# REGIONAL BEHAVIORAL HEALTH PRIORITIES REPORT

# FOR SOUTHWESTERN CONNECTICUT (REGION 1)

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THE HUB: BEHAVIORAL HEALTH ACTION ORGANIZATION FOR SOUTHWESTERN CT

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## CONTRIBUTORS

We would like to thank our many collaborators in the region for the insights they have shared with us in focus groups, key informant interviews, workgroups and committees, trainings, coalition meetings, and countless events throughout the year at which needs, concerns and gaps are discussed. The feedback from individuals living with a behavioral health disorder; DMHAS clients; families; community members; behavioral health providers; municipal, social services, and housing workers, including the Community Care Teams and members of Opening Doors Fairfield County; legislators; and other stakeholders is essential to our understanding of the region and the recommendations included here.

We would particularly like to thank the members of our Regional Advisory Board (RAB), Catchment Area Councils (CACs), Local Prevention Councils (LPCs), and Data Workgroup. Special gratitude to the following members of these groups who helped review the epidemiological profiles, prioritize needs, and provide feedback on the recommendations:

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## ABBREVIATIONS

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

| | |
|---|---|
| SADD | Students Against Destructive Decisions |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SBIRT | Screening, Brief Intervention and Referral to Treatment |
| SDE | State Department of Education |
| SMI | Serious Mental Illness |
| SUD | Substance Use Disorders |
| SW CT | Southwest Connecticut |
| TEDS | Treatment Episode Data Set |
| THC | Tetrahydrocannabinol |
| TRS | Telephone Recovery Support |
| US | United States |
| USDEA | U.S. Drug Enforcement Agency |
| YRBS | Youth Risky Behavior Survey |

## EXECUTIVE SUMMARY

In its role as the Regional Behavioral Health Action Organization (RBHAO) for Southwestern Connecticut, The Hub—a division of RYASAP—was tasked by the Connecticut Department of Mental Health and Addiction Services (DMHAS) with preparing a data-driven analysis of the behavioral health needs of the region, with assistance from key community stakeholders. The report's primary purpose is to inform DMHAS of the behavioral health needs of children, adolescents, and adults in Southwest CT (Region 1), providing data and priority recommendations for prevention, treatment, and recovery services.

The report is comprised of four parts. The introduction describes the data collection and report development process, including the variety of data sources used and the stakeholders involved. In the second part, we provide an **overview of the region** and summarize the current state of key behavioral health issues. This section of the report begins with demographic information and a description of the critical economic factors –housing and transportation—that differentiate Region 1. It examines priority issues in detail, providing **10 regional epidemiological profiles** on each of the following topics: alcohol, tobacco/nicotine, marijuana, prescription drugs, heroin and illicit opioids, cocaine, illicit drugs, problem gambling, mental illness, and suicide. Each two- to three-page profile identifies the prevalence and magnitude of the issue, lists risk factors and at-risk populations, and summarizes the region's capacity and resources to address that problem. These profiles can be used individually or together to provide a snapshot of behavioral health in the region. We have additionally used the data from the profiles to develop infographics for use in community education throughout the region.

The second section of the report also summarizes **emerging issues, resources, and gaps** in the region. Emerging and current trends in the region include the increase in vaping (including vaping of marijuana); changing perceptions around marijuana; increases in mental health disorders and suicide at all ages; the use of benzodiazepines, and concurrent changes in the prevalence of opioids and other drugs such as cocaine and PCP. In terms of resources, Southwest CT benefits from many well networked community partners, a large number of treatment providers, and a wide range of recovery supports. Nonetheless, gaps exist along the prevention, treatment and recovery continuum. In the area of prevention, funding and staffing are insufficient for the desired impact on substance use, mental health, and gambling practices in the region. Current funding and programming are seen as focusing on the opioid epidemic to the detriment of other drug prevention and mental health promotion. Suicide efforts, in particular, are not funded by the state.

Treatment gaps include a dearth of supportive and affordable housing and of case management, which are necessary to provide a safe space for treatment and recovery. There are ongoing serious barriers to accessing prescribers. There continues to be a need for a First-Episode Psychosis program, a program similar to DMHAS's Young Adult Services that is accessible to non-DMHAS clients, respite options (respite beds and/or a peer respite), and longer-term addiction beds, as has been documented previously. Gaps in recovery supports include the expressed need for support groups for postpartum depression, alternatives to suicide, co-occurring disorders, and SMART Recovery groups for adults. There is great need to expand employment options for peers who have been trained as Recovery Support Specialists or Recovery Coaches. The populations identified as underserved include the elderly, the undocumented, individuals with language or cultural differences, and individuals with autism and co-occurring mental illness. The middle class as a whole continues to suffer from financial and insurance barriers to accessing mental health and addiction treatment.

