an accurate across all of the region. Marijuana is still the most commonly used illicit drug by youth in the region.

Risk Factors and Subpopulations at Risk

Risk factors include:

- Availability of marijuana
- Family history of marijuana use
- Favorable parental attitudes towards marijuana
- Low academic achievement and low bonding to school environment
- Peers who use marijuana
- Low peer disapproval of marijuana use
- Prior use of alcohol/tobacco

[1] NSDUH

[2] Connecticut School Health Survey, 2019 (YRBS)

CPES Center for Prevention Evaluation and Statistics

- Sensation seeking behavior/impulsivity
- Childhood abuse/trauma[3]

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

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

SERAC Youth Survey Regional Summary 2018-2019 Estimates:

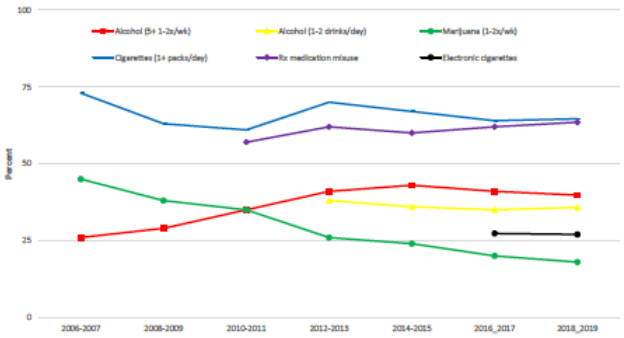
Perceived Harm

- Only 22% of youth report that there is a **great risk** in using marijuana and it is the substance with the highest reported **no risk** across the region.

Peer Disapproval

- 37% of youth report that their peers would think it was very wrong for them to smoke marijuana.

Trends in Reported Great Risk Among Substances in Eastern CT (2018-2019)



There has been a decline in the perception of harm of marijuana use during the past 15 years. This risk factor has been difficult to address with recent legalization attempts and the promotion of marijuana use.

Among youth who report having used marijuana in their lifetime:

- The most common source of marijuana is from **friends**.

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

SERAC Youth Survey Regional Summary 2018-2019 Estimates:

Rates of use by gender:

- Male and female rates of use are similar for recent use (10.8%, 10.3%).
- 41% of 11th graders who prefer to self-describe their gender reported recent marijuana use.
- Lifetime use is slightly higher for females (20.1%) than males (18.6%).

Burden (consequences)

Short-term consequences include[4]

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

Long-term consequences include[4] :

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

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

[4] NIDA, Marijuana

- Increased risk of bronchitis and chronic cough

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

DMHAS Treatment Admissions[5]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
All clients	*	37.5%	29.7%	24.4%	43.4%	35.2%
Primary	13.6%	16.3%	9.8%	9.4%	17.9%	15.3%

- Because marijuana use impairs motor coordination and reaction time, many studies have shown a relationship between blood THC concentration and impaired driving.[4]
- A recent national outbreak of e-cigarette, or vaping product use-associated lung injury (EVALI) was linked to vaping THC, possibly due to the presence of Vitamin E acetate which is used as a diluent in THC-containing products.[6]

Regional Estimates:

- Marijuana is reported 50.9% as a drug of use in individuals receiving treatment ages 18-25.
- 29.7% of individuals age 18-25 report marijuana as the primary drug of use.

Capacity and Service System Strengths

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

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

The Region 3 Community Readiness Survey indicates that respondents feel marijuana is the greatest concern among ages 18-25 and 12-17 years old. The concern for marijuana use among adults was much less of a concern in the region. Key informants also reported that most residents in the region are not very concerned about the legalization of marijuana. The greatest barriers that were identified in the prevention of substance misuse were lack of financial resources, trained staff to serve specific populations, community buy-in and willgness to volunteer.

[5] CT DMHAS, 2019 Treatment Admissions

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

2020 Region 3 Epidemiological Profile: Mental Health

Problem Statement

Mental health refers to emotional, psychological, and social well-being. Mental health has a critical impact on thoughts, feelings and actions. It also determines how individuals handle stress, relate to others, and make life choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Many factors contribute to mental health problems, including: biological factors, such as genes or brain chemistry; life experiences, such as trauma or abuse; family history of mental health problems. Types of mental health disorders include, but are not limited to: depression; anxiety; post-traumatic stress disorder (PTSD); obsessive compulsive disorder; mood and personality disorders; eating disorders; and serious mental illness (SMI). Anxiety and depression are the most commonly reported mental health issues, while SMI has serious consequences for the lives, livelihood, and wellbeing of individuals and families experiencing it.

Anxiety

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

Depression

Depression is a relatively common but serious mood disorder. It interferes with everyday functioning, and includes symptoms like feeling sad all the time, loss of interest in activities previously enjoyed, sleeping too much or too little, having trouble concentrating, and thinking about suicide or hurting oneself.[2] About 1 in 6 adults will have depression at some point in their life.[2] According to the 2018-2019 National Survey on Drug Use and Health (NSDUH), 7.1% of Connecticut respondents reported a major depressive episode in the past year.[4]

Serious Mental Illness

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

Magnitude (prevalence)

Anxiety

The 2018 Connecticut BRFSS showed 11.2% of adults reported feeling nervous, anxious, or on edge for more than half the days or nearly every day in the past 2 weeks.[5]

Depression

The percentage reporting past year major depressive episode was highest among young adults 18-25 (15.3%) compared to youth 12-17 (14.4%), and adults 26+ (5.8%).[4] According to the 2018 Connecticut BRFSS, 15.5% of adults reported being told by a doctor that they had a depressive disorder.[5] Similar to the NSDUH, the BRFSS showed a higher percentage among younger adults 18-24 (19.1%), compared to those 35-54 (15.0%) and those 55+ (13.8%).

Serious Mental Illness

In the 2018-2019 NSDUH, young adults 18-25 had a higher percentage reporting serious mental illness (8.54%) than those 26+ (3.86%).[4]

NSDUH Substate Estimates:

Percent Reporting Past Year Major Depressive Episode, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014 - 16	6.64	5.67	7.16	7.42	6.54	6.59
2016 - 18	6.84	6.05	6.93	7.34	7.34	6.43

Percent Reporting Past Year Serious Mental Illness, ages 18+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014 - 16	3.60	3.14	3.59	4.20	3.62	3.67
2016 - 18	4.15	3.84	4.38	4.36	4.28	3.80

[1] NIMH
[2] CDC, Depression and Anxiety
[3] SAMHSA, Adults with SMI
[4] NSDUH 2018-2019
[5] CT BRFSS 2018

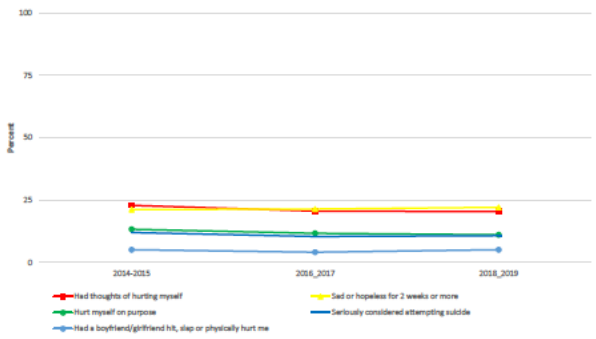
CPES Center for Prevention Evaluation and Statistics

2020 Region 3 Epidemiological Profile: Mental Health

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

SERAC Youth Survey Regional Summary 2018-2019

Trends in Various Mental health Indicators in the Past Year:



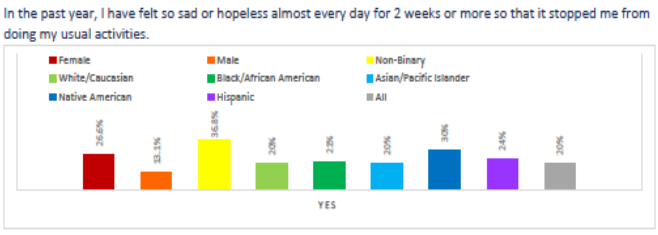
- ☑ In the past year, 1 in 5 youth
  - Report having felt so sad or hopeless for 2 weeks or more that it stopped them from doing their usual activities (22%)
  - Report having had thoughts of hurting themselves (21%)
- ☑ In the past year, 1 in 10 youth
  - Report having hurt themselves on purpose (12%)
  - Report having seriously considered attempting suicide (11%)
- ☑ About 28% of youth **agree** or **strongly agree** that they feel lonely.
- ☑ About 23% of youth **agree** or **strongly agree** that they feel sad most of the time.

Risk Factors and Subpopulations at Risk

- Risk factors for depression and anxiety include[1]:
  - Family history of anxiety, or depression, or other mental illness
  - Experiencing traumatic or stressful events
  - Some physical conditions can produce or aggravate anxiety symptoms, and having medical problems such as cancer or chronic pain can lead to depression
  - Substance use such as alcohol or drugs
- Young adults report higher rates of depression and serious mental illness.[4,5]
- The prevalence of major depressive episodes is higher among adult females than males[1], and among adults reporting two or more races[1]
- The prevalence of any anxiety disorder is higher among females than males.[1]
- LGBTQ individuals are more likely than heterosexual individuals to experience a mental health condition. Individuals who are transgender are four times more likely to experience a mental health condition.[7]

SERAC Youth Survey Regional Summary 2018-2019 Estimates:

Rates of "feeling sad or hopeless…" in the past year by gender and ethnicity:



Mental Health Indicators and Substance Abuse Sub-Analysis Among Youth in Region 3:

Youth who report "I have felt so sad/hopeless for 2 weeks or more that I stopped doing my usual activities":

- Youth who report substance use appear to be more likely (up to 3x) to report having

[6] Connecticut School Health Survey 2019

[7] NAMI

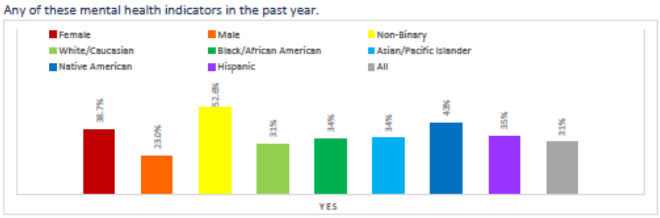
CPES Center for Prevention Evaluation and Statistics

2020 Region 3 Epidemiological Profile: Mental Health

experienced feelings of depression in the past year.

- The difference between users and non-users in the prevalence of having experienced feelings of depression may be greater among middle school youth than among high school youth (any illicit, any prescription drug, prescription drug misuse, other tobacco, marijuana, gambling, electronic cigarettes).

Rates of Any Mental health Indicator in the Past Year Among Youth by Gender and Ethnicity:



Burden (consequences)

- Mental illness (including depression, anxiety, bipolar disorder, among others) is a risk for suicide;
- Depression is the leading cause of disability in the world;[7]
- Mental illness costs Americans $193.2 billion in lost earnings per year;[7]
- 1 in 8 emergency department visits involves a mental health or substance use condition.[7]

Mental Health Treatment Admissions*

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2018	63,148	8,909	16,824	7,956	19,895	9,564
FY2020	58,351	7,421	15,970	7,395	19,237	8,328

*Includes admissions for MH only as well as MH+SA

CT DMHAS Region 3 Mental Health Services:

- 30% of clients received services for mental health alone. This is slightly lower than the other regions in the state. Focus group and key informant information indicates this is likely due to a lack of service providers and access to the existing services.
- 98% of clients in the region access crisis services within the eastern region.
- Only 57% of clients access inpatient or residential services in the region.

