CT Department of Mental Health & Addiction Services
Prevention and Health Promotion Unit

Region 3 Priority Report
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Abbreviations

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

Executive Summary

The following report contains epidemiological profiles for nine issues outlined by the CT Department of Mental Health and Addiction Services (DMHAS) with data sourced from the national, state, and regional levels where available for CT DMHAS Region 3. The region consists of 39 towns in Eastern Connecticut with 19 located in New London County, 15 in Windham County, and 5 in Tolland County. According to CT Economic Resource Center Town Data Profiles (2018) the total population in the 39 towns in eastern CT served by SERAC is approximately 429,936 residents[1]. About 78.8% percent of the population is White/Caucasian, 4.5% Black/African American, 3.6% Asian, 0.5% Native American, 7.2% identify as other and almost 10% report Hispanic. While the median poverty rate for Region 3 is approximately 8% which is lower than the state rate of 10.4%, individual towns range from less than 1% to 28%. The veteran's population in the region is 8.10%. Across the 39 towns in the region 30% (range 19-41%) of individuals have less than a high school diploma. The median household income is approximately $75,500 for the region with a range of $35,357 to $104,732. The average unemployment rate is 2.6%. The eastern region of CT consists of both suburban cities and small rural towns. According to the CT Office of Rural Health (2014) 25 towns out of 39 are considered rural. In the spring of 2019, SERAC conducted several community needs assessment workgroups to review the available epidemiological profiles and rank the 9 priority issues for the eastern region of CT. Key stakeholders also participated in a survey on the adequacy and availability of services in the region. Respondents were also given the opportunity to provide feedback both in person and through confidential surveys on the areas for improvement across prevention, treatment, and recovery.

Priority Issues

Members of the CNAWs prioritized **mental health** issues as the top concern for the region. The conversation regarding mental health issues included topics such as depression and anxiety among youth and young adults as well as adults age 65 and older. Advocating for individuals and families with serious mental health issues was also discussed. Most members felt that risk factors related to mental health across all populations were also at the root of substance use disorders, problem gambling disorders, and suicide. The magnitude, impact, changeability, and the consequence of inaction all ranked very high. Efforts to build the capacity and readiness of the region to address mental health issues are needed.

The consequence of inaction regarding **suicide** was ranked as the top indicator for prioritization. Members also reported capacity and readiness as one of the highest factors in addressing suicide prevention. Among key stakeholders, suicide is seen as a preventable issue with opportunities for early intervention. 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.

Heroin is viewed as the issue with the highest impact on the region. It was also noted as having one of the highest areas for readiness and capacity. This is largely due to increases in heroin- and fentanyl-related 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

[1] CERC Town Profiles 2018 (CT Data Collaborative)

to prevent overdose deaths. As a result of the distribution of naloxone over the past couple years, local towns have recently begun to see a reduction in drug related deaths. The magnitude of the issue ranked fifth among all issues but showed one of the highest impacts, consequences, and readiness. It was acknowledged that the primary at-risk population is adults aged 18 and older.

Alcohol is ranked as the substance with the highest magnitude alongside marijuana use. For all other indicator's alcohol has moderate to high rankings from key stakeholders. Alcohol is still the most commonly misused legal substance among all populations. 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. Combined use of alcohol and prescription drugs among adults is a concern for drug related deaths.

The magnitude of **prescription drug use** was ranked lower than alcohol for the region. The highest concern was the consequences of inaction. 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.

Tobacco had a much lower magnitude than the use of **ENDS**, however the readiness, capacity, and changeability is viewed as lower in the region. In fact, ENDS products ranked the second lowest in capacity and readiness among all priority issues. Local prevention councils and schools request training and informational sessions on "vaping" fairly regularly.

Marijuana was ranked the lowest for changeability and capacity/readiness of all priority issues. 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.

Problem gambling is viewed as the 2nd to lowest priority for the region. Members viewed problem gambling with a high consequence of inaction but 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 with the two casinos in the region. Awareness of other types of gambling that can also present risk factors for addiction are less well known, recognized or discussed. The low prioritization of problem gambling is likely related to low awareness of gambling behaviors as a whole. 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).

Cocaine was ranked as the lowest priority issue for the region. Members felt that cocaine use had one of the lowest magnitudes and impacts. It was also ranked as having the lowest consequence of inaction among the issues. Members seemed to be the least knowledgeable on the issue of cocaine use and its' social impacts. In May, Hartford convened a roundtable to discuss a cluster of overdoses that resulted from the combination of fentanyl and cocaine/crack

cocaine. Key leaders reported that they did not know of any local similar trends in the eastern region but recognize that poly substance use is a problem and drugs are often “laced” and mixed.

Emerging Issues

Over the past few years increasing concerns regarding the overlap of drug related deaths and suicide deaths has risen. In May 2019, DMHAS Commissioner presented on the issue at the SERAC Annual Prevention Conference and highlighted shared risk factors such as physical health problems, behavioral health, trauma/adverse childhood experiences, and social isolation. Demographics are also shared among the populations with regard to age, race, and gender (typical characteristics: white/Caucasian, middle age, and male). Another commonality among the populations is participation in a labor occupation. A common thread in reduction and prevention of negative behavioral health outcomes is through addressing traumatic and adverse childhood experiences. 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. 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.

Key Stakeholder Response Summary

In April 2019, SERAC initiated a survey of reached out to key community stakeholders to request their feedback about the state of the behavioral health system in DMHAS Region 3. The survey included questions about prevention, treatment and recovery services for substance use, mental health and problem gambling. A total of 16 responses to the survey were received. Respondents represented a wide range of sectors including mental health and substance use treatment providers, law enforcement, schools, youth-serving organizations, non-profit organizations, and prevention coalitions.

Available substance use prevention services and mental health promotion services were considered to be very appropriate or somewhat appropriate by the majority of respondents (69% and 67% respectively). Perceptions of the appropriateness of substance use and mental health treatment and recovery services tended to be more evenly distributed across the spectrum of very appropriate to very inappropriate. The largest percentages of respondents considered problem gambling prevention, treatment and recovery services to be appropriate.

Most programs, strategies or policies that respondents report most wanting to see with regard to substance use, mental health and problem gambling tend to fall in the following common categories:

1) Access to treatment: Early identification, more providers/facilities, school-based services)
2) Treatment options: Evidence based, greater variety, alternative therapies
3) Education to raise awareness
4) Policy and Advocacy: Impact of new laws in other states, reducing duplication of services, ensuring money is put toward prevention and treatment

Specific issues of concern include electronic cigarettes/vaping, suicide and prevention and video game-based gambling.

Respondents expressed concerns about the general lack of beds, providers and support groups in the area. Specifically, respondents reported a need for more detox beds, more follow-up care including supportive housing and treatment following discharge. They also expressed specific concern about lack of adequate substance use and mental health treatment services for children and youth. Respondents reported a need for community groups, peer support and drop in services for substance use, mental health and problem gambling. Respondents also emphasized a need to access to alternative therapeutic modalities as well as supportive services such as employment, housing and transportation. Respondents view the RBHAO structure including SERAC and Local Prevention Councils as a strength of the substance use, mental health and problem gambling service systems in the region. They also recognize the value of current campaigns aimed at reducing stigma related to these issues as a strength. The availability of peer support programs is also considered a strength of the current system.

Respondents were asked to identify particular sub-populations not being adequately served by the current system. The top identified groups for each system are listed below.

- Substance use system: youth ages 14-17(50%), young adults 18-25(31%) and adults 65+ (31%)
- Mental health system: youth ages 14-17 (50%), sexual orientation (44%), transgender individuals (44%)
- Problem gambling system: Adults 65+ (31%), Youth 14-17 (19%), military (19%), ESOL (19%)

Emerging issues and opportunities identified by respondents include vaping and electronic cigarettes, changing technology, alternative therapies, peer support programs and changing laws.

Recommendations

Substance Abuse/ Misuse

- Increase awareness and education to reduce access to and availability of alcohol, heroin, prescription drugs.
- Target ages 14-25, 65 and older as well as LBGTQ populations.
- Expand providers and availability of individual therapy.
- Increase availability for long-term inpatient and residential facilities.
- Increase recovery services for youth and young adults.

- Increase recovery supports beyond faith-based model of AA.
- Increase adequate housing supports.

Mental Health

- Local workforce training/education to build capacity.
- Target awareness and education for ages 14- 25 and LBGTQ populations.
- Increase capacity for co-occurring treatment across the region.
- Increase early screening in primary care, school, and community-based services.
- Increase capacity to implement trauma informed care and services.
- Increase mental health recovery support groups for all ages.

Problem Gambling

- Increase education and awareness of problem gambling for older adults.
- Create a targeted campaign for enlisted military and their families.
- Increase availability of problem gambling treatment services in the north sub region.
- Increase access to gambling recovery support groups region wide.

Systems/Other

- Integrate mental health, prevention, and the strategic prevention framework model.
- Increase collaboratives to address adult issues around behavioral health (currently limited to opioid treatment or overdose prevention).
- Increase support for culturally competent recovery models.

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Introduction

History and purpose of the report

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 practiced 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 and impact of the following 9 priority issues of concern in Connecticut and in Region 3: alcohol use, tobacco/electronic nicotine delivery system (ENDS) use, prescription drug misuse, marijuana use, heroin and other illicit opioid use, cocaine use, mental health issues, problem gambling and suicide.