The third section of the report identifies **priorities for the region** as well as recommendations for the regional and state levels. The regional priorities were developed with assistance from a variety of key community stakeholders. Members of The Hub's Regional Advisory Board and Data Workgroup met to use the data from the epidemiological profiles, along with their own individual insights and professional experiences, to prioritize the region's needs based

on the magnitude and impact of each problem, as well as the region's capacity to change. Their ranking process identified Mental Health, Prescription Drugs, and Alcohol as the top 3 priorities in the region, with total scores of 4.4, 3.9, and 3.8 (out of 5), respectively. Stakeholders commented on the importance of directing attention to these issues, given the current societal and governmental focus on opioids.

Mental health ranked first because disorders such as depression and anxiety are more prevalent than substance misuse. Mental illnesses have been increasing dramatically, particularly among teens and young adults, and are associated with the other behavioral health concerns, such as substance misuse, suicide, and gambling. As such, improvements in mental health also serve as upstream ways of reducing substance use disorders. Prescription drugs ranked second: while efforts to reduce dosage and diversion of opioid medications have shown success, benzodiazepines, antidepressants, and stimulants continue to be widely prescribed. Benzodiazepines were identified as an area for community and provider education, given the prevalence of misuse, sharing and diversion and difficulties in discontinuing their use. Alcohol was identified as the third priority due to its ongoing status as the most-used drug, need for education about the common practice of binge drinking, and ongoing education around the social hosting law.

Nicotine (including vaping), suicide, and illicit opioids tied for fourth place. Stakeholders saw these issues as important and also tied to the other topics. They observed that efforts to address behavioral health issues such as mental health and substance use should not be done in siloes. Marijuana was ranked in fifth place, ahead of cocaine and problem gambling, which tied in last place in the ranking, reflecting their very low prevalence. Although stakeholders agreed that marijuana is harmful to youth and often serves as a gateway drug, most felt that it is in such common use that efforts to prevent legalization were unlikely to succeed.

The priorities section of the report includes **specific recommendations** regarding these topics as well as other areas of prevention, treatment, and recovery. Recommendations are made separately for the region and for the state. At the regional level, The Hub will seek to raise awareness of the issues and resources in this report, educate the public and providers, advocate for changes and support legislation, and coordinate among the various stakeholders to help address the identified needs. At the state level, we propose recommendations to address the programmatic and educational needs that are under the purview of the state agencies. At all levels, stakeholders recommend reducing fragmentation of services.

The final section of the report is an appendix that includes an eight-page **summary of community feedback**. This includes responses from consumers and providers to questions about the appropriateness of available services, prevention needs, inadequate levels of care, needed support services, system strengths, underserved populations, emerging needs, and opportunities.

Our hope is that this report will be useful in the following ways:

- The state will use the information for strategic planning and to inform the use of federal block grants for substance use and mental health.
- At the regional level, The Hub and its strategic community partners will use the findings to support capacity and readiness building; strategic planning; implementation of evidence-based programs, practices and strategies; and evaluation of efforts to reduce substance abuse, problem gambling and mental health issues.
- At the local level, the data and recommendations will be shared with legislators, provider agencies, and municipalities to inform their decision making, policies and resource allocation.

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# INTRODUCTION

## BACKGROUND

Biannually, the Connecticut Department of Mental Health and Addiction Services (DMHAS) planning division conducts a Priority Planning Process to develop plans for mental health and addiction services at the local, regional, and state levels and inform the state's application for the federal block grants allocated by the United States Substance Abuse and Mental Health Service Administration (SAMHSA). The priorities process is based on regionally-developed needs assessments that identify target populations and their needs, as well as strengths and critical gaps in the service delivery system. This process also informs and is informed by SAMHSA's Strategic Prevention Framework (SPF) model, which is a five-step, data-driven process known to promote youth development and prevent problem behaviors across the lifespan.

In Southwest CT (SW CT), The Hub, a program of the Regional Youth Adult Social Action Partnership (RYASAP), is the Regional Behavioral Health Action Organization (RBHAO) charged with conducting this process in order to assess the behavioral health needs of children, adolescents and adults regarding substance misuse, mental health and problem gambling.