Focus group and key informant responses indicate a lack of multi-tiered services within the region. Clients who are unable to access local services are less likely to be engaged and retained in treatment programs for sufficient periods of time in order to reach stability and recovery.

Capacity and Service System Strengths

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

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

The readiness for Region 3 is slightly lower than other regions with regard to mental health promotion. According to the CRS Region 3 report, the greatest mental health concern among 12-17 year old youth is anxiety. The greatest concern among all 18 and older populations is depression. The age group with the highest reported concern for depression is 66 or older. The strongest area of support from the community as reported by key informants is the early identification in children and youth. Information also suggests that residents are concerned about mental health in their communities but maybe uncomfortable discussing the issue. It was also mentioned that there are not sufficient mental health supports in educational settings in region 3. The highest barriers to address mental health promotion were limited financial resources followed by the lack of a regional strategic plan to address mental health needs, and trained staff to serve specific at-risk subpopulations.

CPES Center for Prevention Evaluation and Statistics

2020 Region 3 Epidemiological Profile: Prescription Drug Misuse

Problem Statement

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

Magnitude (prevalence)

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

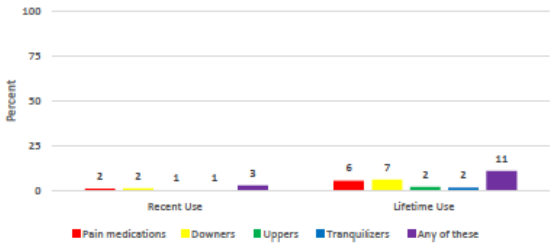
NSDUH Substate Estimates:
Percent Reporting Past Year Pain Reliever Misuse, Ages 12+

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

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

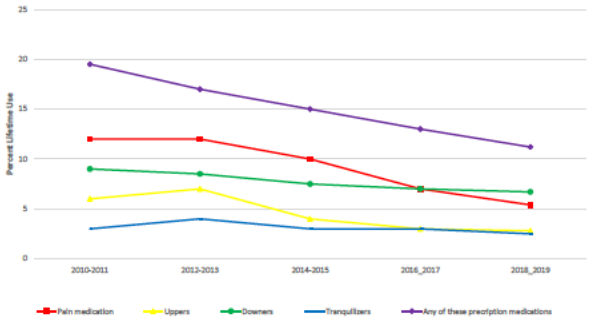
SERAC Youth Survey Regional Summary 2018-2019:

Rates of Recent and Lifetime Use Among High School Students:



Lifetime use of "downers" is the highest category of prescription drug misuse among youth in the region, followed by pain medications.

Trends in Prescription Drug Use Among Youth:



Prescription drug misuse in the region has declined over the years as a whole. The categories of prescription drug misuse that are the biggest concern among youth trends appear to be "downers."

Risk Factors and Subpopulations at Risk

- Persons at risk of misusing prescription drugs include[4] :
  - Those with past year use of other substances, including alcohol, heroin,

[1] NIDA, Misuse of Prescription Drugs Research Report
[2] NSDUH (2017-2018)
[3] Connecticut School Health Survey, 2019 (CT YRBSS)
[4] Bali V. Research in Social and Administrative Pharmacy 2013; 9(3): 276–287.

marijuana, inhalants, cocaine and methamphetamine.
    - People who take high daily dosages of opioid pain relievers.
    - Persons with mental illness.
    - People who use multiple controlled prescription medications, often prescribed by multiple providers.
    - Individuals with disabilities are at increased risk of prescription opioid misuse and use disorders.[5]
- Among all fatal overdoses involving prescription opioids in Connecticut in 2019, the majority occurred among non-Hispanic whites, with male deaths occurring 1.3-2.8 times more frequently than females in each racial/ethnic group[6]
- The elderly population may be at risk of consequences of prescription drug misuse, as they use prescription medications more frequently compared to the general population and may be at higher risk of medication errors[7]
- According to the 2019 Connecticut School Health Survey, Hispanic students had the highest rates of taking prescription drugs without a doctor's prescription (14.2%), significantly higher than White non-Hispanic students (8.0%). The rates among Black students (12.8%) were also significantly higher than White non-Hispanics. The NMUPD rates were slightly higher among females (11.3%) than males (9.1%).[3]

SERAC Youth Survey Regional Summary 2018-2019 Estimates

Rates of Youth Use by Gender:

- Females report slightly higher rates of use of pain killers in the past 30 days (1.7%) than males (0.09%).
- Females report slightly higher lifetime use (5.3%) than males (4.4%).
- Use of recent (30 days) downers is similar across genders (approximately 4.4%) however lifetime use is slightly higher among females (7.4%) than males (6.4%).
- Recent use of "uppers" is also similar across genders (female 1.5%, male 1.7%) as well as lifetime use (female 4.1%, male 4.9%).

SERAC Community Survey 2020

- More than 25% of parents reported that it is "definitely or mostly not true" that they secure prescription drugs in their home.
- 30% of non-parent respondents reported that they do not secure prescription drugs in their home.

Burden (consequences)

- Prescription opioid misuse is a risk factor for heroin and other illicit opioid misuse, including illicitly manufactured fentanyl. While the estimated proportion of individuals who transition to heroin following prescription opioid misuse is low (<5%), a majority of those who use heroin initiated opioid use with non-medical use of prescription drugs (NMUPD).[8,9]
- According to reports from the Office of the Chief Medical Examiner (OCME), Connecticut experienced 1,127 opioid-involved fatalities in 2019, including 131 that involved a prescription opioid; 92 involved oxycodone, 20 oxymorphone, 14 hydrocodone, 15 tramadol, and 14 hydromorphone.[6]
- Approximately 12% of all opioid overdose fatalities involved a prescription opioid, but only 15% of those overdoses involved only the prescription opioid. The majority involved multiple substances; 54% also involved fentanyl, 38% involved benzodiazepines, and 20% involved heroin.[6]
- There were 1062 non-fatal stimulant overdoses in 2018, and 2372 in 2019.[10]

NSDUH Substate Estimates:
Percent Meeting Criteria Past Year Pain Reliever Use Disorder, ages 12+

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

[5] Lauer EA et al. Disability and Health Journal 2019;12(3):519-522
[6] Connecticut Office of the Chief Medical Examiner, 2019
[7] Perez-Jover V et al. Int J of Environmental Research and Public Health 2018; 15:310.
[8] Jones CM. Drug Alcohol Depend 2013; 132:95-100
[9] Muhuri PK et al. CBHSD Data Review, 2013.
[10] CT DPH, EpiCenter

2020 Region 3 Epidemiological Profile: Prescription Drug Misuse

Prescription Drug-Involved Fatal Overdoses in 2019[3]

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
N	126	25	42	13	26	20
Rate	3.53	3.57	5.08	3.08	2.59	3.27

***Rate per 100,000 population**

Treatment Admissions: Other Opiates and Synthetics

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
FY2018	1829	208	662	298	343	318
FY2020	3260	394	904	555	908	499

Region 3 is the 3rd highest region in the state to meet the criteria for past year pain reliver use disorder. It ranks 4th in prescription drug involved fatal overdoes (2019). The number of treatment admissions is ranked 3rd in the region. The region is ranked 3rd for treatment admissions. Focus group information indicated a lack of detox, inpatient, and sober living support services in the northeastern are of the region.

Capacity and Service System Strengths

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

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

According the Region 3 CRS (2020) report prescription drug misuse is the highest concern among ages 66 or older followed by ages 26-65. It was the lowest concern among ages 12-17. Results on community attitudes show that the majority of respondents believe the community are concerned about preventing substance misuse and that it is a good investment in the community. Approximately 30% of respondents felt that financial resources to address substance abuse prevention was a great barrier in the region followed by a lack of trained staff to serve appropriate populations, as well as low community buy-in and low willingness to volunteer.

2020 Region 3 Epidemiological Profile: Problem Gambling

Problem Statement

Problem gambling, sometimes referred to as gambling addiction, includes gambling behaviors which disrupt or damage personal, family, or vocational pursuits.[1] Symptoms include: increasing preoccupation with gambling, needing to bet more money more frequently, irritability when attempting to stop, and continuation of the gambling behavior despite serious negative consequences.[1]

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

Magnitude (prevalence)

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

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

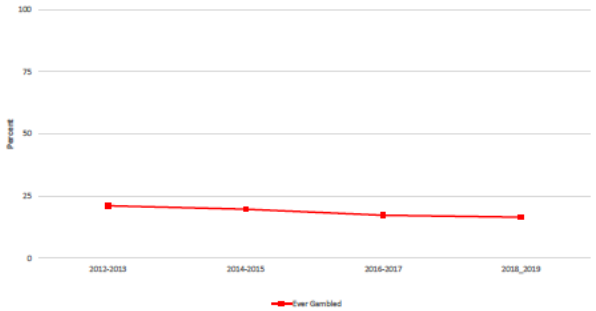
SERAC Youth Survey Regional Summary 2018-2019

- ☑ Overall, about 16% of youth report ever having gambled while 1% of youth report that they gamble on a daily basis.
- ☑ 17.7% of youth report that they have gambled in the past year.
- ☑ 9% of youth report that someone in their family has gambled so much that it created problems at home, at work or with friends.

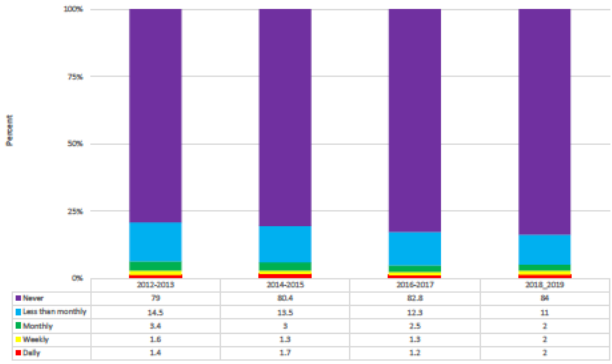
Among youth who report ever having gambled in their lifetime:

- About 30% report ever having tried to cut back on their gambling
- About 11% report that a family member has expressed concern about their gambling
- About 10% think they might have a gambling problem.

Trends in Lifetime Gambling Among High School Youth



Trends in Gambling Frequency Among High School Youth:



Risk Factors and Subpopulations at Risk

Risk Factors include:[4]

- Having an early big win
- Having easy access to preferred form of gambling
- Holding mistaken beliefs about odds of winning

[1] National Council on Problem Gambling
[2] American Psychiatric Association, Gambling Disorder
[3] Connecticut School Health Survey, 2019
[4] Risk Factors for Developing a Gambling Problem, Centre for Addiction and Mental Health (CAMH)

CPES Center for Prevention Evaluation and Statistics

- Having a recent loss or change, such as divorce, job loss, retirement, death of a loved one
- Financial problems
- A history of risk-taking or impulsive behavior
- Depression and anxiety
- Having a problem with alcohol or other drugs
- A family history of problem gambling

- The Connecticut School Health Survey shows that 34.6% of high school males reported gambling, compared to 16.2% of females. The prevalence among 12th graders was significantly higher (31.7%) than any other grade (22.1%-24.3%). Differences among race/ethnicity were not statistically significant.[3]
- Problem gambling rates double for individuals living within 50 miles of a casino.