Data Sources

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

- SERAC Youth Survey
- SERAC Young Adult Survey
- SERAC Community Survey
- SERAC Key Stakeholder Survey
- National & State Surveys: Including National Survey of Drug Use and Health (NSDUH)
- Youth Risk Behavior Surveillance System (YRBSS)
- Connecticut School Health Survey (CTSHS)
- DMHAS Community Readiness Survey (CRS)
- CERC Town Data Profiles (2018)
- CT Data Collaborative
- DMHAS Treatment and Admission Report

Strengths and Limitations

This profile attempts to summarize data collected at the National, State and regional level. 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. Also, for some relevant indicators current data are not available. In cases when data sources were 5 or more years old, they were omitted for ranking. Approximately 36 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 9 statewide priorities were compiled, tabulated and summarized. Next, a Community Needs Assessment Workgroup (CNAW) was convened with the purpose of reviewing the profiles 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. Three CNAW sessions were conducted and members ranged from local prevention council members, catchment area council attendees, and other key leaders from the community. There was a wide range of sectors represented including youth serving organizations, law enforcement, treatment providers, healthcare, and public health leaders. In developing their rankings, CNAW members were asked to consider not only the sheer magnitude of individual issues but also the impacts or consequences associated with that issue as well and the changeability of that issue.

Region 3 Priority Report

Description of the Region

According to CT Economic Resource Center Town Data Profiles (2018) the total population in the 39 towns in eastern CT served by SERAC is approximately 429,936 residents[2]. About 78.8% percent of the population is White/Caucasian, 4.5% Black/African American, 3.6% Asian, 0.5% Native American, 7.2% identify as other and almost 10% report Hispanic. While the median poverty rate for Region 3 is approximately 8% which is lower than the state rate of 10.4%, individual towns range from less than 1% to 28%. The veteran's population in the region is 8.10%. Across the 39 towns in the region 30% (range 19-41%) of individuals have less than a high school diploma. The median household income is approximately $75,500 for the region with a range of $35,357 to $104,732. The average unemployment rate is 2.6%. The eastern region of CT consists of both suburban cities and small rural towns. 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 region varies 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.

[2] CERC Town Profiles 2018 (CT Data Collaborative)

ALCOHOL

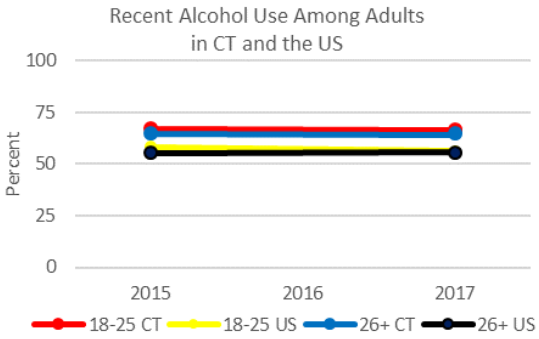
Description

Alcohol, also known as ethanol, is a psychoactive substance that is the active ingredient in drinks such as beer, wine, and distilled spirits. It is one of the oldest and most common recreational substances, causing the characteristic effects of alcohol intoxication. Among other effects, alcohol produces a mood lift and euphoria, decreased anxiety, increased sociability, sedation, impairment of cognitive, memory, motor, and sensory function, and generalized depression of central nervous system function. Alcohol is the most widely used and abused substance in the United States.

Magnitude

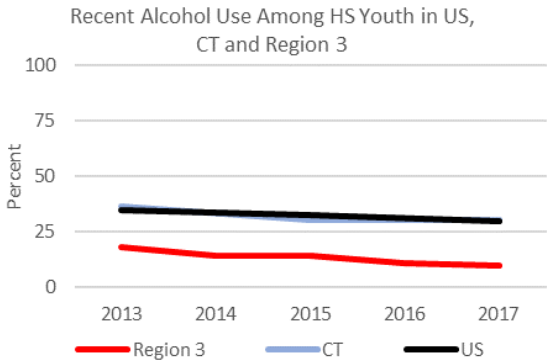
Recent Use

Current data from the National Survey of Drug Use and Health (NSDUH) suggest that recent (past 30 day) alcohol use rates among adults age 18-25 and age 26 and older in Connecticut have been relatively stable since 2015 but tend to be higher than the corresponding national rates.



Source: NSDUH

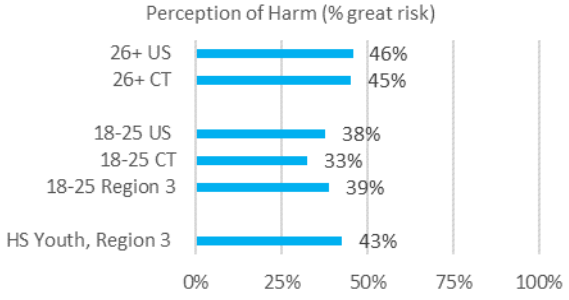
According to the Youth Risk Behavior Surveillance System (YRBSS), the rate of recent alcohol use among Connecticut high school youth was similar to the national average (30%) in 2017 while the recent use among high school youth in Region 3 was just 10% (*SERAC Regional Youth Survey Data)*. Recent alcohol use among high school youth in the US, CT and Region 3 tended to decline from 2013 to 2017. However, according to the SERAC Young Adult Survey (2018) approximately 38% of respondents had consumed alcoholic beverages in the past 30 days and 20% had consumed 5 or more on a single occasion.



Source YRBSS, SERAC Regional Youth Survey Data

Perception of Harm

According to the 2017 NSDUH, the percentage of adults in Connecticut who perceive that there is great risk associated with consuming 5 or more alcoholic drinks 1 to 2 times per week tend to be similar to the corresponding national rates. This perception of harm tends to be lower among young adults (18 to 25) than among individuals over the age of 25. The perceived harm reported by a small sample of young adults, aged 18-25, surveyed at a community college located within Region 3 in 2018 is similar to state and national rates.



Source: NSDUH, SERAC Regional Youth Survey Data, SERAC Young Adult Survey

Risk Factors and Subpopulations At-Risk

Binge drinking is defined as consuming 4 or more drinks on an occasion (2-3 hours) for women and 5 or more drinks on an occasion for men. U.S. adults consume more than 17 billion binge drinks, or about 470 binge drinks per binge drinker annually. While binge drinking is more common among young adults aged 18-34 years, more than half of the binge drinks consumed each year are by adults aged 35 years or older. Adult binge drinkers binge frequently, about once a week, and at high intensity, averaging seven drinks per binge, significantly increasing the risk of harm to themselves and others [3]. Another

[3] CDC (2018)

subpopulation of great concern in our region is the military and veteran populations. Military members and their families have unique risk factors such as transient housing and relocation. Deployments and lack of social support increase the risk for substance use. Also co-occurring issues such as PTSD within this population place them at higher risk. Two large casino venues are located in the eastern region of CT which presents a unique risk factor for alcohol use through heavily promoted drinking events, and high areas of access and availability of alcohol. This also places the region at a higher risk for alcohol involved accidents and fatalities.

Burden

The consequences and impacts of alcohol use, abuse and dependence include increased crime, long- and short-term negative health effects and unintentional injury and death. According to the CT DMHAS Annual Statistical Report 2018, alcohol was the primary drug reported in 35% of all admissions, 30% of all substance abuse admissions and 45% of all mental health admissions at DMHAS-funded treatment programs in Connecticut in 2018.

Region 3 represents 12% of Connecticut's population.

- In 2017, Region 3 experienced 492 DUI crashes (15% of state), 10 DUI fatalities (22% of state) and 107 DUI injuries (12% of state). [4]
- From 2010-2014, the crude rate of alcohol-induced deaths in Region 3 was 7.8 per 100,000. This was higher than the state average of 6.3 per 100,000. [5]
- From 2014-2016, the rate of alcohol abuse or dependence in Region 3 was 2.85% among 12-17 year olds, 12.76% among 18-25 year olds, and 5.69% for individuals over the age of 25.[6]
- In 2017, approximately 20% of high school aged drinkers reported that they had consumed 4 or more drinks during a single occasion.

Capacity and Service System Strengths

According to the 2018 DMHAS Community Readiness Survey, the overall readiness for Substance Abuse Prevention in Region 3 is 4.35. This means that the Region is somewhere between recognizing the existence of a substance abuse problem (4.0) and planning for substance abuse prevention (5.0). The statewide average level of readiness is 5.3. Overall, key informants from Region 3 "somewhat agree" that most community residents are concerned about preventing alcohol abuse (average rating = 2.9, 2=somewhat disagree, 3= somewhat agree). Key informants from Region 3 feel that 1) limited financial resources, 2) too few community members with time or willingness to volunteer and 3) perception that substance abuse us a personal problem, not a community problem are the largest barriers to substance abuse prevention activities in the region. Key informants feel that the community is most ready to raise community awareness about substance abuse problems and convene community meetings to address substance abuse issues and is least ready to allocate local funds for substance abuse prevention. Throughout the region, there is a long-standing awareness of and support for the prevention of alcohol abuse, especially among youth. Many communities have school resource officers and drug and alcohol prevention programming in and out of school. Schools have included more evidence-based curriculum, some starting at 5th grade. More and more communities have gone back to the campaign, "Parent Who Host Lose the Most" to address the Social Hosting Law in the state. A few schools also have breathalyzers at school functions. We have seen a decrease in mock crashes, one-time speakers and shock and awe presentations. SERAC has been active in supporting communities in completing compliance checks. With consistent checks in identified communities, noncompliance has improved. A follow-up is offering seller-server training to employees of alcohol retailers throughout the region. Several Local Prevention Councils have taken on this area of concern that include the reduction of youth alcohol use as a priority. Additional resources are needed to promote continued awareness about the dangers of alcohol use for all ages, not just youth. We have yet to address the 35+ age that has the higher rate of binge drinking.
Towns should also address the following environmental strategies: include limiting the number of alcohol outlets in a geographic area, limiting days and hours of sale, and legal liability for outlets that illegally serve underage or intoxicated customers.