The present report is the result of the 2018-2019 priorities process in Southwestern CT, designated by DMHAS as "Region 1." In completing the report, The Hub developed a regional plan that includes epidemiological profiles and priority recommendations for prevention, treatment, and recovery services. The findings will be used by DMHAS to generate identify initiatives and funding priorities for the federal block grants, to develop recommendations and priorities within the Prevention Division, and to compare findings across regions. The report will also be disseminated to partners within the region, including municipal health and social services departments, treatment agencies, prevention councils, consumer groups, legislators, and funding agencies, to inform regional and local initiatives. This will help the partners support state and community-level data driven processes, including readiness assessment and capacity building, strategic planning, implementation of evidence-based programs and strategies, and evaluation of those programs and strategies.

## DATA SOURCES

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

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

**Regional Surveys:** Including the 2018 and 2015 surveys of adults over 18 in the Bridgeport, Norwalk, Stamford and Greenwich sub-regions, conducted by DataHaven as part of the Community Health Needs Assessments, and the 2018 Community Readiness Survey conducted by The Hub.

**State Data**: Including 211 call data, the Connecticut School Health Survey, CT Behavioral Risk Factor Surveillance Survey, accidental overdose deaths and suicides from the Office of the Chief Medical Examiner, arrests, motor vehicle accidents and fatalities, treatment admissions, school suspensions and expulsions, and other statistics compiled by the CT Data Collaborative from state and federal sources and available through the State Epidemiological Outcomes Workgroup website.

**National Data**: Including Census data, National Survey of Drug Use and Health, Youth Risky Behavior Surveillance System.

**Qualitative Data:** Including focus groups with Catchment Area Councils (CACs) and Community Care Teams; key informant interviews with behavioral health consumers and providers; discussions at Local Prevention Council (LPC) meetings; and identification of needs and gaps at subregional meetings and task forces, including the Greenwich Community Health Improvement Project, the Bridgeport Health Improvement Alliance, the Health and Housing Stability Workgroup, Opening Doors Fairfield County, Region 1 Gambling Awareness team, and other meetings throughout the year.

## STRENGTHS AND LIMITATIONS

This report attempts to summarize behavioral health prevention, treatment, and recovery needs and recommendations for CT's Region 1. Although we believe the information presented is reliable and valid, it is neither practical nor possible to cover such a wide spectrum in a single report.

The strengths of this report are that is based as much as possible on state, regional and local data, as well as input from a broad range of behavioral health stakeholders with a deep understanding of the region. The epidemiological profiles present regional information in comparison to national and state data, with local data where possible. The recommendations are consistent with past needs and community suggestions.

The report is limited by inconsistencies in the data sources available. While all data presented are the most current available, they are not all from the same year. Some indicators are available only at the state level but not the regional or local. The phone surveys conducted throughout the region in 2018 were largely the same but not identical to the surveys in 2015. Youth surveys were conducted in some, but not all, local communities between 2017 and 2019. Although prevalence data from these youth surveys has been included as an illustration, they cannot be considered representative of the entire region.

## PROCESS FOR DEVELOPING REPORT

The development of this report represents work throughout the year as well as a focused effort in the spring of 2019. Initial identification of concerns and recommendations derived from focus groups and key informant interviews conducted in the summer and fall of 2018, with additional focus groups and interviews in the spring of 2019. Those findings were updated based on further discussions with strategic partners throughout the year.

In early 2019, Hub staff invited members of Local Prevention Councils (LPCs), Catchment Area Councils (sCAC), and the Regional Advisory Board (RAB) to participate in a Regional Data Workgroup. Volunteers included a cross section of consumers, family members and providers with deep experience with substance use and mental health. Workgroup members met in person twice to discuss the process and sample data. Some also provided additional data from their towns. Hub staff then researched and produced draft epidemiological profiles on 10 required topics, which were shared with workgroup members. Members provided feedback on drafts via email or phone. Hub staff incorporated the feedback and produced revised epidemiological profiles, which were shared with workgroup members and other interested parties.

In early June, the stakeholders met to review the compiled information, share anecdotal information and feedback about the issues from their local perspectives, and participate in a consensus-building discussion to rank the various topics (see matrix in appendix). Staff then produced a draft summary of regional feedback (included in appendix) which was reviewed by workgroup and RAB members, followed by draft recommendations, which were also reviewed by the workgroup and RAB members. All feedback was incorporated in the present document.

# BEHAVIORAL HEALTH IN SOUTHWESTERN CT

## DESCRIPTION OF THE REGION

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

## DEMOGRAPHICS

Table 1 (see next page) lists the population and basic demographic statistics for each municipality in the region, based on the 2017 American Community Survey 5-Year Estimates, a project of the U.S. Census. In each column, the maximum value is highlighted in **blue** and the minimum in **red**; the average percentages for the region are shown in **grey**. Also reported for comparison purposes are data for Fairfield County, since Region 1's population of 943,823 represents 74.4% of the county population.