SERAC Youth Survey Regional Summary Report 2018-2019 Estimates:

Rates reported by gender (all grades 7-12[j]):

- Males report daily gambling (2.0%) more frequently than females (0.4%).
- Youth who prefer ***not to say*** their gender report gambling on a daily basis at 7.6%.
- Youth who prefer to ***self-describe*** their gender reported gambling on a daily basis at 12%.

Burden (consequences)

Treatment Admissions:

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

CT DMHAS Bettor Choice Program

- 291 individuals were treated for problem gambling (2019-2020) in CT.
- 93 of those individuals were in region 3.
- Region 3 has the highest number of individuals of receiving treatment from problem gambling (2019-2020).

CT DMHAS Problem Gambling Treatment Subpopulation Estimates (2019-2020):

- The majority of individuals receiving treatment for problem gambling are white/Caucasian.
- The second highest ethnic population is black/African American individuals at 8%.
- About 7.5% of the treatment population are Hispanic speaking individuals.
- Approximately 3.4% are of Asian/Pacific Islander descent.

Capacity and Service System Strengths

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

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

According to the Region 3 CRS report (2020) key informants believe that the community is concerned about older adults (age 65 and older) being vulnerable to gambling problems. They also reported that the community likely felt like it was more ***okay*** to give youth under the age of 18 lottery or scratch off tickets than to allow youth to gamble with parental supervision. Approximately 73% of respondents felt it was either ***very or somewhat important*** to prevent problem gambling/gaming addiction in the region. About 90% of respondents felt that their community had a low ability to raise awareness about the risks of problem gambling/gaming addiction. Only 32% reported that residents in the region are either ***very or somewhat*** aware that gambling activities can be an addiction for some people.

2020 Region 3 Epidemiological Profile: Suicide

Problem Statement

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

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

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

Magnitude (prevalence)

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

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

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

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

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

According to CTVDRS, Region 3 has experienced 347 suicide deaths between 2015-2021.

SERAC Youth Survey Regional Summary Report 2018-2019 Estimates:

In the past year, approximately 1 in 10 youth:

- Report having hurt themselves on purpose (12%)
- Report having seriously considered attempting suicide (11%)

Region 3 has shown an increased in the number of individuals reporting that they have had serious thoughts of suicide in the past year. Currently, the region has the highest rate in the state of CT.

Risk Factors and Subpopulations at Risk

- On average, men account for 88% of suicides in CT.[3]
- White non-Hispanic males account for 78% of suicides in CT.[3]
- Nationally, non-Hispanic American Indian/Alaska Natives experience high rates of suicide.[1]
- Other disproportionately impacted populations include Veterans and military personnel and certain occupational groups such as construction and sports.[1]
- Sexual minority youth experience increased suicidal ideation and behavior compared to their peers.[1]

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

CPES
Center for Prevention Evaluation and Statistics

- Mental illness is a risk for suicide, including depression, anxiety, bipolar disorder, and general depressed mood.[3]
- For those over 45, other risks include physical illness, such as terminal illness and chronic pain, as well as intimate partner problems.[3]

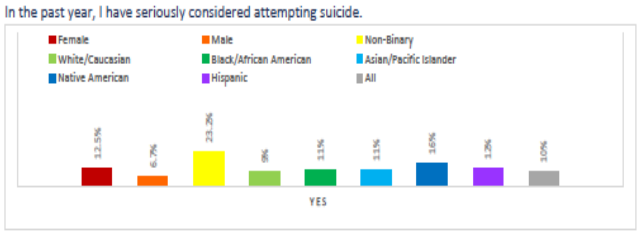
Other risk factors include[1]:

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

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

Data from the SERAC Youth Survey Regional Summary Report (2018-2019) showed that approximately 11.5% of youth in the eastern region of CT think it would be ***very easy or sort of easy*** to access a gun if they wanted to.[8] One in four youth report that it would ***very easy or sort easy*** to access a prescription drug without a prescription. About one- quarter of youth ***agree or strongly agree*** with the statements, "I feel lonely" and "I feel sad most of the time." Nearly three-quarters of youth (64%) report that when they have a problem, they ***often or always/almost always*** talk with a friend. Approximately half of youth (57%) report keeping it to themselves while only about 40% say they talk to a parent or guardian. About 22% of youth report having felt so sad or hopeless almost every day for 2 weeks or more that it stopped them from doing their usual activities in the past year.

Rates of "seriously considering attempting suicide" in the past year by gender and ethnicity:



Suicidality and Substance Abuse Sub-analysis:

*Youth who report that they have "**seriously considered attempting suicide**" in the past year:*

- Are more likely (up to 11x) to report using cigarettes, using other tobacco, using marijuana, using alcohol, using illicit drugs, misusing prescription drugs, using electronic cigarettes or engaging in gambling behavior.
- The difference appears to be greater among middle school- aged youth for cigarette use, other tobacco use, marijuana use, alcohol use, illicit drug use, gambling, and electronic cigarette use.

Burden (consequences)

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

The long-term effects of suicide deaths result in post-traumatic stress and depression for survivors. SERAC

[8] SERAC Youth Survey Regional Summary Report 2018-2019

has provided intermediate assistance in posttraumatic stress management. However, there have been several requests to provide more postventions services and follow up planning session after a suicide death has occurred. In several communities in the region there have been multiple suicide deaths compounding the burden on current residents and institutions that serve the public.

Capacity and Service System Strengths

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

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

Almost 65% of respondents from the CRS in the region indicated that there was ***a lot or some support*** to implement suicide prevention efforts in eastern CT. The majority of respondents felt that the ability was either medium or high to implement activities. Some of the areas that were noted for more capacity building included support groups, regular on-going training, postvention intervention and the assistance to develop local postvention community plans.

Region 3 is currently in Readiness Stage 5: Preparation. The is a clear recognition of the issue and local stakeholder are in agreement that action needs to occur to address suicide deaths in the region. There are several active leaders in the region that provide support and guidance in statewide and regional planning activities.

2020 Region 3 Epidemiological Profile: Tobacco & ENDS

Problem Statement

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

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

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

Magnitude (prevalence)

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

DataHaven's 2018 Community Wellbeing Survey showed 19% of all respondents reported using vape pens or e-cigarettes.[4] This percentage is higher in urban core (25%) and urban periphery (21%) communities, and lower in wealthy communities (14%).[4]

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

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

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

Percent Reporting Past Month Cigarette Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	17.6	15.5	17.6	21.3	17.6	17.5
2016-2018	16.6	13.7	16.1	17.2	17.3	18.6

Percent Reporting Past Month Cigarette Use, ages 12+

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2014-2016	17.6	15.5	17.6	21.3	17.6	17.5
2016-2018	16.6	13.7	16.1	17.2	17.3	18.6

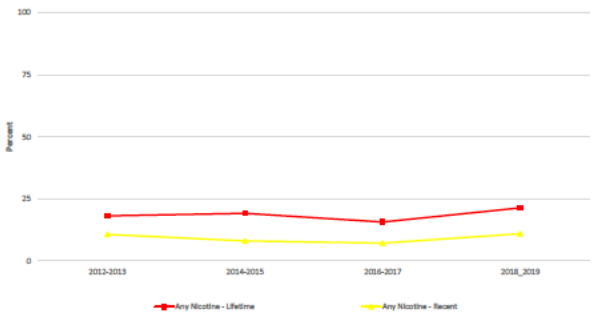
[1] NSDUH 2018-2019
[2] Zheng X. (2018) CT BRFSS.
[3] Connecticut School Health Survey, 2019 (YRBS)
[4] DataHaven and Siena College Research Institute (2018). 2018 DataHaven Community Wellbeing Survey.

CPES Center for Prevention Evaluation and Statistics

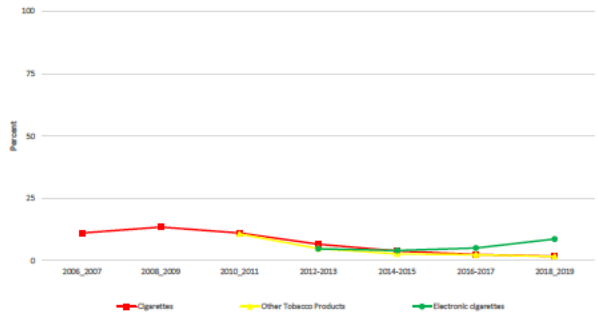
2020 Region 3 Epidemiological Profile: Tobacco & ENDS

SERAC Youth Survey Regional Summary Estimates:

Trends in Recent Use Among High School Students in Region 3 (All Nicotine)



Trends in Recent Use Among High School Students in Region 3 (Cigarette, Other Tobacco, Vaping)



Overall, cigarettes and tobacco use have shown a decline in the region in the past decade. Electronic nicotine delivery devices have seen an increased since becoming an emerging trend in 2012. One in 5 youth (age 12-17) reported that either a parent or guardian smokes in their home and approximately 9% use ENDS. In the spring of 2020, SERAC conducted an online community survey of adults in the region (parents and nonparents). Between 9-11% of all adults reported that someone in their household smokes cigarettes and 8% use electronic cigarettes.[5] Almost 20% percent of youth report that it is ***definitely not true or mostly not true*** that their family has clear rules regarding smoking cigarettes, other tobacco use, or the use of ENDS. Less than 5% of parents and nonparents reported that it is ***definitely or mostly*** not true that they have clear rules.

Risk Factors and Subpopulations at Risk

Populations at-risk for smoking cigarettes are[6]:

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

Populations most at-risk for using ENDS are:

- Youth (12-17)[7]
- Young adults (18-34)[1]
- Males[1]
- Hispanics[1]
- Current smokers
- Those living in urban communities[4]
- Adults from households earning less than $35,000[2]
- Adults with disabilities[2]
- Those with a high school diploma or less[2]
- Adults without health insurance[2]

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

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

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

[5] SERAC Community Survey 2020
[6] CDC (2020), Current Cigarette Smoking Among Specific Populations- United States
[7] Centers for Disease Control and Prevention. (2019). Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults. Retrieved from https://www.cdc.gov/tobacco/basic_information/e-cigarettes/

in females (30.0%) than males (24.1%). White students reported significantly higher use (30.0%) than Black students (19.4%). Current use among Hispanic students (26.0%) is also significantly higher than Black students.

SERAC Youth Survey Regional Summary Estimates:

Rates of use by Gender:

- The rate of females and males who report cigarette use is approximately the same (2.6%, 2.0%).
- Lifetimes use of cigarette use was higher for males at 8.3% than females at 6.3%.
- Rates of other tobacco use is higher for males (3.6%) than females (1.4%).
- Lifetime use of other tobacco is also higher for males (9.9%) than females (3.1%).

Perception of Harm and Access:
Approximately 80% of youth (age 12-17) in the region report that they feel there is a ***great or moderate risk*** associated with smoking cigarettes (1 or more packs a day). Only a little more than 60% of youth report that there is a ***great or moderate risk*** associated with electronic cigarettes. Almost half (46%) of youth report that is would be ***very easy or sort of easy*** to get electronic cigarettes if they wanted to, compared to roughly 34% for cigarettes.