[4] SAMHSA NSDUH accessed through the SEOW Data Portal
www.preventionportal.ctdata.org

[5] Centers for Disease Control and Prevention
https://www.cdc.gov/tobacco/data_statistics/fact_sheets/index.htm?s_cid=osh-stu-home-spotlight-001

[6] Centers for Disease Control and Prevention
https://www.cdc.gov/tobacco/basic_information/health_effects/index.htm

TOBACCO/ENDS

Description

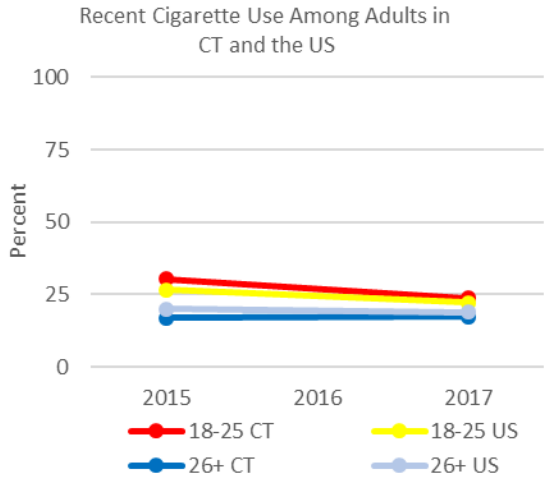
Tobacco products are products made entirely or partly of leaf tobacco as raw material, which are intended to be smoked, sucked, chewed or snuffed. All contain the highly addictive psychoactive ingredient, nicotine. Tobacco is most commonly ingested by cigarettes. A number of countries have legislation restricting tobacco advertising, and regulating who can buy and use tobacco products, and where people can smoke[7].

Electronic nicotine delivery systems (ENDS), also called electronic cigarettes, e-cigarettes, vaping devices, or vape pens, are battery-powered devices used to smoke or "vape" a flavored solution. Electronic cigarettes can be used to deliver marijuana and other drugs. Additional research is still needed to understand the long-term effects of electronic cigarette use.

Magnitude

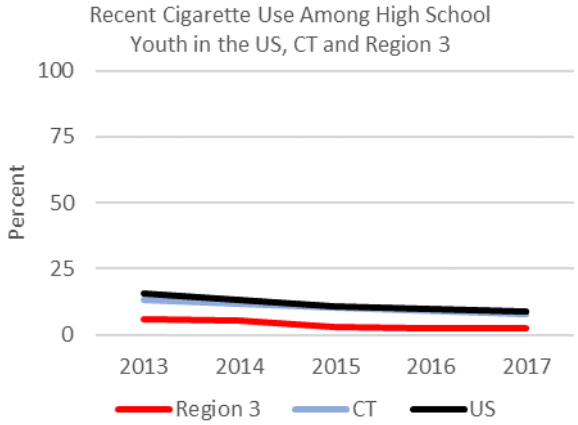
Recent Use

According to the National Survey of Drug Use and Health (NSDUH), recent use of cigarettes among adults in the US generally declined from 2015 to 2017. Use among young adults ages 18 to 25 tends to be higher than use among adults over the age of 25.



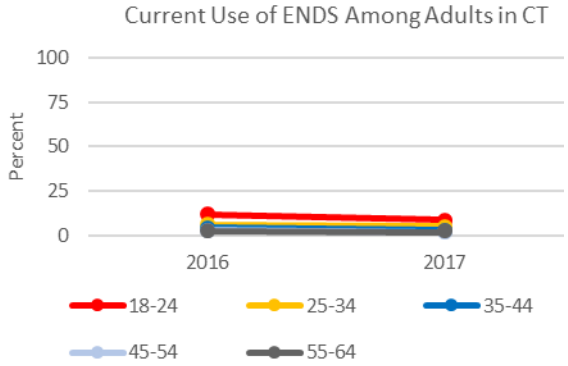
Source: National Survey of Drug Use and Health

Between 2013 and 2017, recent cigarette use among high school youth has tended to in the US, in CT and in Region 3. Recent use among high school youth in Region 3 tends to be lower than state and national averages.



Source: YRBSS, CT School Health Survey, SERAC Regional Youth Survey Data

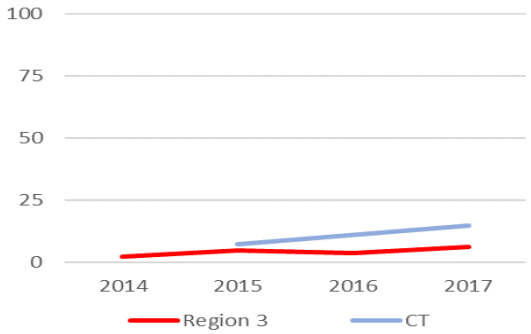
Use of ENDS is an emerging issue. It appears that current ENDS use tends to be lower than recent cigarette use among adults in CT. As with cigarette use, ENDS use tends to be higher among younger adults than among older age groups.



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Jan 28, 2019]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

In contrast to the decline is the use of cigarettes among high school youth, the use of electronic cigarettes appears to be trending higher among high school youth in CT and in Region 3.

[7] WHO (2018)



Source: CT School Health Survey, SERAC Regional Youth Survey Data

According the SERAC Youth Survey (2018) 11% of adults reported using cigarettes and 14% using ENDS in the past 30 days.

Perception of Harm

The percentage of individuals who perceive that there is great risk associated with smoking 1 or more packs of cigarettes per day tends to be 70-75% among all age groups (high school, 18-25, 26+. Data not shown, s*ource: NSDUH, SERAC Regional Youth Survey Data, SERAC Young Adult Survey*

SERAC Regional Youth Survey data shows that only 31% of high school youth in Region 3 perceive that there is great risk associated with the use of ENDS. Between the 2015-16 and 2017-18 school years, the number of sanctions associated with the use of electronic nicotine delivery systems went from 349 to 2,160. (CT DED)

Risk Factors and Subpopulations At-Risk

Due to the high access and availability of ENDS, youth often experiment with nicotine before other substances. "Vaping" products are often marketed to youth and advertised as "safe". Individuals who have smoked cigarettes are also at risk for ENDS use due to marketing campaigns that promote them as safer alternatives.

Burden

Smoking costs the US billions of dollars every year and is the leading cause of preventable death.[8]

According to the Centers for Disease Control and Prevention, more than 16 million Americans are living with a disease caused by smoking. Smoking causes cancer, heart disease, stroke, lung disease, diabetes and chronic obstructive pulmonary disease. Secondhand smoke exposure contributes to approximately 41,000 deaths among nonsmoking adults and 400 infant deaths each year.

In Region 3

- FDA Compliance data for Region 3 shows that from October 2017 through September 2018, 30 of the 370 inspections (8%) resulted in sales to minors. More than half (57%) of those sales involved ENDS or e-liquids.

- Smoking is a leading cause of lung cancer. According to the CT Department of Public Health, from 2010-2014, Region 3 experienced 1088 lung cancer deaths. This corresponds to a crude rate of 46.1 deaths per 100,000. (Age adjusted rates were not available for a significant number of towns in Region 3). This rate is similar to the state rate of 47.5 deaths per 100,000[9]

Capacity and Service System Strengths

According to the 2018 DMHAS Community Readiness Survey, the overall readiness for Substance Abuse Prevention in Region 3 is 4.35. This means that the Region is somewhere between recognizing the existence of a substance abuse problem (4.0) and planning for substance abuse prevention (5.0). The statewide average level of readiness is 5.3. Overall, key informants from Region 3 "somewhat agree" that most community residents are concerned about preventing alcohol abuse (average rating = 2.9, 2=somewhat disagree, 3= somewhat agree). Key informants from Region 3 feel that 1) limited financial resources, 2) too few community members with time or willingness to volunteer and 3) perception that substance abuse us a personal problem, not a community problem are the largest barriers to substance abuse prevention activities in the region. Key informants feel that the community is most ready to raise community awareness about substance abuse problems and convene community meetings to address substance abuse issues and is least ready to allocate local funds for substance abuse prevention.

[8] Centers for Disease Control and Prevention

[9] https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html

Prescription Drugs

Description

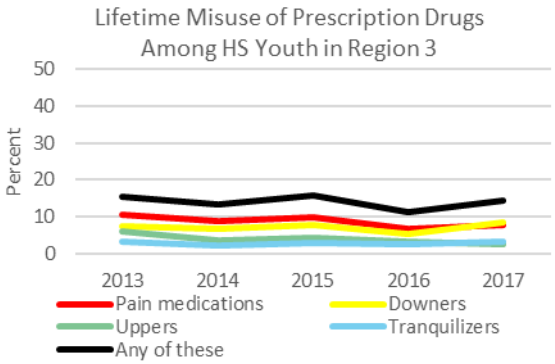
A prescription drug (also prescription medication or prescription medicine) is a pharmaceutical drug that legally requires a medical prescription to be dispensed.

Magnitude

According to the National Institutes of Health misuse of prescription medications is a serious public health problem in the US. In 2017, an estimated 18 million people had misused prescription medications in the past year. Data from the 2017 National Survey on Drug Use and Health showed that approximately 5480 people begin misusing prescription pain relievers every day.