Region 1 is predominantly Caucasian. Among the 14 municipalities, Bridgeport stands out as the only place where Caucasians are a minority ethnic group, at 40.4%.

- The municipalities with a significant African-American population are Bridgeport, Norwalk, Stratford, and Stamford (listed from largest to smallest percent African-American). At 35%, Bridgeport's African-American population is more than twice as high as the next-largest in the region.
- Municipalities with significant Latino populations include, in descending order, Bridgeport (39%), Norwalk (27%), Stamford (27%), Stratford (15%), and Greenwich (13%).
- While Asians make up only 6% of Fairfield County's population overall, six municipalities in Region 1 have Asian populations greater than this average: Stamford (8.6%), Greenwich, Wilton, Westport, Darien and Trumbull.

Southwest CT is younger overall than Fairfield County, with one quarter of the region's population under age 18, compared with 22.5% of the county's population. Darien, Weston, New Canaan and Wilton have significant youth populations, with around one third of the population under age 18. Bridgeport, Darien, Stamford and Weston all have much smaller populations of older adults (ages 65 and up) than the regional or county average. Meanwhile, Stratford, Trumbull, Easton and Fairfield have higher populations of seniors than the county average.

Across Fairfield County, 30% of households speak a language other than English at home. Within Southwest CT, the largest cities (Bridgeport, Stamford and Norwalk) have much higher proportions of households speaking a foreign language at home. In Bridgeport, almost half (48%) of households speak another language in the household. The most common foreign language is Spanish.

## TABLE 1: DEMOGRAPHIC PROFILE OF SOUTHWEST CT (REGION 1)

| Town | Pop Est. for 2018 | % White | % Black | % Asian | % 2+ Races | % Latino | % Youth <18 | % Pop 65+ | % Persons age 5+ in poverty | % Lang. Other than English Spoken in Home |
|---|---|---|---|---|---|---|---|---|---|---|
| **Bridgeport** | 144,900 | **40.4%** | **35.3%** | 3.1% | **4.6%** | **39.2%** | 23.7% | **10.7%** | **20.8%** | **47.5%** |
| **Darien** | 21,753 | 91.1% | 0.7% | 6.3% | 1.6% | **3.1%** | **32.5%** | 12.0% | 3.7% | 14.4% |
| **Easton** | 7,517 | **96.5%** | **0.0%** | **2.5%** | **0.7%** | 4.9% | 23.5% | 17.7% | 4.3% | 12.5% |
| **Fairfield** | 61,952 | 89.2% | 1.8% | 4.5% | 3.1% | 6.3% | 24.0% | 15.6% | 4.7% | 18.1% |
| **Greenwich** | 62,727 | 84.1% | 3.3% | 7.8% | 2.9% | 12.7% | 25.8% | 16.9% | 6.6% | 28.7% |
| **Monroe** | 19,470 | 92.4% | 0.2% | 4.6% | 2.1% | 4.2% | 24.9% | 14.6% | 3.8% | **10.9%** |
| **New Canaan** | 20,213 | 93.5% | 2.1% | 2.6% | 1.5% | 5.3% | 29.6% | 15.6% | 3.7% | 15.9% |
| **Norwalk** | 89,047 | 73.2% | 15.6% | 5.2% | 2.1% | 26.9% | 21.0% | 14.2% | 9.2% | 38.3% |
| **Stamford** | 129,775 | 62.4% | 14.6% | **8.6%** | 2.8% | 26.5% | 20.3% | 13.8% | 9.3% | 42.5% |
| **Stratford** | 51,967 | 74.3% | 15.6% | 3.3% | 2.9% | 15.3% | **18.6%** | **19.5%** | 8.2% | 19.8% |
| **Trumbull** | 35,802 | 85.7% | 4.3% | 6.1% | 2.3% | 8.4% | 24.2% | 18.7% | **1.9%** | 16.4% |
| **Weston** | 10,247 | 92.5% | 0.3% | 3.0% | 3.7% | 6.5% | 30.8% | 12.9% | 2.6% | 13.9% |
| **Westport** | 28,115 | 88.9% | 0.6% | 6.8% | 3.3% | 4.4% | 27.6% | 16.4% | 4.3% | 14.9% |
| **Wilton** | 18,397 | 88.5% | 1.0% | 7.6% | 2.5% | 3.2% | 29.2% | 15.4% | 3.5% | 13.6% |
| ***Region 1 averages*** | 701,882 | 82.3% | 6.8% | 5.1% | 2.6% | 11.9% | 25.4% | 15.3% | 6.2% | 22.0% |
| ***Fairfield County*** | **943,823** | **78.7%** | **12.7%** | **5.8%** | **2.1%** | **20.2%** | **22.5%** | **15.9%** | **8.8%** | **29.5%** |