Burden (consequences)

- Evidence shows that young people who use e-cigarettes may be more likely to smoke cigarettes in the future.[6]
- A recent CDC study found that 99% of e-cigarettes sold in the US contained nicotine, which can cause harm to parts of the adolescent brain that control attention, learning, mood, and impulse control.[6]
- E-cigarette aerosol can contain several potentially harmful substances, including diacetyl (in flavorings), which is a chemical linked to serious lung disease. It can also contain volatile organic compounds, cancer causing chemicals, and heavy metals such as nickel and lead.[6]
- Some ENDS devices, including those that are particularly popular among youth, have been modified to allow for higher doses of nicotine to be delivered. They also facilitate the use of THC, and in higher potency. This is especially problematic in youth use, because of the increased risk of tobacco and cannabis use disorders later in life.[8]
- As of January 7, 2020, a total of 2,602 cases of e-cigarette or vaping product use-associated lung injury (EVALI) had been reported to the CDC across all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Of these, 57 resulted in deaths. The median age of these patients was 24 years old, and 62% were between 18 and 34 years old. EVALI appears to be primarily driven by the use THC-containing vaping products, possibly due to substances, such as vitamin E acetate, added to the formulations. [7]

SERAC Environmental Scan Results in 2019:

- In 2019 SERAC conducted environmental scans through 5 school districts to collect informal information on the amount of confiscated ENDS/vaping devices for THC residue. Approximately 18% of devices showed some level of THC residue.

Capacity and Service System Strengths

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

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

In region 3, about 55% of key informants reported that electronic nicotine delivery devices/vaping were the top concern among youth ages 12-17 whereas only 1.7% reported the same for tobacco/cigarettes. Focus group respondents reported that the concern to ENDS/vaping is possibly linked to marijuana use among youth. Several school systems have done THC testing on confiscated ENDS. The capacity and readiness to address ENDS/vaping has increased due to increase in public education and awareness activities through the work of local prevention councils and school systems.

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

Priorities

Ranking	Priority Issue	Mean Total Score
1	Suicide	21
2	Depression	19
3	Anxiety	19
4	Alcohol	19
5	Heroin/Fentanyl	19
6	Trauma	19
7	Prescription Drugs	18
8	Electronic Nicotine Delivery/Vaping	18
9	Post-Traumatic Stress Disorder	17
10	Serious Mental Illness	17
11	Marijuana	16
12	Early Serious Mental Illness	16
13	Serious Emotional Disturbance	16
14	Tobacco	15
15	Problem Gambling	15
16	Cocaine	14

Ranking	Substance Abuse Priority Issue	Mean Total Score
1	Alcohol	19
2	Heroin/Fentanyl	19
3	Prescription Drugs	18
4	Electronic Nicotine Delivery/Vaping	18
5	Marijuana	16
6	Tobacco	15
7	Problem Gambling	15
8	Cocaine	14
Ranking	**Mental Health Priority Issue**	**Mean Total Score**
1	Suicide	21
2	Depression	19
3	Anxiety	19
4	Trauma	19
5	Post-Traumatic Stress Disorder	17
6	Serious Mental Illness	17
7	Early Serious Mental Illness	16
8	Serious Emotional Disturbance	16

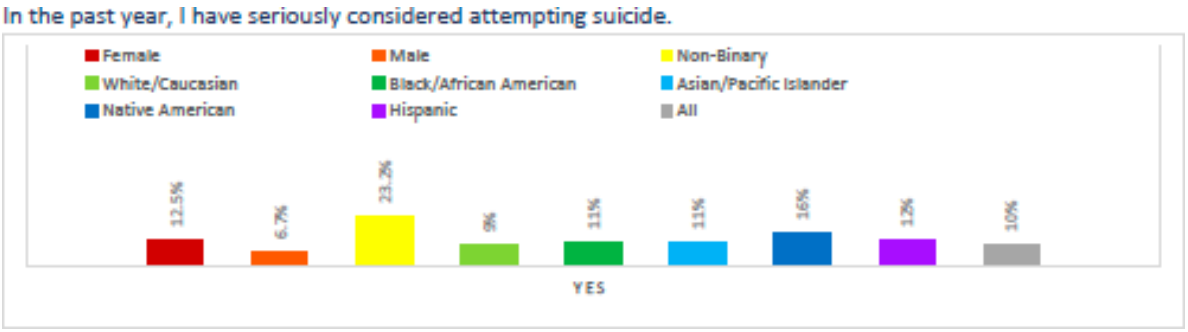
Key Findings

Priority Issue: Suicide

The consequence of inaction regarding suicide was ranked as the top indicator for prioritization. Impact was ranked as the second highest indicator. Changeability was ranked higher than previous years indicating that awareness and prevention activities have had an impact on the stigma that *suicide is not preventable.* Among key stakeholders, suicide is seen as a preventable issue with opportunities for early intervention and they have received increased training throughout the past years. Members reported magnitude and capacity/readiness as the lowest factors in addressing suicide. This is largely due to a lower workforce, lack of prevention funding, and training for early intervention and consistent local level response planning to post-vention. It was also noted that the culmination of risk factors across mental health, substance abuse, and problem gambling place individuals at the highest levels of suicide risk. Suicide was deemed as the highest priority evidence by the data in the epidemiological profiles and quantitative data sources that show Eastern CT as the highest region in the state for suicide attempts and suicide deaths. Most recently, in the past year during the pandemic the region has seen a rise in deaths. Qualitative information indicated that youth feel like a burden on parents and teachers in light of the changes and stress presented by the pandemic. This includes additional time and counseling at school, asking for academic assistance and advising, childcare, parental monitoring, financial and technology challenges, along with basic needs.

Below is a chart of the rate of youth that have seriously considered suicide by subpopulation. This chart shows responses from 34 communities across the state of CT since 2015.

Figure 1: Seriously Considered Attempting Suicide Rates Among CT Youth (SERAC 2015-2019)



Sub-populations among youth:

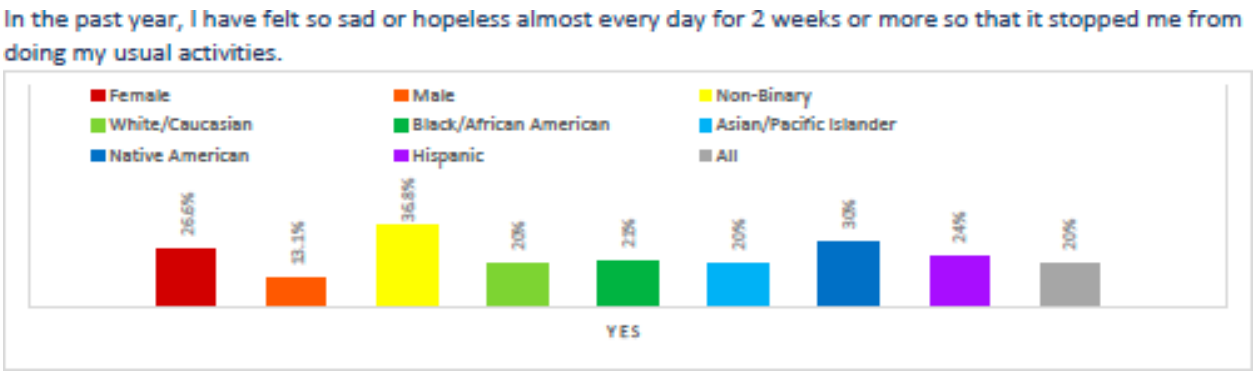
Both qualitative and quantitative data indicate priority concerns among youth sub-populations that are nonbinary, native/indigenous, and female. The rates of youth who have ***seriously considered attempting suicide in the past year*** among white/Caucasian males among youth appears lower than other subpopulations including Hispanic speaking, black/African American, and Asian/Pacific Islander. While current rates over the lifespan of suicide deaths typically indicate a white/Caucasian male as the highest population of concern there is data to support that prevention efforts among youth should be targeted to subpopulations in ethnic and gender minority groups (including new trends in immigrant and transgender populations). Other subpopulations that were identified at higher risk for suicide included youth who are transitioning school systems, transient families, first responders, teachers, healthcare workers, small busines owners (including private practices and banks), veterans and military individuals returning from Iraq/Afghanistan) and single adult households.

<u>Priority Issues: Depression, Anxiety, Alcohol, Heroin, and Trauma</u>

Depression was ranked as the top mental health concern in the region. The top indicator for this ranking was magnitude. This was supported through both local youth survey data and focus groups showing that depression was a primary issue both prior to the pandemic in 2020 and as an emerging concern as we transition back into typical schedules for both

employment, school, and social settings. Also, the lack of access to treatment during the pandemic and intrepidness of individuals to begin or maintain treatment through telehealth services has also contributed to growing rates of depression. Depression is also a risk factor for suicide. Participants in focus groups reported that the co-occurring nature of these issues was very significant. Other issues related to depression that were mentioned included exposure to increased discrimination and prejudice (particularly among nonbinary gender identifying individuals, native/indigenous, Asian/Pacific Island Americans and black/African Americans). These risk factors were exacerbated through social media messaging and events of civil unrest. Isolation during the pandemic placed individuals at risk for low spiritual connectivity and low social support. Another key risk factor that was noted in depression was dealing with the loss of loved ones related to covid-19. There is a lack of bereavement services across the region to assist individuals to deal with loss. Overall, key informants emphasized a rise in helplessness and low self-efficacy, coupled with a fear for physical health and safety. Followed by magnitude, the next ranked indicators were high in the areas of impact and consequence of inaction. Participants felt there was a medium level of changeability and a low to medium level of capacity and readiness.

Figure 2: Past Year feeling Sad or Hopeless Every Day for 2 Weeks or More Among CT Youth (SERAC 2015-2019)



Anxiety was ranked similarly to depression with high scores in the area of magnitude followed by impact and consequence of inaction. Issues related to anxiety that were noted among focus groups included an increase in social anxiety among school aged children, lack of

basic needs (particularly food insecurity), increase in eating disorders, a rise in autism and social emotional challenges, increased anxiety related to contracting covid-19, complications and receiving vaccines, and issues related to agoraphobia. Changeability was ranked as medium indicator with a low to high capacity and readiness to address the issue across the reason. Issues related to lower capacity and readiness appear to stem from the need for a higher level of collaboration with local social service agencies, the lack of social services agencies (specifically in the northeast region) and the integration of mental health screening in universal and primary settings that are consistent, culturally intelligent and inclusive, with regular follow up procedures to at risk individuals prior to a crisis or incident.

Alcohol is ranked as the substance with the highest magnitude of all substances and problem gambling. Alcohol is still the most commonly misused legal substance among all populations. Indicators for impact and consequence of inaction are also ranked high. Prevention efforts are aimed at reducing underage drinking and youth access to alcohol. Less attention has been placed on the prevention and early intervention of youth ages 18-25 and binge drinking. Capacity/readiness was ranked at medium and the lowest indicator was changeability. The low changeability is believed to be a direct impact from the increased promotion of alcohol use during the pandemic. Social and family norms that are favorable toward alcohol use as a coping mechanism throughout the pandemic are contributing to the increased concern in a rise in alcohol misuse and abuse across all subpopulations. Focus group information provided deeper insight on possible higher risk population for alcohol misuse and abuse in CT including individuals with co-occurring mental health issues, youth ages 12-17, young adults ages 18-25, LGBTQIA individuals, youth and young adults with high ACES scores, individuals with family use and history (particularly mentioned was older sibling use), and emerging adults entering into the workforce.