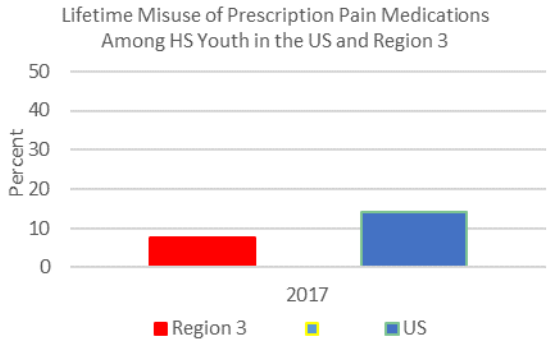
Use

SERAC Regional Youth Survey data shows that lifetime misuse of prescription medications by high school youth in Region 3 has been relatively stable since 2013. The most commonly misused types of prescription medications are pain medications and downers (barbiturates, sleeping pills, sedatives).



Source: SERAC Regional Youth Survey Data

In 2017, the reported lifetime rate of misuse of prescription pain medications among high school youth in Region 3 tended to be lower than the reported national rate.



Source: SERAC Regional Youth Survey Data, YRBSS,

According to the SERAC Young Adult Survey (2018) approximately 3% of individuals reported the misuse of "uppers", 2% "downers", and 1% of pain medications.

Risk Factors and Subpopulations At-Risk

Although misuse of prescription drugs affects many Americans, certain groups including youth and older adults may be at higher risk.[9]

- Individuals who receive a legitimate prescription for opioids during adolescence are at greater risk of future opioid misuse. This is especially true among young adults with no history of drug use. Youth who misuse prescription medications are also more likely to report use of other drugs.
- More than 80% of adults ages 57-85 use at least one prescription medication on a daily basis. More than 50% take more than 5 medications or supplements daily. This access and exposure increases the opportunity to intentional or unintentional misuse of prescription medications.

Burden

An increasing problem, prescription drug abuse can affect all age groups, including teens. The prescription drugs most often abused include opioid painkillers, anti-anxiety medications, sedatives and stimulants.

The opioid epidemic is strongly impacting EDs, with 2018 data from the CDC indicating that there has been a 30% increase in visits for opioid overdose from July 2016 – September 2017.

Capacity and Service System Strengths

According to the2018 DMHAS Community Readiness Survey, the overall readiness for Substance Abuse Prevention in Region 3 is 4.35. This means that the Region is somewhere between recognizing the existence of a substance abuse problem (4.0) and planning for substance abuse prevention (5.0). The statewide average level of readiness is 5.3. Overall, key informants from Region 3 "somewhat agree" that most community residents are concerned about preventing alcohol abuse (average rating = 2.9, 2=somewhat disagree, 3= somewhat agree). Key informants from Region 3 feel that 1) limited financial resources, 2) too few community members with time or willingness to volunteer and 3) perception that substance abuse us a personal problem, not a community problem are the largest barriers to substance abuse prevention activities in the region. Key informants feel that the community is most ready to raise community awareness about substance abuse problems and convene community meetings to address substance abuse issues and is least ready to allocate local funds for substance abuse prevention.

Awareness about prescription drug misuse and the willingness to address the issue within the region has increased significantly. In the past couple of years, SERAC has worked with Local Prevention Councils in several communities to coordinate Prescription Drug Take Back Days. On average, 8 town participate in the 2 DEA days, taking in an average of 180 lbs of medication. Each police station that can have a drop box has one in its lobby for everyday returns. SERAC has also received a grant from EVERFI to provide information to High Schools and community groups on prescription drug misuse/abuse.

SERAC's Regional Prevention Committee has begun to expand its membership to include representatives from up North. The group also expanded to include treatment and recovery professional. This is due to a common goal of reducing the impact of prescription medication misuse.

Marijuana

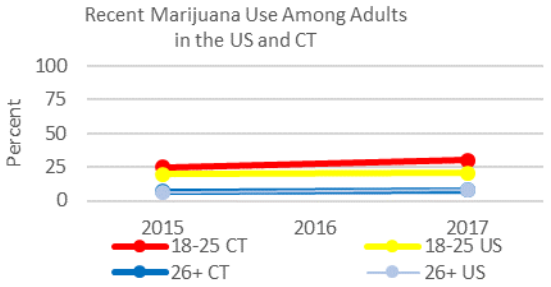
Description

An approved medical and recreational drug that comes from the hemp plant cannabis sativa. The pharmacologically active ingredient in marijuana is tetra-hydro-cannabinol (THC). The long-term effects may include a decrease in motivation and have harmful effects on the brain, heart, lungs, and reproductive system. SAMHSA reports that marijuana is the most commonly abused illicit drug in the United States[10].

Magnitude

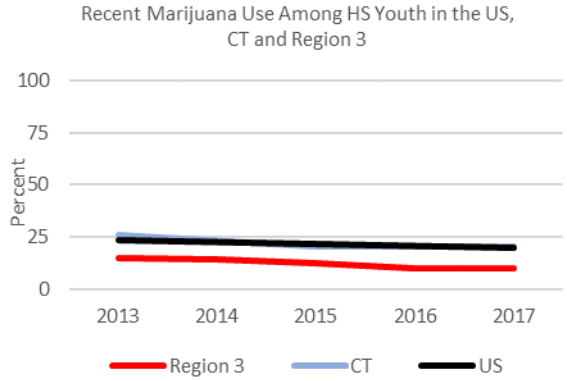
Recent Use

According to data from the National Survey of Drug Use and Health (NSDUH), recent marijuana use among adults in the US and in CT increased slightly from 2015 to 2017.



Source: NSDUH

Since 2013, recent use of marijuana among high school youth in the US, CT and Region 3 appears to be decreasing. The rate of recent use among high school youth in Region 3 tends to be lower than the state and national averages.

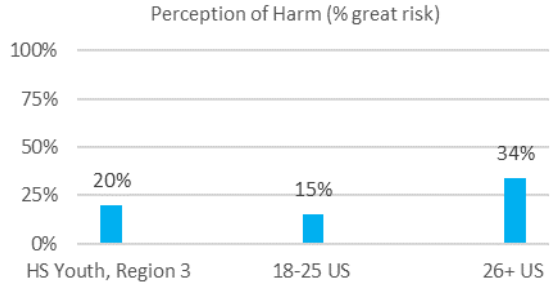


Source: YRBSS, CT School Health Survey, SERAC Regional Youth Survey Data

According to the SERAC Young Adult Survey (2018) 26% of individuals reporting using marijuana in the past 30 days.

Perception of Harm

The percent of individuals who perceive that there is great risk associated with use of marijuana 1 to 2 times per week is generally low and is lowest among individuals aged 18 to 25.



Source: SERAC Regional Youth Survey Data, NSDUH

Risk Factors and Subpopulations At-Risk

According to the SERAC Youth Survey (2017-2019) youth that are recent e-cigarette users are 9 times more likely to report recent marijuana use. In many cases the electronic delivery system is similar, and the odor of THC is not as easily detectable. Individuals with medical marijuana certificates in the state of CT, may be at higher risk for developing cannabis use disorders. Youth and young adult populations who view marijuana with a low perception of harm are at a higher risk for use and dependency.

Burden

According to SAMHSA[11]

- Short-term negative effects of marijuana use can include slower reaction times, decreased coordination
- Long-term negative effects of marijuana use include permanent IQ loss in individuals who start using at a young age, increased risk of depression, anxiety, suicide planning and psychotic episodes as well as relationship problems, low career achievement and reduced life satisfaction.
- Marijuana use during pregnancy may result in fetal growth restriction, premature birth, stillbirth, and problems with brain development resulting in hyperactivity and reduced cognitive function.

[10] https://www.samhsa.gov/marijuana

[11] https://www.samhsa.gov/marijuana

- SAMHSA estimates that 10% of individuals who use marijuana will become addicted. If use begins before the age of 18, the rate rises to 17%.

Connecticut has legalized the use of marijuana for certain medical purposes and have decriminalized the possession of certain amounts of marijuana. Each year adding more physical and mental ailments to the list to extend patients. Other states have legalized the recreational use of marijuana by adults.

In Region 3:
According to the CT DMHAS Annual Statistical Report 2018, marijuana was the primary drug reported in 13% of all admissions, 10% of all substance abuse admissions and 20% of all mental health admissions at DMHAS-funded treatment programs in Connecticut in 2018.

Capacity and Service System Strengths

According to the 2018 DMHAS Community Readiness Survey, the overall readiness for Substance Abuse Prevention in Region 3 is 4.35. This means that the Region is somewhere between recognizing the existence of a substance abuse problem (4.0) and planning for substance abuse prevention (5.0). The statewide average level of readiness is 5.3. Overall, key informants from Region 3 "somewhat agree" that most community residents are concerned about preventing alcohol abuse (average rating = 2.9, 2=somewhat disagree, 3= somewhat agree).

Key informants from Region 3 feel that 1) limited financial resources, 2) too few community members with time or willingness to volunteer and 3) perception that substance abuse us a personal problem, not a community problem are the largest barriers to substance abuse prevention activities in the region. Key informants feel that the community is most ready to raise community awareness about substance abuse problems and convene community meetings to address substance abuse issues and is least ready to allocate local funds for substance abuse prevention.
Local partners recognize that marijuana is the most commonly abused illicit drug in the sub-region. SERAC's Prevention Committee still identifies marijuana as a significant concern among the youth population throughout the Region. Partners find it more and more difficult to combat the marijuana industry as they move to expand in CT. SERAC has worked with a few LPC's to help keep growers and dispensaries out of their community. This is a long process and, as of yet, none have passed and still sit in the Planning and Zoning Committees. Many of the local LPC's are still able to gather forces and rally against the legalization of marijuana.

Heroin

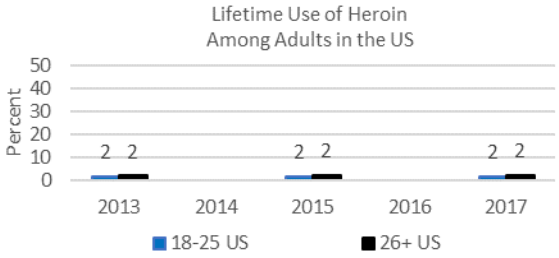
Description

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others (NIH, 2019). Heroin is an illegal, highly addictive drug processed from morphine, a naturally occurring substance extracted from the seed pod of certain varieties of poppy plants. It is typically sold as a white or brownish powder that is "cut" with sugars, starch, powdered milk, or quinine. Highly pure heroin can be snorted or smoked. Impure heroin is usually dissolved, diluted, and injected into veins, muscles, or under the skin.

Magnitude

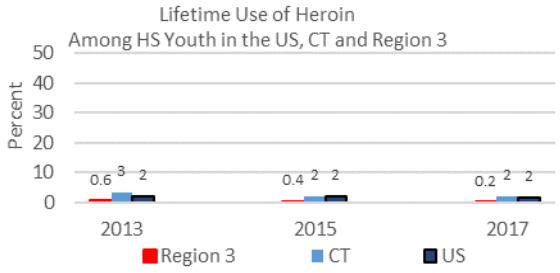
Use

Overall, about 2% of adults in the US report ever having used heroin.



Source: NSDUH

Similarly, about 2% of high school youth in the US and in CT report ever having used heroin. Since 2013, the reported heroin lifetime use rates among high school youth in Region 3 have been less than 1% and have tended to be on the decline.



Source: SERAC Regional Youth Survey Data, CT School Health Survey, YRBSS

According to the SERAC Young Adult Survey (2018) no adults reported using heroin in the past 30 days however, 5% reported lifetime use of heroin.

Risk Factors and Subpopulations At-Risk

Individuals with co-occurring substance abuse disorders are at higher risk for heroin use. Many drug related deaths involving heroin are poly-substance involved including other drugs such as alcohol and cocaine use. Individuals across the lifespan who experience a physical injury (sport or occupation related) and have received prescription opioids for pain management are at higher risk for transitioning to heroin.

Burden

For many, heroin addiction is a lifelong battle characterized by repeated cycles of drug use and abstinence. Users are at increased risk for crime, incarceration, health problems and death. In one 33 yearlong longitudinal NIDA (National Institute on Drug Abuse)-supported study conducted at University of California at Los Angeles, the death rate among a group of heroin addicts was 50-100 times the rate in the general population (*NIDA Notes, Vol. 16, No.4, 2001)*.

Heroin use is associated with serious health consequences including collapsed veins, bacterial infections, viral infections (including HIV Hepatitis), liver and kidney disease, spontaneous abortion, depressed breathing and fatal overdose (NIDA). Regular users often have difficulty concentrating and staying awake. The need to obtain heroin and get high can lead to lateness, absenteeism, poor performance and possible job loss. When finances are insufficient to support the addict's need, family stability and housing can be threatened and the need to resort to criminal activity to support the addiction may arise.

In Region 3

- According to the CT DMHAS Annual Statistical Report 2018, heroin was the primary drug reported in 33% of all admissions, 44% of all substance abuse admissions and 6% of all mental health admissions at DMHAS-funded treatment programs in Connecticut in 2018.

Capacity and Service System Strengths

According to the2018 DMHAS Community Readiness Survey, the overall readiness for Substance Abuse Prevention in Region 3 is 4.35. This means that the Region is somewhere between recognizing the existence of a substance abuse problem (4.0) and planning for substance abuse prevention (5.0). The statewide average level of readiness is 5.3. Overall,

key informants from Region 3 “somewhat agree” that most community residents are concerned about preventing alcohol abuse (average rating = 2.9, 2=somewhat disagree, 3= somewhat agree). Key informants from Region 3 feel that 1) limited financial resources, 2) too few community members with time or willingness to volunteer and 3) perception that substance abuse us a personal problem, not a community problem are the largest barriers to substance abuse prevention activities in the region. Key informants feel that the community is most ready to raise community awareness about substance abuse problems and convene community meetings to address substance abuse issues and is least ready to allocate local funds for substance abuse prevention.

As awareness about prescription drug misuse rises, awareness of the danger of transition from pain medications to heroin seems to be following. At this point, prevention activities are focused primarily on raising awareness and building partnerships.

Cocaine

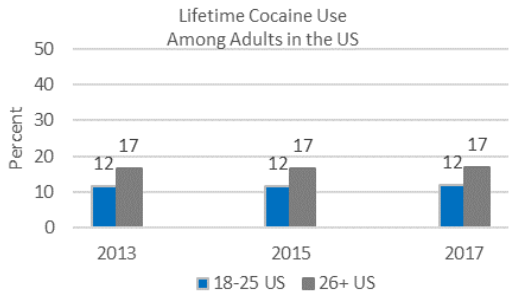
Description

Cocaine is a powerfully addictive stimulant drug that can alter brain structure and function if used repeatedly.

Today, cocaine is a Schedule II drug, which means that it has high potential for abuse but can be administered by a doctor for legitimate medical uses, such as local anesthesia for some eye, ear, and throat surgeries. As a street drug, cocaine appears as a fine, white, crystalline powder and is also known as *Coke*, *C*, *Snow*, *Powder*, or *Blow*.

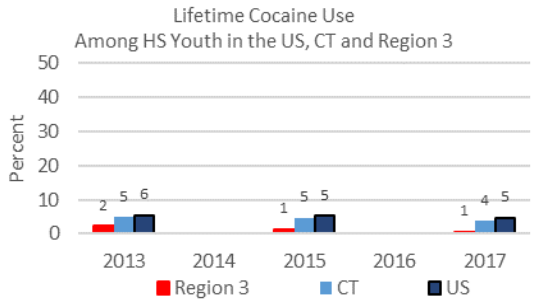
Magnitude

Use:
Since 2013, about 12% of young adults age 18-25 have reported ever having used cocaine in their lifetime. The rate among individuals over the age of 26 has been about 17% since 2013.



Source: NSDUH

Lifetime cocaine use among high school youth in the US, CT and Region 3 has been relatively stable since 2013. The rate in Region 3 tends to be lower than the rate in CT which tends to be similar to the national rate.



Source SERAC Regional Youth Survey Data, CT School Health Survey, YRBSS

According to the SERAC Young Adult Survey (2018) 14% of adults reported having ever used cocaine in their lifetime and 1% in the past 30 days.

Risk Factors and Subpopulations At-Risk

Individuals who engage in poly substance use may be at higher risk for cocaine use. Cocaine is often mixed with other drugs and individuals may be at risk for "speed-balling", a practice that involves chasing stimulants with depressants. Some of those depressants include alcohol and opioids.

Burden

Cocaine can be taken in a variety of ways including orally, by snorting and by injection (NIDA, 2018). Any route of exposure can result in absorption of toxic amounts of cocaine which can lead to cardiovascular and/or cerebrovascular emergencies, seizures and death. Other adverse effects of cocaine use include loss of sense of smell, problems swallowing, irritation of the nasal septum, gangrene of the bowel, infection (bacterial and viral) weight loss and malnourishment.

In Region 3:

- According to the CT DMHAS Annual Statistical Report 2018, cocaine was the primary drug reported in 5% of all admissions, 6% of all substance abuse admissions and 3% of all mental health admissions at DMHAS-funded treatment programs in Connecticut in 2018.

Capacity and Service System Strengths

According to the2018 DMHAS Community Readiness Survey, the overall readiness for Substance Abuse Prevention in Region 3 is 4.35. This means that the Region is somewhere between recognizing the existence of a substance abuse problem (4.0) and planning for substance abuse prevention (5.0). The statewide average level of readiness is 5.3. Overall, key informants from Region 3 "somewhat agree" that most community residents are concerned about preventing alcohol abuse (average rating = 2.9, 2=somewhat disagree, 3= somewhat agree). Key informants from Region 3 feel that 1) limited financial resources, 2) too few community members with time or willingness to volunteer and 3) perception that

substance abuse us a personal problem, not a community problem are the largest barriers to substance abuse prevention activities in the region. Key informants feel that the community is most ready to raise community awareness about substance abuse problems and convene community meetings to address substance abuse issues and is least ready to allocate local funds for substance abuse prevention.

As with heroin, most people seem to be aware of the dangers of cocaine use, but many residents of the sub-region seem unaware of or in denial of the existence of illicit drug use (in general) and cocaine use (in particular). Many seem to feel that cocaine use is only a problem in larger cities. Awareness is slowly increasing due, in part, to media coverage of several recent arrests and overdoses in the area. At this point, prevention activities are focused primarily on raising awareness and building partnerships.

Mental Health

Description

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make 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

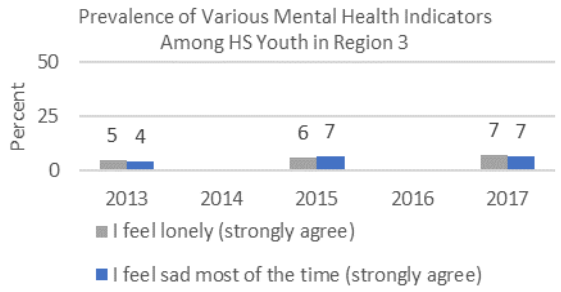
Mental health problems are common but help is available. People with mental health problems can get better and many recover completely.