Heroin and illicit opioid use are viewed as the issue with the highest impact, consequence of inaction, and capacity and readiness in the region. This is largely due to heroin and illicit opioid deaths in the past few years. Local public health leaders have formed task forces to address heroin related deaths at the town level. Norwich, New London, Windham, and Putnam have all developed local collaborations with police, hospitals, treatment providers,

and social services to address barriers to accessing resources and distributing naloxone to prevent overdose deaths. Quantitative data shows that heroin use and related deaths are relatively low. The concern for fentanyl use and other illicit opioids is a primary concern within this substance category.

Table 1: SERAC Youth Survey Regional Summary Estimates of Heroin/ Opioid Use 2018-2019

		Grade						
		7	8	9	10	11	12	Total
Pain Medications	Never	93.0%	93.2%	94.7%	93.9%	94.5%	94.9%	94.1%
	Lifetime	7.0%	6.8%	5.3%	6.1%	5.5%	5.1%	5.9%
	Recent	1.6%	2.0%	1.4%	1.7%	1.1%	1.2%	1.5%
Heroin	Never	99.9%	99.7%	99.8%	99.7%	99.6%	99.7%	99.7%
	Lifetime	n<5	n<5	n<5	n<5	0.4%	n<5	0.3%
	Recent	0.0%	0.0%	n<5	0.0%	n<5	n<5	0.1%

Trauma was ranked as the 3rd issue with the highest magnitude in the region. Quantitative information on specific rates of trauma in the region is a gap in data collection efforts. Even with the lack of local quantitative data, focus groups, and open-ended surveys, indicated that the effects of the pandemic have had a tremendous influence on the number of individuals experiencing trauma. These issues are related to experiencing a collective trauma by all residents in the region during the past year. Other anecdotal information indicated that there were increases in child neglect (educational and basic needs). Statements from students such as "*feeling I am stuck in an escape room"* and references to the day "*the world shutdown"* have indicated that a lack of safety and security have been primary risk factors for trauma. Issues related to grief and loss of freedom as well as structured routines have resulted in shattered assumptions for both youth and adults about the current state of events and unknown future. Youth and adults speak frequently about a "covid/quarantine" anniversary date in March demonstrating signs of flashbacks and emotional distress. Youth report experiencing vicarious trauma from teachers and adults, noticeably trying to cope with the burden on adults both in the workplace and the home. In addition, the direct loss of family and friends to covid-19 and the media coverage of death tolls have presented traumatic experiences for populations across the lifespan. Some target subpopulations may include:

ethnic minorities at higher risk for covid-19 (native indigenous, black/African Americans), youth at transition years (high school graduates and first year freshman), unemployed individuals, first responders and frontline health care workers, elderly populations and single adult dwelling households. Both the impact and consequence of inaction were ranked as high indicators for ranking and the changeability and capacity/readiness were ranked as medium.

Priority Issues: Prescription Drug and Electronic Nicotine Delivery Systems

The highest concern of prescription drug use was the consequences of inaction. The magnitude for prescription drug was ranked as a medium indicator. The indicators of impact, changeability, and capacity/readiness were also ranked as medium. CNAW members noted the progression from prescription drug use to heroin as a major concern. This is supported by the experimentation rates of prescription pain medications among youth across the region. However, the capacity to address prescription drugs has a slightly lower ranking in part due to the controlling agents of the supply at both the pharmaceutical and black-market production levels. Community members often report that this issue is challenging from a local and grassroots effort when combating risk factors such as Big Pharma and internet drug trafficking. Nonetheless, prescription drugs were ranked as the third substance of priority for the region falling above tobacco/nicotine, marijuana, and cocaine. More information and data are needed on the misuse of various types of prescription medications among subpopulations.

The ranking process this year separated the issues of tobacco and electronic nicotine delivery systems in order to assess to better understand the nuances of “vaping trends.” ENDS/vaping was ranked with a medium to high magnitude. All other domains including impact, changeability, capacity/readiness and consequence of inaction were ranked medium as well. Local prevention councils and schools request training and informational sessions on “vaping” fairly regularly. Focus group members noted that many youth are using electronic vaping devices to ingest marijuana (flower and liquid). The recent legislation to legalize adult use of cannabis in the state of CT has increased the concern that “vaping” trends will increase. However more data needs to be collected regarding the contents of the electronic vaping devices that are confiscated at school and being used by underage youth.

Priority Issue: Marijuana

Marijuana highest indicator was magnitude. This supports the anecdotal information that the concern for vaping marijuana is a primary concern for the region. Both the impact and the consequence for inaction were ranked as medium concern with changeability and capacity /readiness indicators ranked at low. Members acknowledge that marijuana use has increased, and the perception of harm has decreased since the passage of decriminalization laws and the implementation of the state medical marijuana program. Marijuana use is also being consumed through ENDS and in edible forms making it more difficult to detect. Messaging regarding the harm associated with marijuana use is often challenged by youth and adult members of the public. Prevention professionals indicated their concern for the growing use of marijuana among youth under age 18 as well treatment providers indicated the growing number of clients seeking treatment for cannabis use disorder.

Figure 3: Illicit Drug Use Among High School Youth

SERAC Regional Youth Survey Summary 2018-2019

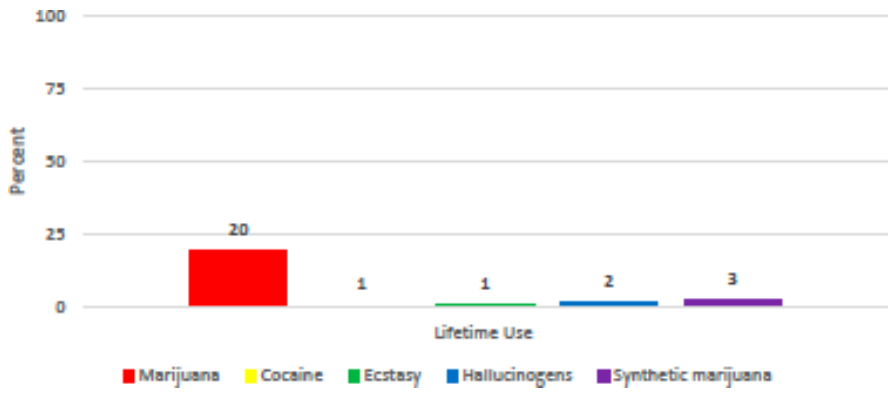
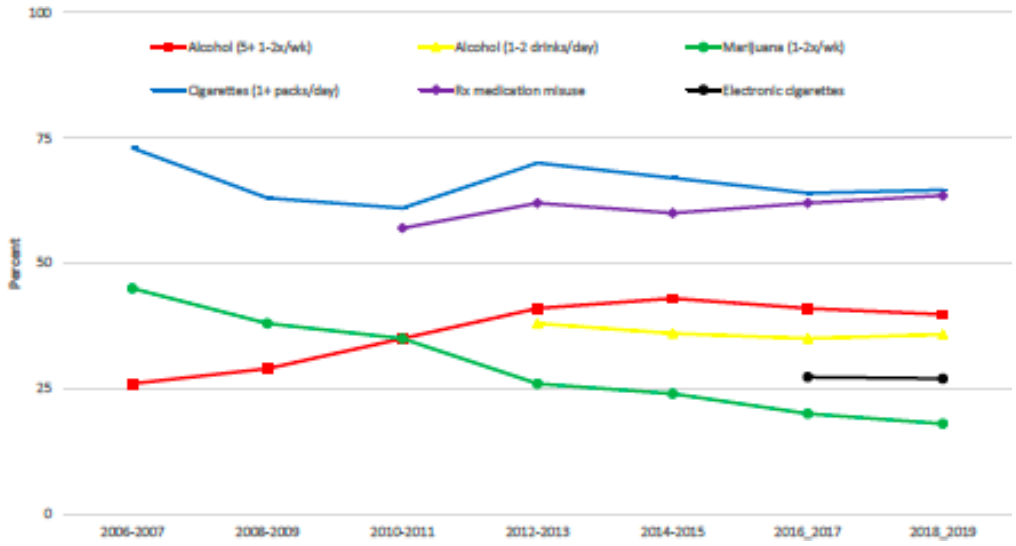


Figure 4: Trends in Perceived Great Risk of Substances Among High School Youth

SERAC Regional Youth Survey Summary 2018-2019



Priority Issues: Post-traumatic Stress-Disorder, Serious Mental Illness, Early Serious Mental Illness, Serious Emotional Disturbance

Post-traumatic stress disorder was ranked as a medium concern across indicators as a priority of for the region. Serious Mental Illness was slightly lower with the indicators of changeability and capacity/readiness falling in the lower range. Both Early Serious Mental Illness and Serious Emotional Disturbances also ranked similarly showing the lowest indicators of changeability and capacity/readiness as well. The highest area was the consequence of inaction for Serious Mental Illness. Key prevention sector representative had the least knowledge regarding these issues and how best to prevent clinical disorders from a community-based level. Risk factors and intervention related to these issues are often individualistic and vary a great deal in range and severity.

Priority Issues: Tobacco and Problem Gambling

Tobacco was ranked second to last as the substance with the lowest magnitude in the region. All other indicators (impact, changeability, capacity/readiness, and consequence of inaction) were all ranked as medium concern. Focus group members noted that they have seen a decrease in cigarette and other tobacco trends recently due to protective factors related to the pandemic. These factors include lower access to cigarettes and other tobacco use, targeted prevention education and local campaigns spearheaded by local prevention councils, the statewide age increase from 18 to 21, and general health related concerns for respiratory related risk factors and covid-19. It was also noted that students who attended school in-person were more closely monitored in bathrooms and restrictions in social gatherings contributed to recent decline in tobacco use.

Problem gambling is viewed as the 2nd to lowest priority for the region. Members viewed problem gambling with a high magnitude, impact, and consequence of inaction but the changeability and the readiness/capacity for the region is low. Main challenges for problem gambling are the continued need to integrate problem gambling prevention into existing mental health and substance abuse prevention activities. Individuals primarily associate gambling behavior solely with gambling activities at the two casinos in the region. Low awareness of other types of gambling present risk factors for addiction such as keno, sports betting, online gambling, and gaming. The low prioritization of problem gambling is likely related to the lack of knowledge on evidence-based prevention strategies related to gambling such as addressing public policy, minimum age restrictions, promotion of gambling in the region and favorable community norms that view gambling as entertainment. There is still denial and lack of acceptance of problem gambling as an addiction (often similar to the stigma associated with substance use and bad choices).

Priority Issue: Cocaine

Cocaine was ranked as the lowest priority issue for the region. The indicators of impact and consequences of inaction were ranked as medium concern. Members ranked the indicators of magnitude, changeability, and capacity/readiness as low. . Members seemed to be

the least knowledgeable on the local and regional incidents related to cocaine use and its' social impacts.