Source:MentalHealth.gov

Magnitude

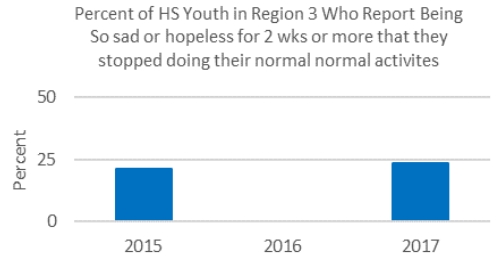
Prevalence

The percentage of high school youth in Region 3 who strongly agree that they feel lonely or feel sad most of the time tended to be higher in 2017.



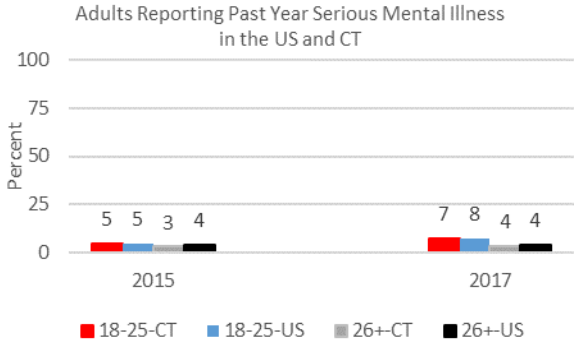
Source: SERAC Regional Youth Survey Data

The percentage of high school youth in Region 3 who strongly agree that they have been so sad or hopeless for 2 weeks or more that it stopped them from doing their normal activities tended to increase from 21% in 2015 to 23% in 2017.



Source: SERAC Regional Youth Survey Data

The rate of past year serious mental illness among adults in CT tends to be similar to the national rate.



Source:NSDUH

According to the SERAC Young Adult Survey (2018) 28% of individuals reported that they have felt sad or hopeless for 2 weeks or more that it stopped them from doing their usual activities. Twenty two percent report having had thoughts of hurting themselves and 9% have actually hurt themselves on purpose.

Risk Factors and Subpopulations At-Risk

Individuals who experience or witness violence can be at an increased risk for mental health challenges. Children who have experienced adverse life experiences can be more susceptible to the risks of developing mental health disorders. According the SERAC Young Adult Survey (2018) 9% of individuals report that a boyfriend/girlfriend has hit, slapped, or physically hurt them.

Burden

Our local LPC report higher cases being seen at the JRB's and Family with Service Needs due to minor crimes, truancy and school behavior. Many of these students have reported undiagnosed mental health concerns with themselves or in their family.

Capacity and Service System Strengths

The level of readiness to address issues of mental health issues in Region 3 is generally lower than the state average. This is a primary area for improvement and development across the eastern region. Cultural norms around mental health present a barrier to accessing treatment and resources. Many individuals and families believe mental health problems are a personal and private issue and should be discussed

openly. There is a lot of stigma associated with mental health that make it difficult to advocate that recovery is possible. Community members and key leaders have a limited understanding of mental health and associated risk factors and it is often "left to professionals" and not viewed as a community issue.

According to key stakeholders, most community residents ….	**Mean Score Region 3**	**Mean Score CT**
Are concerned about improving mental health	3.09	3.20
Would support measures for early identification of mental health problems	3.28	3.32
Are concerned about access to mental health services for adults	3.12	3.21
Believe mental health problems are a private matter to be addresses at home	2.60	2.48

1= strongly disagree, 2=somewhat disagree, 3=somewhat agree, 4=strongly agree

Source: 2018 DMHAS Community Readiness Survey

Suicide

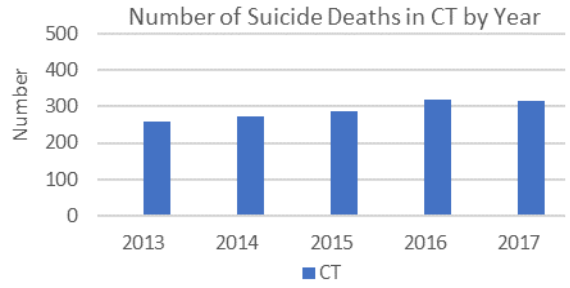
Description

Suicide is death caused by injuring oneself with the intent to die. There are many risk factors associated with suicide including co-occurring issues such as substance abuse disorders and gambling disorders.

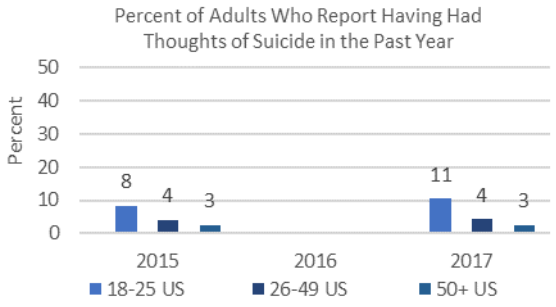
Magnitude

Suicide is a large and growing public health problem. Suicide is the 10th leading cause of death in the United States. It was responsible for nearly 45,000 deaths in 2016, with approximately one death every 12 minutes. Many more people think about or attempt suicide and survive. In 2016, 9.8 million American adults seriously thought about suicide, 2.8 million made a plan, and 1.3 million attempted suicide.

The number of suicide deaths in CT tended to increase from 2013 through 2017.

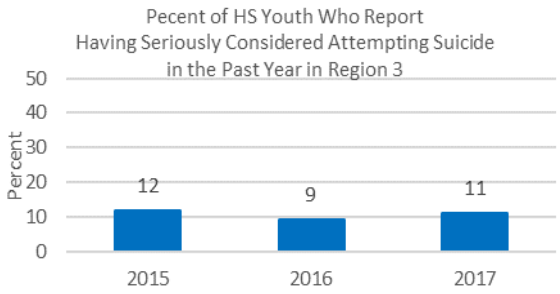


According to the National Survey of Drug Use and Health (NSDUH), among adults, individuals aged 18 to 25 report the highest rate of having had thoughts of suicide in the past year. Between 2015 and 2017, the rate tended to increase in this age group while it remained unchanged among older age groups.



Source: NSDUH

The percent of high school youth in Region 3 who report having seriously considered attempting suicide in the past year tends to be similar to or slightly higher than the rate among young adults ages 18 to 25 in the state and tended to be relatively steady from 2013 through 2017.



Source: SERAC Regional Youth Survey Data

Risk Factors and Subpopulations At-Risk

According to the CDC, some groups have higher rates of suicide than others. Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the life span occurring among non-Hispanic American Indian/Alaska Native and non-Hispanic White populations. Other Americans disproportionately impacted by suicide include Veterans and other military personnel and workers in certain occupational groups. Sexual minority youth bear a large burden as well, and experience increased suicidal ideation and behavior compared to their non-sexual minority peers.

In addition, suicide risk is higher among people who have experienced violence, including child abuse, bullying, or sexual violence. Other characteristics associated with suicide include a history of suicide attempts and lack of problem-solving skills.

Burden

Suicide affects all ages. Suicide is a problem throughout the life span. It is the second leading cause of death for people 10 to 34 years of age, the fourth leading cause among people 35 to 54 years of age, and the eighth leading cause among people 55 to 64 years of age.

Capacity and Service System Strengths

According to the 2018 DMHAS Community Readiness Survey:

- 88% of respondents in Region 3 agree that suicide prevention efforts are needed in the community compared to 94% in Connecticut overall

- The perceived ability to implement suicide prevention efforts in Region 3 is low to medium (mean score 2.7, 2=low, 3=medium)
- Respondents perceive that there is “some” support for suicide prevention efforts in Region 3 (mean score 2.9; 2=a little support, 3=some support)

Problem Gambling

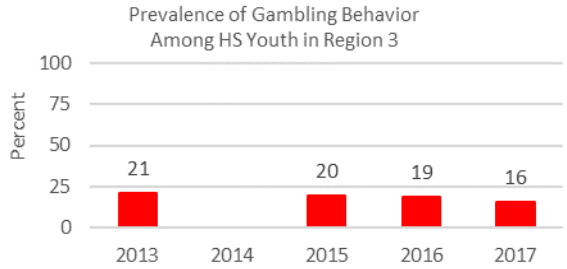
Description

According to the CT Council on Problem Gambling, problem gambling is a disorder or addiction characterized by obsession or loss of control with regard to gambling behavior such that the gambling behavior interferes with the individual's normal activities and responsibilities and negatively impacts personal relationships, finances, school or work performance and health. Pathological gambling is the most severe form of problem gambling.

Magnitude

Prevalence

According to SERAC Regional Youth Survey data, the reported prevalence of gambling behavior among high school youth in Region 3 has tended to decline slightly from 21% in 2013 to 16% in 2017.



Source: SERAC Regional Youth Survey Data

According to the SERAC Young Adult survey (2017, 2018) about one-quarter of young adults between ages 18-25 reported ever gambling in their lifetime and 3% on a monthly basis.

Risk Factors and Subpopulations At-Risk

Data and anecdotal information suggest that youth and young adults age 14-25 are at risk for gambling. Older adults aged 65 and older are at a higher risk for developing gambling use disorders due to the targeted promotion of gambling activities as recreation through senior and social services. Many times older adults have higher access to gambling venues through organized day trips and events.

Burden

According to the CT Council on Problem Gambling:

- Gambling often occurs in association with psychiatric problems and other addictive behaviors.
- Problems gamblers may resort to crime in order to get more cash. Most of these crimes do not involve violence but some, such as robbery and breaking and entering may result in serious injury.
- 20% of pathological gamblers have attempted suicide.
- We are located in the region with the 2 casinos and anecdotally are very aware that problem gambling has on our community.

Capacity and Service System Strengths

According to the2018 DMHAS Community Readiness Survey, 12% of respondents feel it is “very important” to prevent problem gambling (compared to 14% in CT overall) while 35% feel it is “not important at all” to prevent problem gambling (compared to 28% in CT overall).

Due to the presence of two casinos in the Region, SERAC and local community officials are acutely aware of the impacts of problem gambling on the Region. However, even with SERAC regularly bringing forth the need for concern, problem gambling prevention is not a primary focus of most local prevention activities. SERAC continues to work to incorporate problem gambling awareness into existing prevention programming. We have worked with two after school youth programs to educate all youth on the concerns. The students presented to town officials and made other aware by creating a PSA that is shown on the SERAC Wellness TV system. In addition, other professional Problem Gambling PSA are shown in the 16 locations in Eastern CT.

Emerging Issues

Over the past few years increasing concerns regarding the overlap of drug related deaths and suicide deaths has risen. In May 2019, DMHAS Commissioner presented on the issue at the SERAC Annual Prevention Conference and highlighted shared risk factors such as physical health problems, behavioral health, trauma/adverse childhood experiences, and social isolation. Demographics are also shared among the populations with regard to age, race, and gender (typical characteristics: white/Caucasian, middle age, and male). Another commonality among the populations is participation in a labor occupation. A common thread in reduction and prevention of negative behavioral health outcomes is through addressing traumatic and adverse childhood experiences.

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.

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.

Resources, Strengths and Assets

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 discussion to provide remote services, however it is a challenge to maintain the needed

technology such as computers, smart phones, tablet devices, and internet access. With limited providers in the region, access to culturally competent services is a barrier.

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 new 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.

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.

Conclusions

Key Findings

Priority Issue #1: Mental Health

Members of the CNAWs prioritized mental health issues as the top concern for the region. The conversation regarding mental health issues included topics such as depression and anxiety among youth and young adults as well as adults age 65 and older. Advocating for individuals and families with serious mental health issues was also discussed. Most members felt that risk factors related to mental health across all populations were also at the root of substance use disorders, problem gambling disorders, and suicide. The magnitude, impact, changeability, and the consequence of inaction all ranked very high. Efforts to build the capacity and readiness of the region to address mental health issues are needed.

Priority Issue #2: Suicide

The consequence of inaction regarding suicide was ranked as the top indicator for prioritization. Members also reported capacity and readiness as one of the highest factors in addressing suicide prevention. Among key stakeholders, suicide is seen as a preventable issue with opportunities for early intervention. 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.

Priority Issue #3: Heroin

Heroin is viewed as the issue with the highest impact on the region. It was also noted as having one of the highest areas for readiness and capacity. This is largely due to increases in heroin- and fentanyl-related 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. As a result of the distribution of naloxone over the past couple years, local towns have recently begun to see a reduction in drug related deaths. The magnitude of the issue ranked fifth among all issues but showed one of the highest impacts, consequences, and readiness. It was acknowledged that the primary at-risk population is adults aged 18 and older.

Priority Issue #4: Alcohol

Alcohol is ranked as the substance with the highest magnitude alongside marijuana use. For all other indicators alcohol has moderate to high rankings from key stakeholders. Alcohol is still the most commonly misused legal substance among all populations. 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. Combined use of alcohol and prescription drugs among adults is a concern for drug related deaths.

Priority Issue #5: Prescription Drugs

The magnitude of prescription drug use was ranked lower than alcohol for the region. The highest concern was the consequences of inaction. 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.

Priority Issue #6: Tobacco/Electronic Nicotine Delivery Systems (ENDS)

Tobacco had a much lower magnitude than the use of ENDS, however the readiness, capacity, and changeability is viewed as lower in the region. In fact, ENDS products ranked the second lowest in capacity and readiness among all priority issues. Local prevention councils and schools request training and informational sessions on “vaping” fairly regularly.

Priority Issue #7: Marijuana

Marijuana was ranked the lowest for changeability and capacity/readiness of all priority issues. 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.

Priority Issue #8: Problem Gambling

Problem gambling is viewed as the 2nd to lowest priority for the region. Members viewed problem gambling with a high consequence of inaction but 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 with the two casinos in the region. Awareness of other types of gambling that can also present risk factors for addiction are less well known, recognized or discussed. The low prioritization of problem gambling is likely related to low awareness of gambling behaviors as a whole. 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 #9: Cocaine

Cocaine was ranked as the lowest priority issue for the region. Members felt that cocaine use had one of the lowest magnitudes and impacts. It was also ranked as having the lowest consequence of inaction among the issues. Members seemed to be the least knowledgeable on

the issue of cocaine use and its' social impacts. In May, Hartford convened a roundtable to discuss a cluster of overdoses that resulted from the combination of fentanyl and cocaine/crack cocaine. Key leaders reported that they did not know of any local similar trends in the eastern region but recognize that poly substance use is a problem and drugs are often "laced" and mixed.

Recommendations

Problem/Issue	**Prevention**	**Treatment**	**Recovery**
Substance Abuse/ Misuse	Increase awareness and education to reduce access to and availability of alcohol, heroin, prescription drugs. Target ages 14-25, 65 and older as well as LBGTQ populations	Limited-individual therapy Lack of local long-term facilities	Increase recovery services for youth and young adults Increase recovery supports beyond faith-based model of AA Increase adequate housing supports
Mental Health	Local workforce training/education to build capacity Target awareness and education for ages 14-25 and LBGTQ populations	Increase in co-occurring capability Increase early screening Increased emphasis on Trauma Informed care	Increase mental health recovery support groups
Problem Gambling	Education and Awareness of Problem Gambling for Older adults. Targeted campaign for enlisted military and their families. (Sub-base)	Lack of problem gambling treatment services in the north sub region	Increase access to gambling recovery support groups

Systems/Other ***(optional)***	Integration of mental health, prevention, and the strategic prevention framework model	Increase collaboratives to address adult issues around behavioral health (currently limited to opioid treatment or overdose prevention)	Increased support for culturally competent recovery models

Appendix A

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/ READINESS	CONSEQUENCE OF INACTION	TOTAL	MEAN SCORE (higher score, higher priority)	RANK (1-highest)
Alcohol	67	69	63	63	70	332	66	4
Tobacco	54	59	64	65	63	305	61	6
Electronic Nicotine Delivery Systems (ENDS), vaping, juuling	64	63	53	50	69	299	60	7
Marijuana	67	66	47	46	69	295	59	8
Prescription Drug Misuse	63	68	63	58	71	323	65	5
Heroin	65	75	63	65	78	346	69	3
Cocaine	54	62	57	52	62	287	57	10
Problem Gambling	56	60	53	52	68	289	58	9
Mental Health Issues	73	77	70	62	79	361	72	1
Suicide	68	70	67	65	80	350	70	2

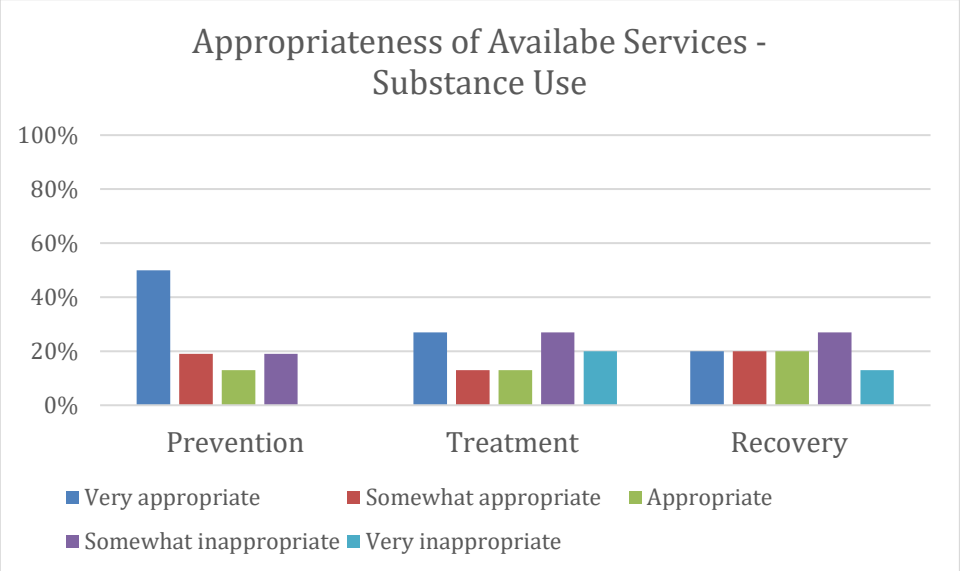
Appendix B

Key Stakeholder Survey Respondents

Respondent Description	Number	%
DHMAS-funded mental health treatment provider	3	19%
DHMAS-funded substance abuse treatment provider	1	6%
Human Services	1	6%
Non-profit helping with Substance Abuse	1	6%
Law Enforcement	1	6%
Prevention Coalition	2	13%
School personnel	2	13%
Youth Serving Organization	5	31%
Total	**16**	**100%**