Emerging Issues

The most frequent issue among mental health, substance abuse, and suicide was the need to increase access to services and staff and funding. Issues with capacity and the workforce particularly in the northeast corner were present before the pandemic but have become heightened in light of the new barriers that have been presented to accessing treatment especially in rural communities where technology and internet access can be challenging. Following this issue were the issues related to COVID such as isolation, anxiety, housing, financial issues, and job loss. The worry was frequently expressed that the pandemic has overwhelmed people and they may be turning to substances in order to cope. Marijuana legalization concerns were noted here as well. Specific to suicide, youth mental health during the transition to college and the effects of social media were noted as a population and risk factor that are likely to present heightened concerns due to the lack of long-term planning for transition during the pandemic. It was also noted that sleeping issues and disorders among youth and adults are increasing. There is limited information on this current trend but it can be assumed that it related risk factors may include increased anxiety, depression, trauma, life event stressors.

COVID-19 Pandemic

The number one COVID-related issue across substance abuse, mental health, and problem gambling from the key stakeholder survey was the lack of access to resources due to the pandemic. Issues included the closing of offices, clients not having access to virtual meetings, and the ineffectiveness of virtual treatment (e.g., "sometimes virtual isn't enough"). A related concern was engagement and retention in programs. Many respondents expressed concern about meeting attendance, the availability of meetings, and the lack of engagement and feelings of support with virtual meetings. Similarly, a concern was expressed about the inability to monitor for warning signs of problem behavior and poor coping due to isolation.

Substance Use and Problem Gambling

While cocaine use was ranked as the last priority issue for the region, anecdotal information suggests that cocaine use may be an emerging trend and a concern for the region. Cocaine involved deaths in the eastern region are the 3rd highest in the state. Anecdotal information suggests that cocaine is laced with fentanyl and other synthetic opioids. The concern for an increase in stimulant use has been noted most recently with an added concern of increases in methamphetamine use. Populations at higher potential for risk are college students who are struggling with the transitions and inconsistency of schedules, hybrid classes, and the impact of living on/off campus during a pandemic. While marijuana and "vaping" did not rank among the top priority issues in Region 3 it is an emerging trend among adults and youth. Informal observations have confirmed that confiscated electronic nicotine delivery systems have tested positive for THC in multiple local school systems. The promotion and availability of cannabidiol (CBD) products in the state and region has presented some concerns regarding the distinction between pure CBD products and those that may also contain tetrahydrocannabinol (THC). Inconsistent information is available to the public and there are limited ways to ensure product efficacy.

Mohegan Sun Casino and Foxwoods Casino are both located in the southern sub-region. While casino expansion remains a risk factor for problem gambling disorder, efforts to expand gambling through online venues such as iLottery present a unique risk to individual subpopulations such as youth, college students, and those without transportation. Sports betting continues to be an emerging trend among youth and college populations. The eastern region of CT has seven collegial institutions: University of CT, Connecticut College, Eastern CT State University, Coast Guard Academy, Three Rivers Community College, and Quinebaug Valley Community College, and Mitchell College. Other at-risk populations include youth under age 18 and elderly populations with limited income.

Resources, strengths, assets in the region

Prevention

The most noted strength of prevention work across substance abuse, mental health, and problem gambling was efforts to educate youth and the community and public education. Second, most noted strength was the level of community support to implement support groups and community activities. Senior Centers, libraries, and food pantries were specifically noted as local resources for population level information dissemination. Local level digital newsletters, info briefs, and marketing campaigns were mentioned as a strength in the region. The primary local level strength is the coordination of local prevention councils that represent key sectors in the community to address substance abuse. A strength in the south sub-region is the availability of youth data collected through the SERAC Youth Survey and local prevention coalitions. The north sub region has far less local youth data. Efforts to engage the school and youth serving sectors to collect data is a need in the northern sub-region. Some of the strengths across the region include multiple safe disposal sites and recurrent local efforts to promote national take back events. Community collaboratives for youth mental health and juvenile justice are also a strength in the region. There are two systems of care collaboratives: Southeastern Mental Health System of Care and Tri Collaborative. There are several summer camps in the area including a Department of Social Services funded Camp Quinebaug for youth with special needs. There is a YMCA in Putnam that offers a variety of recreational services along with the very well-established Mansfield Recreation Center. There is also a local interagency service team in the south sub-region as well as a regional youth service bureau network.

Treatment and Recovery

Treatment efficacy was often noted as the greatest strength of all topics, followed by access to services and support groups. Many members noted that the ability for some providers to transition to telehealth services during the pandemic was an asset. For some individuals who had difficulty maintaining in-person appointments prior, the increased support and allowance for insurance to cover telehealth was extremely helpful in maintaining recovery and increasing engagement in treatment on a regular basis. For individuals who struggled with social anxiety, the use of technology was a tool that helped clients to feel more at ease and comfortable in their sessions. Due to this increase in telehealth services, clients were also able to participate in more intensive programs and sessions than they had previously been able to commit to. In parts of the region, it was noted that the SEAT bus transportation system was an asset and strength for clients because the schedules and routes being in line with appointments and sessions. Continued/ongoing access to support via organizations and community support groups was the most often noted strengths of the recovery phase of all three categories. Having a support plan in place for the recovery process was also often noted. The ongoing activities and supports of the clubhouses particularly in the northeast region have been an asset and strength before, during, and after the pandemic. It was also mentioned that AARP was also offering support groups through virtual platforms and individuals have accessed them and been very satisfied with the service.

Resource gaps and needs in the region

Prevention

Across substance abuse, mental health, and problem gambling the most common responses included the need to increase education and awareness among youth, parents, and the community as well as increasing access to service and resources and recovery support. It was often reported that there simply are not enough members in the workforce to reach all populations across the region. There is an increased need to obtain local data. Since many data

collection activities were canceled due to the barriers related the pandemic, 2020 will present a "gap year" in data. There was previously limited data in the north region prior to the pandemic but recent barriers have made setbacks in the efforts to collect student survey data and community-based survey information.

The number one cited barrier to suicide prevention was lack of awareness and education, notably the ability to identify the warning signs and the need for more education efforts in the community. The stigma associated with suicide was the second barrier – which leads to a lack of communication and an avoidance or "denial" of suicidal thoughts and/or ideation. The third barrier was a lack of resources, including a lack of social support and a lack of access to support services.

Treatment and Recovery

Access to services and the ineffectiveness of the current level of care were the most frequent responses to these questions. Specifically, many respondents noted that there simply were not any clinics in their town or that the availability of resources were taxed (e.g., lack of beds, understaffed, underfunded) and expressed the desire for more funding and advanced training for current staff. Barriers to care were also noted as needing to be addressed. Most frequently, lack of transportation and housing issues were expressed as well as a desire to incorporate some kind of program to solve these barriers in their community. The most important issue noted repeatedly was access to care and the barriers of both the client and the organization. Higher funding to hire more staff, increase the salary of staff to avoid burnout, and to create accessible locations for clients was also listed as primary needs. Also, the need for increased outreach efforts and disseminating education materials was noted.

The 39 towns in DMHAS region 3 have the widest variability in resources. The north sub-region (communities in Windham and Tolland County) are the most limited in all areas across the behavioral health continuum (prevention, treatment, recovery). Access to treatment in the north sub-region remains a primary concern with transportation barriers and local availability. There is no bus system in the north sub-region and the vendor who provides a medical cab is reported to be unreliable at times. This creates many problems for people

seeking medical help or mental/behavioral health services as they often do not arrive on time or even get picked up at all. Agencies are forced to discharge patients because of missed appointments. There has been some challenges to maintain the needed technology such as computers, smart phones, tablet devices, and internet access. There is also a limited number of providers in the region to provide culturally inclusive services and supports.

Underserved Subpopulations

Substance Use. Low-income individuals, Spanish-only speakers, minorities and people of color, veterans, LBGTQI, the very young, and senior citizens were identified as underserved populations. The most frequent response was minorities and people of color generally, but specifically noting the issue of the language barrier with Spanish-only speakers and the lack of resources available to them.

Mental Health. Senior citizens were listed most frequently as being underserved in the area of mental health, followed by the LGBTQI community and Spanish-only speakers, respectively. Caregivers of the elderly, low-income individuals, and children of drug/alcoholic parents were also listed.

Gambling Problem. The LGBTQI community was most frequently listed as underserved in this category. Low-income individuals, Spanish-only speakers and people of color, seniors, veterans, and specifically Asians were also mentioned.

Conclusion/Recommendations

Regional

In conclusion the regional priority report demonstrates the clear need to prioritize co-occurring mental health and substance abuse issues for future regional and local planning purposes in conjunction with a strong emphasis on addressing disparate and at-risk subpopulations that have been noted. In terms of what could be done to address health disparity, the most frequent response was to continue to offer workshops and education materials for providers and families, in both English and Spanish. It was also suggested that SERAC could try to increase financial aid for communities by identifying grant funding that would help support local efforts. Local technical assistance to address the needs of

communities and outreach efforts in order to link small rural communities with limited resources was noted as critical gap that can be filled in prevention, treatment, and recovery.

State

DCF & DMHAS. In regard to what service systems could do differently to serve the subpopulations mentioned in the previous questions, the most frequent response was to increase the access to services, their capacity to meet needs, and increase their staff. It was often expressed that DCF is understaffed and unable to support the communities in the way they need. Increasing efforts to educate and spread awareness was also a common answer as well as addressing client barriers, such as homelessness/affordable housing and transportation. More generally, it was suggested that DCF & DMHAS conduct research to understand and address the needs of the communities they serve in the new climate since the pandemic.

Regarding substance abuse specifically, there was some concern about the legalization of marijuana in CT and the imminent need to research and plan for prevention strategies to handle this emerging issue. Similarly, the need to implement more secondary prevention strategies, such as decriminalization and harm reduction strategies, was also recommended.

Recommendations

- Almost 30% of respondents in the CRS, 2020 indicated that financial resources were the greatest barrier to substance abuse prevention efforts in region 3 and efforts to secure long term sustainable prevention funding was a critical issue.
- Implementation of bereavement and grief groups in schools for students and teachers dealing with the loss of individuals from suicide, overdose, covid 19, and/or other critical losses.
- No cost/sliding scale 6 sessions for stabilization (early intervention model not clinical).
- Conduct regional data collection/study on risk factors for mental health crisis, challenges, disorders in the region.

- Increase universal screening for early suicidality risk factors in community-based settings.
- Universal screening for ACES in school systems and youth serving organizations.
- Mental health services tailored for individuals who experienced covid or loss someone from covid.
- Distribute mental health and addiction resource information at covid testing and vaccination clinics.
- Develop a state or regional parent-focused education campaign on mental health.
- Incorporate family therapy in school settings.
- Incorporate workplace wellness programs (incentives to businesses to participate).
- Increase subclinical programs and secondary prevention efforts.
- Target outreach to disparate population regarding warning signs and risk factors beyond Hispanic speaking populations.
- Expand treatment to include youth and young adult gaming and internet addiction disorders.
- Increase detox, treatment, long term care facilities, and sober homes in the northeast corner.
- Focus ATOD prevention efforts to target emerging adult populations.
- Expand suboxone access in the northeast CT.
- Develop a positive statewide or regional asset prevention campaign.
- Develop regional strategic prevention plans.
- Increase mental health services and support groups in school settings.
- Increase intensive outpatient mental health services for youth and children in eastern CT.
- Develop a regional or statewide community awareness/education plan to educate youth and adults on the new laws regarding the legal age for cannabis use in CT.

Statewide recommendations:

- Develop a consistent electronic system for student records across school systems so information is not lost in transitions from one school to another.
- Create statewide certificate programs for mental health, addiction, suicide prevention to increase the capacity of the current workforce in their current positions through the CCB.
- State budgeted prevention funding that is not solely dedicated to federal funding and changes.
- Develop a plan to secure a percentage of taxes and revenues from legal substance sales and gambling.