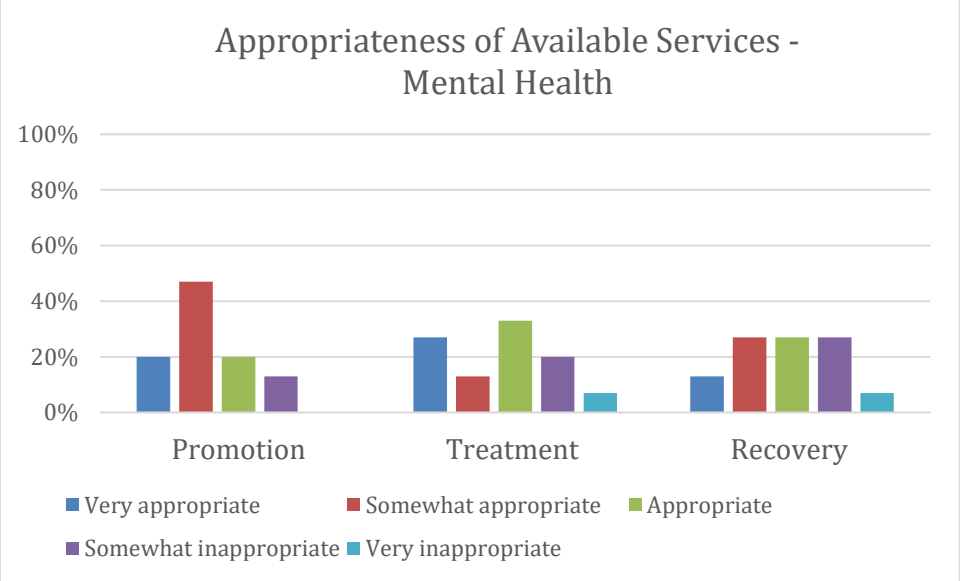
How appropriate are the available services to meet the need for the following:

Service Need	Response	%
Substance Use Prevention	Very appropriate	50%
	Somewhat appropriate	19%
	Appropriate	13%
	Somewhat inappropriate	19%
	Very inappropriate	0%
Substance Use Treatment	Very appropriate	27%
	Somewhat appropriate	13%
	Appropriate	13%
	Somewhat inappropriate	27%
	Very inappropriate	20%
Substance Use Recovery	Very appropriate	20%
	Somewhat appropriate	20%
	Appropriate	20%
	Somewhat inappropriate	27%
	Very inappropriate	13%



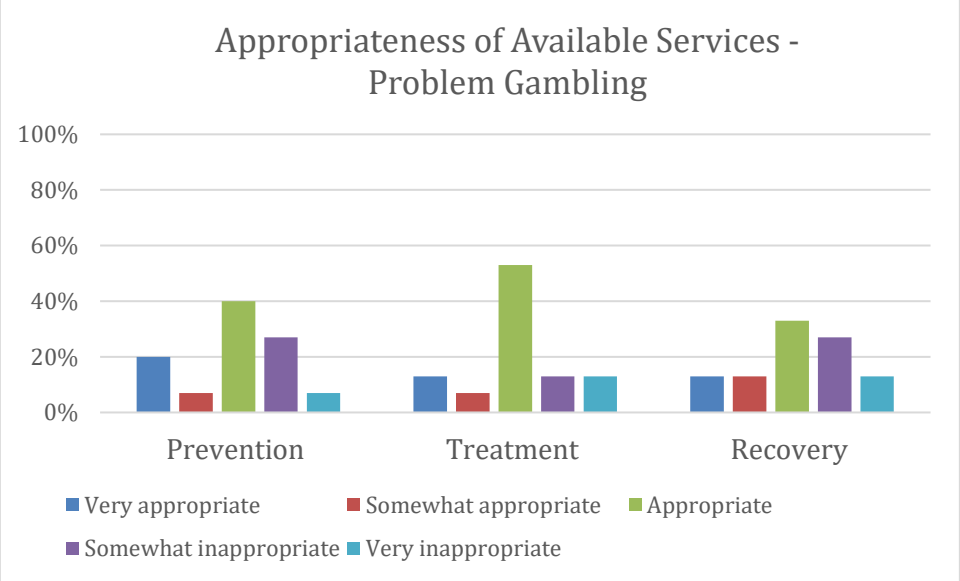
How appropriate are the available services to meet the need for the following:

Service Need	Response	%
Mental Health Promotion	Very appropriate	20%
	Somewhat appropriate	47%
	Appropriate	20%
	Somewhat inappropriate	13%
	Very inappropriate	0%
Mental Health Treatment	Very appropriate	27%
	Somewhat appropriate	13%
	Appropriate	33%
	Somewhat inappropriate	20%
	Very inappropriate	7%
Mental Health Recovery	Very appropriate	13%
	Somewhat appropriate	27%
	Appropriate	27%
	Somewhat inappropriate	27%
	Very inappropriate	7%



How appropriate are the available services to meet the need for the following:

Service Need	Response	%
Problem Gambling Prevention	Very appropriate	20%
	Somewhat appropriate	7%
	Appropriate	40%
	Somewhat inappropriate	27%
	Very inappropriate	7%
Problem Gambling Treatment	Very appropriate	13%
	Somewhat appropriate	7%
	Appropriate	53%
	Somewhat inappropriate	13%
	Very inappropriate	13%
Problem Gambling Recovery	Very appropriate	13%
	Somewhat appropriate	13%
	Appropriate	33%
	Somewhat inappropriate	27%
	Very inappropriate	13%



What prevention program, strategy or policy would you like most to see accomplished related to each of the following?

Substance Use
Access: Access to treatment, more facilities, more beads, more school-based services
Treatment: psychological treatment along with MAT, use of evidence based programs, youth nicotine cessation programs
Education: Early education, protective factors, more education in schools
Secondary prevention for those living with addiction
Supportive services: housing
Specific substances: electronic cigarettes, vaping
Policy and advocacy: impact of marijuana legalization in adjacent states

Mental Health
Access: Early screening and rapid access to services, more school based services
Treatment: increased staffing ratios, exploration of alternative therapies, peer supports
Education: MHFA in schools. Co-occurring
Specific issues: Suicide prevention, Depression
Policy and Advocacy: more funding for non-profits, efforts to eliminate duplication of services provided by the State of CT

Problem Gambling
Treatment: More screening in community health centers, focus on safe gambling practices and self-imposed restrictions to accessing money
Education: Problem gambling prevention and education for youth
Specific issues: video game-based gambling
Policy and Advocacy: curtain gambling options, monies collected by cities and towns from OTB and casinos should go toward prevention not general funds, renegotiate agreements with tribes

What treatment levels of care do you feel are unavailable or inadequately provided for each of the following?

Substance Use
Access: too few beds, wrong insurance, wrong level of care
Treatment: detox beds, follow up care, long and short term sober/supportive housing, inpatient beds, family treatment, school-based services/prescribers
Specific substances: vaping products, cocaine/crack
Specific populations: Youth

Mental Health
Access: available beds, wrong level of care, long waiting lists, early screening
Treatment: counseling services, psychiatric care/evaluation, crisis/emergency, brief care
Specific populations: Children, youth
Policy and Advocacy: funding disparity between agencies for per client expenditures

Problem Gambling:
Access: GA meetings are not available in this area
Treatment: Inpatient, family treatment, support groups

What adjunct services/support services/recovery supports are most needed to assist individuals with each of the following?

Substance Use
Treatment: Community based groups, Drop-in support, Individual treatment, family support, peer support/recovery coaches, alternative therapies, follow up treatment/outpatient counseling
Supportive Services: employment, (recovery) housing, education, transportation, financial

Mental Health Issues
Treatment: Alternative therapies, drop in support, follow up, school-based services
Supportive Services: Employment, housing, education, transportation, financial

Problem Gambling
Access: More GA meetings, additional treatment facilities
Treatment: drop-in support
Supportive services: financial recovery, professional referrals (tax professional, lawyers, debt) transportation, financial

What would you say is the greatest strength/asset of each of the following?

Substance Use Prevention/Treatment/Recovery Service System
Campaigns to reduce stigma
Local Prevention Councils, primary prevention, community education
MAT
Recovery Coaches/Peer Support Programs, strong recovery community
SERAC

Mental Health Promotion/Treatment/Recovery Service System
211
Campaigns to raise awareness and reduce stigma
Current level of awareness
Agencies that provide broad range of services (clinical treatment, medication. Employment
Peer support
SERAC

Problem Gambling Prevention/Treatment/Recovery Service System
Availability of treatment
Increasing awareness
Peer support
SERAC

Are there any particular sub-populations that are not being adequately served by the **substance use service system**?

Sub-population	Number	%
Youth 14-17	8	50%
Young adults 18-25	5	31%
Adults 65+	5	31%
Sexual orientation	4	25%
Transgender individuals	4	25%
Youth under age 13	3	19%
Military (active, veteran)	3	19%
Adults 26-64	2	13%
English as a second language	2	13%
Ethnic/Racial – please specify: non-white	1	6%
Females	0	0%
Males	0	0%

Are there any particular sub-populations that are not being adequately served by the **mental health service system**?

Sub-population	Number	%
Youth 14-17	8	50%
Sexual orientation	7	44%
Transgender individuals	7	44%
Young adults 18-25	6	38%
Youth under age 13	5	31%
Adults 65+	5	31%
Adults 26-64	4	25%
Military (active, veteran)	4	25%
English as a second language	3	19%
Females	1	6%
Males	1	6%
Ethnic/Racial – please specify: Asian	1	6%

Are there any particular sub-populations that are not being adequately served by the **problem gambling service system**?

Sub-population	Number	%
Adults 65+	5	31%
Youth 14-17	3	19%
Military (active, veteran)	3	19%
English as a second language	3	19%
Young adults 18-25	2	13%
Sexual orientation	2	13%
Transgender individuals	2	13%
Youth underage 13	1	6%
Adults 26-64	1	6%
Females	1	6%
Males	1	6%