Summary of Priority Recommendations Region 3

Problem/Issue	Prevention	Treatment	Recovery
Substance Abuse/Misuse			
Region	Regional education and community awareness plan on new policies on adult cannabis use.	Increase detox, treatment, long term care, and sober living homes in the northeastern corner.	Increase support groups for children who have lost parents/family/guardian to overdose or current substance use.
State	Develop a plan to secure funding at the state level based on percentages of revenue and taxes from legal substances and gambling.	Expand suboxone access in the northeast corner.	N/A
Mental Health			
Region	Provide 6 no cost/sliding scale sessions for subclinical services to provide secondary prevention and intervention through education, training, and culturally appropriate engagement.	Increase intensive outpatient mental health services in Eastern CT for children.	Increase targeted support groups for individuals experiencing loss, trauma, and grief from the pandemic based on the identified populations in the priority report.
State	Develop a plan to create a consistent and universal electronic system for youth transitioning between communities and schools.	Increase funding to expand treatment providers in the northeast area of the region.	Implementation of a statewide peer support program for mental health recovery.
Problem Gambling			
Region	Increase data collection through a regional study on risk factors for problem gambling disorders.	Expand treatment services to include youth gaming and online addiction disorders as possible co-occurring disorders.	Implement youth support groups and alternative activities for gaming, internet, and gambling addiction.
State	Increase prevention funding across the 5 regions to increase readiness and awareness.	Increase clinical workforce to specialize in problem gambling/gaming disorder.	Develop a state plan to implement consistent support groups across the lifespan.

Appendix A: Priority Ranking Matrix Mean Scores

Mental Health and Suicide

SCALE: **1=LOWEST** **2=LOW** **3=MEDIUM** **4=HIGH** **5=HIGHEST**

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/READINESS	CONSEQUENCE OF INACTION	TOTAL
ANXIETY	4.43	4.18	3.43	2.93	4	19
DEPRESSION	4.43	4.31	3.37	2.87	4.37	19
POST TRAUMATIC STRESS DISORDER	3.5	3.62	3.18	3	3.75	17
TRAUMA	4	4.12	3.25	3.31	3.93	19
SERIOUS EMOTIONAL DISTURBANCE	3.12	3.68	2.75	2.56	3.75	16
EARLY SERIOUS MENTAL ILLNESS	3.18	3.75	2.81	2.56	3.87	16
SERIOUS MENTAL ILLNESS	3.31	3.87	2.87	2.56	4.06	17
SUICIDE	3.81	4.62	4	3.81	4.81	21

Priority Ranking Matrix Mean Scores

Substance Use/Misuse/Addiction

SCALE: **1=LOWEST** **2=LOW** **3=MEDIUM** **4=HIGH** **5=HIGHEST**

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/READINESS	CONSEQUENCE OF INACTION	TOTAL
ALCOHOL	4.23	4.05	2.94	3.35	4.05	19
TOBACCO	2.82	3	2.94	3.11	3.11	15
ELECTRONIC NICOTINE DELIVERY SYSTEMS (ENDS), VAPING, JUULING, ETC.	3.82	3.47	3.47	3.17	3.64	18
MARIJUANA	3.82	3.64	2.76	2.64	3.52	16
PRESCRIPTION DRUG MISUSE	3.52	3.88	3.35	3.35	4.23	18
HEROIN AND FENTANYL	3.76	4.41	3.17	3.41	4.58	19
COCAINE	2.58	3.05	2.58	2.52	3.23	14
PROBLEM GAMBLING	3.05	3.17	2.76	2.41	3.23	15

Appendix B: Key Stakeholder Survey

Pursuant to the Substance Abuse Prevention and Treatment (SABG) and Mental Health Block Grant (MHBG) requirements, states must annually: assess needs, strengths and critical gaps of their service delivery systems; and, identify target populations and the priorities for the populations. As strategic community partners, SERAC is insisting with this process by assessing the behavioral health needs of children, adolescents and adults across the regions and developing Regional Strategic Plans to include epidemiological profiles and priority recommendations for prevention, treatment and recovery services. We value your experience and expertise and ask that you complete the following survey.

Thank you for your time.

1. Please identify the community sector in which you are completing this survey:
Individual with lived experience Prevention Provider/Coalition Youth services/Youth Serving Organization Recovery Support Substance Abuse Treatment Agency/Provider Mental Health Treatment Agency/Provider Council/Task Force/CHIP Member Social/Human Service Agency Hospital Health District Public Health School College/University Mental Health Service Provider Faith Based Organization Youth Parent Other (please specify)

2. Please enter your name:

3. Please enter your email:

4. Please select the town(s) that your represent:
Bozrah Colchester East Lyme Franklin Griswold Groton Ledyard Lisbon Lyme/Old Lyme Montville New London North Stonington Norwich Preston Salem Sprague Stonington Voluntown Waterford Ashford Brooklyn Canterbury Chaplin Columbia Coventry Eastford Hampton Killingly Lebanon Mansfield Plainfield Pomfret Putnam Scotland Sterling Thompson Union Willington Windham Woodstock Other (please specify)

5. How appropriate are available services to meet the needs of substance abuse prevention?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure Other (please specify)

6. How appropriate are available services to meet the needs of substance abuse treatment?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure Other (please specify)

7. How appropriate are available services to meet the needs of substance abuse recovery?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure Other (please specify)

8. How appropriate are available services to meet the needs of mental health promotion?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure Other (please specify)

9. How appropriate are available services to meet the needs of mental health treatment?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure
Other (please specify)

10. How appropriate are available services to meet the needs of mental health recovery?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure
Other (please specify)

11. How appropriate are available services to meet the needs of problem gambling prevention?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure
Other (please specify)

12. How appropriate are available services to meet the needs of problem gambling treatment?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure
Other (please specify)

13. How appropriate are available services to meet the needs of problem gambling recovery?
Appropriate Adequate Somewhat Appropriate Less than Appropriate Not at all Appropriate Unsure
Other (please specify)

14. What prevention program, strategy or policy would you most like to see accomplished related to substance abuse?

15. What prevention program, strategy or policy would you most like to see accomplished related to mental health?

16. What prevention program, strategy or policy would you most like to see accomplished related to problem gambling?

17. What treatment levels of care do you feel are unavailable or inadequately provided related to substance abuse?

18. What treatment levels of care do you feel are unavailable or inadequately provided related to mental health?

19. What treatment levels of care do you feel are unavailable or inadequately provided related to problem gambling?

20. What adjunct services/support services/recovery supports are most needed to assist persons with substance abuse issues?

21. What adjunct services/support service/recovery supports are most needed to assist persons with mental health issues?

22. What adjunct services/support services/recovery supports are most needed to assist persons with problem gambling?

23. What would you say is the greatest strength/asset of substance abuse prevention?

24. What would you say is the greatest strength/asset of substance abuse treatment?

25. What would you say is the greatest strength/asset of substance abuse recovery?

26. What would you say is the greatest strength/asset of mental health promotion?

27. What would you say is the greatest strength/asset of mental health treatment?

28. What would you say is the greatest strength/asset of the mental health recovery system?

29. What would you say is the biggest strength/asset of the problem gambling prevention service system?

30. What would you say is the greatest strength/asset of the problem gambling treatment service system?

31. What would you say is the greatest strength/asset of the problem gambling recovery service system?

32. Are you aware of the Region 3 Suicide Advisory Board
Yes No

33. Are you aware of suicide prevention efforts in your community?
Yes No
If yes, please specify prevention effort:

34. What would you say is the greatest barrier of suicide prevention?

35. Are you aware of any post-mention efforts in your community?
Yes No
Other (please specify)

36. Are you aware of any supports for suicide in your community (survivors of suicide, attempt survivors, families who have lived through suicide/an attempt)?
Yes No
If yes, please specify:

37. Are there any sub populations (ex. veterans, LGBTQI, Latinx, etc.) that aren't being adequately served by the substance use service system?

38. Are there any sub populations (ex. veterans, LGBTQI, Latinx, etc.) that aren't being adequately served by the mental health service system?

39. Are there any sub populations (ex. veterans, LGBTQI, Latinx, etc.) that aren't being adequately served by the problem gambling service system?

40. Is there anything you feel the service system (including DCF and DMHAS) can do differently for the subgroup(s) you are identifying?

41. What do you think SERAC can do to promote health equity and/or address health disparities in Region 3 for the subgroup(s) you are identifying?

42. What are the emerging prevention, treatment or recovery issues that you are seeing or hearing about with regard to mental health?

43. What are the emerging prevention, treatment or recovery issues you are seeing or hearing about with regard to substance use?

44. What are the emerging prevention, treatment or recovery issues you are seeing or hearing about with regard to problem gambling?

45. What are the emerging prevention, treatment or recovery issues you are seeing or hearing about with regard to the issue of suicide?

46. Are there opportunities for the DMHAS service system that aren't being taken advantage of (technology, integration, partnerships, etc.)?
Yes No
I don't know
If yes, please explain:

47. How has the COVID-19 pandemic affected prevention, treatment or recovery in the area of substance abuse?

48. How has the COVID-19 pandemic affected prevention, treatment or recovery in the area of mental health?

49. How has the COVID-19 pandemic affected prevention, treatment or recovery in the area of problem gambling?

50. Do you feel your community is prepared to adequately handle post-pandemic substance abuse, mental health, problem gambling or suicide needs?

51. Do you feel the DMHAS or DCF service system is adequately prepared to handle post-pandemic substance abuse, mental health, problem gambling, or suicide needs?
Yes No
I don't know Other (please specify)

School Data
An important part of our prioritization process is collecting school survey data. We look to our towns and school districts for this data. The following questions pertaining to school-based youth survey implementation will help us

identify assets and barriers within Region 3 communities.

52. Has your school district ever completed a student survey?
Yes No
I don't know If yes, when?

53. Have you experienced any of the following barriers when conducting or attempting to conduct a school-based youth survey? Check all that apply:
School Admin Buy-In
Town Buy-In
Board of Education Buy-In
Cost Barrier
Cannot Identify Appropriate Survey Instrument
School Data is not Needed
Not Applicable
Other (please specify)

Demographics
Is it important for us to ensure diverse stakeholder representation and capture demographic information?

54. What is your race?
White or Caucasian Black or African American Hispanic or Latino
Asian or Asian American American Indian or Alaska Native
Native Hawaiian or other Pacific Islander Another race
Other (please specify)

55. What is your ethnicity?
Non-Hispanic Hispanic

56. Please select your age group:
Under 18
18-24
25-34
35-44
45-54
55-64
65+

57. Please select how you identify:
Male Female
Non-Binary Rather not say
Other (please specify if you are comfortable doing so)

Conclusion
Thank you for taking the time to complete this survey. We value your responses.

58. Is there anything else you would like to share?

Appendix C: Key Stakeholder Response Summary (Quantitative Responses Only)

Q1 Please identify the community sector in which you are completing thissurvey:

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Individual with lived experience	10.34%	3
Prevention Provider/Coalition	6.90%	2
Youth services/Youth Serving Organization	6.90%	2
Recovery Support	0.00%	0
Substance Abuse Treatment Agency/Provider	0.00%	0
Mental Health Treatment Agency/Provider	27.59%	8
Council/Task Force/CHIP Member	0.00%	0
Social/Human Service Agency	3.45%	1
Hospital	0.00%	0
Health District	0.00%	0
Public Health	0.00%	0
School	37.93%	11
College/University	0.00%	0
Mental Health Service Provider	10.34%	3
Faith Based Organization	0.00%	0
Youth	0.00%	0
Parent	10.34%	3
Other (please specify)	17.24%	5
Total Respondents: 29		

Q4 Please select the town(s) that your represent:

ANSWER CHOICES	RESPONSES	
Bozrah	3.45%	1
Colchester	3.45%	1
East Lyme	6.90%	2
Franklin	3.45%	1
Griswold	3.45%	1
Groton	10.34%	3
Ledyard	6.90%	2
Lisbon	3.45%	1
Lyme/Old Lyme	0.00%	0
Montville	6.90%	2
New London	13.79%	4
North Stonington	3.45%	1
Norwich	13.79%	4
Preston	3.45%	1
Salem	3.45%	1
Sprague	10.34%	3
Stonington	6.90%	2
Voluntown	6.90%	2
Waterford	3.45%	1
Ashford	13.79%	4
Brooklyn	24.14%	7
Canterbury	17.24%	5
Chaplin	13.79%	4
Columbia	13.79%	4
Coventry	13.79%	4
Eastford	13.79%	4
Hampton	13.79%	4
Killingly	17.24%	5
Lebanon	13.79%	4
Mansfield	24.14%	7
Plainfield	24.14%	7
Pomfret	17.24%	5

Putnam	17.24%	5
Scotland	17.24%	5
Sterling	17.24%	5
Thompson	20.69%	6
Union	10.34%	3
Willington	17.24%	5
Windham	31.03%	9
Woodstock	27.59%	8
Other (please specify)	13.79%	4
Total Respondents: 29		

Q5 How appropriate are available services to meet the needs of substanceabuse prevention?

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Appropriate	13.79%	4
Adequate	6.90%	2
Somewhat Appropriate	27.59%	8
Less than Appropriate	20.69%	6
Not at all Appropriate	13.79%	4
Unsure	10.34%	3
Other (please specify)	6.90%	2
TOTAL		29

Q6 How appropriate are available services to meet the needs of substanceabuse treatment?

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Appropriate	6.90%	2
Adequate	10.34%	3
Somewhat Appropriate	31.03%	9
Less than Appropriate	20.69%	6
Not at all Appropriate	17.24%	5
Unsure	10.34%	3
Other (please specify)	3.45%	1
TOTAL		29

Q7 How appropriate are available services to meet the needs of substanceabuse recovery?

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Appropriate	6.90%	2
Adequate	6.90%	2
Somewhat Appropriate	37.93%	11
Less than Appropriate	13.79%	4
Not at all Appropriate	24.14%	7
Unsure	10.34%	3
Other (please specify)	0.00%	0
TOTAL		29

Q8 How appropriate are available services to meet the needs of mentalhealth promotion?

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Appropriate	10.34%	3
Adequate	13.79%	4
Somewhat Appropriate	27.59%	8
Less than Appropriate	27.59%	8
Not at all Appropriate	17.24%	5
Unsure	3.45%	1
Other (please specify)	0.00%	0
TOTAL		29

Q9 How appropriate are available services to meet the needs of mentalhealth treatment?

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Appropriate	10.34%	3
Adequate	13.79%	4
Somewhat Appropriate	10.34%	3
Less than Appropriate	34.48%	10
Not at all Appropriate	17.24%	5
Unsure	10.34%	3
Other (please specify)	3.45%	1
TOTAL		29

Q10 How appropriate are available services to meet the needs of mentalhealth recovery?

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Appropriate	6.90%	2
Adequate	6.90%	2
Somewhat Appropriate	24.14%	7
Less than Appropriate	31.03%	9
Not at all Appropriate	17.24%	5
Unsure	10.34%	3
Other (please specify)	3.45%	1
TOTAL		29

Q11 How appropriate are available services to meet the needs of problemgambling prevention?

Answered: 27 Skipped: 2

ANSWER CHOICES	RESPONSES	
Appropriate	11.11%	3
Adequate	11.11%	3
Somewhat Appropriate	11.11%	3
Less than Appropriate	14.81%	4
Not at all Appropriate	7.41%	2
Unsure	44.44%	12
Other (please specify)	0.00%	0
TOTAL		27

Q12 How appropriate are available services to meet the needs of problemgambling treatment?

ANSWER CHOICES	RESPONSES	
Appropriate	11.11%	3
Adequate	7.41%	2
Somewhat Appropriate	7.41%	2
Less than Appropriate	14.81%	4
Not at all Appropriate	14.81%	4
Unsure	44.44%	12
Other (please specify)	0.00%	0
TOTAL		27

Q13 How appropriate are available services to meet the needs of problemgambling recovery?

Answered: 28 Skipped: 1

ANSWER CHOICES	RESPONSES	
Appropriate	10.71%	3
Adequate	7.14%	2
Somewhat Appropriate	7.14%	2
Less than Appropriate	14.29%	4
Not at all Appropriate	17.86%	5
Unsure	42.86%	12
Other (please specify)	0.00%	0
TOTAL		28

Q32 Are you aware of the Region 3 Suicide Advisory Board

Answered: 28 Skipped: 1

ANSWER CHOICES	RESPONSES	
Yes	25.00%	7
No	75.00%	21
TOTAL		28

Q33 Are you aware of suicide prevention efforts in your community?

Answered: 27 Skipped: 2

ANSWER CHOICES	RESPONSES	
Yes	77.78%	21
No	22.22%	6
TOTAL		27

Q35 Are you aware of any post-vention efforts in your community?

Answered: 24 Skipped: 5

ANSWER CHOICES	RESPONSES	
Yes	8.33%	2
No	91.67%	22
TOTAL		24

Q36 Are you aware of any supports for suicide in your community (survivors of suicide, attempt survivors, families who have lived throughsuicide/an attempt)?

Answered: 25 Skipped: 4

ANSWER CHOICES	RESPONSES	
Yes	32.00%	8
No	68.00%	17
TOTAL		25

Q51 Do you feel the DMHAS or DCF service system is adequately prepared to handle post-pandemic substance abuse, mental health,problem gambling, or suicide needs?

Answered: 24 Skipped: 5

ANSWER CHOICES	RESPONSES	
Yes	4.17%	1
No	58.33%	14
I don't know	37.50%	9
TOTAL		24

Q52 Has your school district ever completed a student survey?

Answered: 24 Skipped: 5

ANSWER CHOICES	RESPONSES	
Yes	25.00%	6
No	4.17%	1
I don't know	70.83%	17
TOTAL		24

Q53 Have you experienced any of the following barriers when conductingor attempting to conduct a school-based youth survey? Check all that apply:

Answered: 19 Skipped: 10

ANSWER CHOICES	RESPONSES	
School Admin Buy-In	5.26%	1
Town Buy-In	5.26%	1
Board of Education Buy-In	0.00%	0
Cost Barrier	5.26%	1
Cannot Identify Appropriate Survey Instrument	5.26%	1
School Data is not Needed	0.00%	0
Not Applicable	68.42%	13
Other (please specify)	15.79%	3
Total Respondents: 19		

Q54 What is your race?

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
White or Caucasian	100.00%	29
Black or African American	0.00%	0
Hispanic or Latino	0.00%	0
Asian or Asian American	0.00%	0
American Indian or Alaska Native	0.00%	0
Native Hawaiian or other Pacific Islander	0.00%	0
Another race	0.00%	0
Other (please specify)	0.00%	0

Q55 What is your ethnicity?

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Non-Hispanic	100.00%	29
Hispanic	0.00%	0
TOTAL		29

Q56 Please select your age group:

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Under 18	0.00%	0
18-24	0.00%	0
25-34	3.45%	1
35-44	10.34%	3
45-54	24.14%	7
55-64	41.38%	12
65+	20.69%	6
TOTAL		29

Q57 Please select how you identify:

Answered: 29 Skipped: 0

ANSWER CHOICES	RESPONSES	
Male	31.03%	9
Female	68.97%	20
Non-Binary	0.00%	0
Rather not say	0.00%	0

Appendix D: Sample Focus Group Questions

*These questions are only a sample. They were modified for focus groups that were conducted on problem gambling, mental health, and substance abuse.

Priority Report Questions
Facilitator notes:
The group should be less than 10 people, and no more than an hour long. Record the meeting so you do not have to try to keep notes and facilitate the meeting. Add each question to the chat to help each participant remember question.
Make sure to ask each person their thoughts for each question, so one person is not dominating the conversation. At the end of each question, ask if anyone has anything else to add. Remind them they can use the chat if they think of anything else they wanted to add.
Share with the group:
All answers will be recorded anonymously. No names or towns will be included in our priority report. Ask if anyone minds that this meeting is being recorded for note taking purposes. If anyone does mind, they can be excluded and done on a one on one at another time. (*this could be brought up in the ask email as well).
We will be using polls and asking for individual thoughts. We will go around and ask each person for their thoughts about each question. If you do not have anything else to add to the discussion, you can say pass and we will move to the next person.

1. **Poll**: In your community, what population is at the highest risk for suicide?

2. **Discussion question**: Within each of the populations, what are the high-risk subpopulations? *Ask each participant. * Remind them they can use the chat if they think of anything else they wanted to add.
Ex. Males, females, LGBTQIA+, Single family homes, children of individuals with lived experience, vet/military, farmers, ethnic groups, those with a mental health diagnosis, those with trauma

4. **Poll then discussion**: What are some of the risk factors that contribute to suicide deaths? *Ask each participant. discuss and dig deeper if needed. * Remind them they can use the chat if they think of anything else they wanted to add.
Individual:

- Previous suicide attempt
- Mental illness, such as depression
- Social isolation
- Criminal problems
- Financial problems
- Impulsive or aggressive tendencies
- Job problems or loss
- Legal problems
- Serious illness
- Substance use disorder

Relationship:

- Adverse childhood experiences such as child abuse and neglect
- Bullying
- Family history of suicide
- Relationship problems such as a break-up, violence, or loss
- Sexual violence

Community:

- Barriers to health care
- Cultural and religious beliefs such as a belief that suicide is noble resolution of a personal problem
- Suicide cluster in the community

Societal:

- Stigma associated with mental illness or help-seeking
- Easy access to lethal means such as firearms or medications
- Unsafe media portrayals of suicide

Probing examples for further discussion:
* IF COVID, transportation, or any other typical response come up, have them think of what does that actually do to contribute to substance use in their community.
Ex. Covid; Adults use alcohol more because of the increase of community norms to cope during traumatic situations (covid)

5. **Discussion question**: What are the strengths and assets in your community? *Ask each participant. Could be where they work or live. *Ask each participant. * Remind them they can use the chat if they think of anything else they wanted to add.

6. **Discussion question**: What is needed in your community right now, or going forward in Prevention, Treatment, Recovery? This is – 3 separate questions. *Ask each participant. * Remind them they can use the chat if they think of anything else they wanted to add.

7. **Discussion question**: Are there any recommendations for emerging trends for Prevention, Treatment, Recovery. This is – 3 separate questions. *Ask each participant. * Remind them they can use the chat if they think of anything else they wanted to add.