Source: American Community Survey 5-Year Estimates based on 2017 updates, accessed on 6/26/19 from www.census.gov/quickfacts

## ECONOMIC PROFILE, INCLUDING HOUSING AND TRAVEL

The most striking difference in the region is economic. Based on American Community Survey 2017 data, the median household income ranges from a low of $44,841 in Bridgeport (one-half the median income for the county, which is $89,773) to a high of $219,868 in Weston (2.5 times the county median). In Bridgeport, one in five individuals lives in poverty compared with one in 50 in Trumbull.

The Cost of Living Index (COLI)[1] is a way of comparing the cost of living in a particular community to the median cost of living for the U.S., which is represented by a score of 100. In Fairfield County, the COLI is 140, or 40% higher than the U.S. as a whole. This is also much higher than the state COLI of 118.4.

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

- The Housing COLI for the county is 176, compared with 126 for the state. The housing index ranges from 87.4 in Bridgeport (lower than state and US) to **727** in Darien. Behavioral health agencies that are located in the region's urban areas have to contend with much higher housing costs than agencies located in other cities in the state: 212.5 in Norwalk and 154.6 in Stamford. (The Norwalk housing COLI has surpassed Stamford's in the past couple of years.)
- The Transportation COLI for the county is 147.7, compared with 128 for the state. It is even higher in Bridgeport, at 150.7.

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

## REGIONAL EPIDEMIOLOGICAL PROFILES

The following pages profile 10 aspects of behavioral health in the region: **alcohol, tobacco, marijuana, prescription drugs, heroin/illicit opioids, cocaine, illicit drugs, problem gambling, mental health, and suicide.** For each, we present information about the topic, prevalence data, risk factors, information about the impact of the problem, and a brief discussion of resources in the region that address the issue. In the following section we discuss the findings, trends, and recommendations. (Note some possible redundancies in the information provided, as these profiles are expected to also serve as independent handouts.)

[1] COLI data generated from Sperling, accessed 6/26/19

**Alcohol** is the most frequently used and misused substance in Connecticut and in the United States. People who drink to excess, including binge drinkers (bingeing refers to having 5+ drinks on a single occasion for men, 4+ for women), have an increased risk for alcohol abuse and dependence and can even die from alcohol poisoning. Alcohol misuse is especially problematic among youth and college-aged populations. People who begin drinking before the age of 15 are four times more likely to develop alcohol dependency than those who wait until age 21, and each additional year of delayed drinking onset reduces the probability of alcohol dependence by 14%.[2] Alcohol use, including underage drinking, is socially and culturally acceptable in many settings. Many adults are unaware of the social hosting law that holds them legally responsible for underage drinking on their property.

## Magnitude:

Alcohol continues to be the most commonly used substance nationally. Consumption in Connecticut is higher than the national average, and consumption in Southwest Connecticut (SW CT) is higher than both, as shown in Figure 1 from the National Survey of Drug Use and Health (NSDUH).

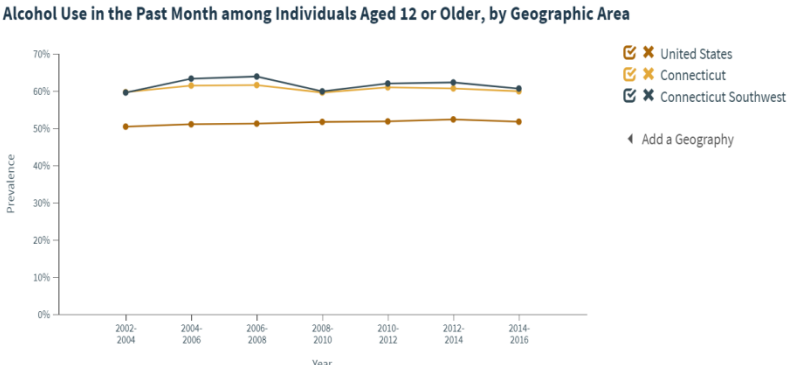



Figure 1: Past Month Alcohol Consumption In US, CT AND SW CT

Binge drinking was reported by 3% of Stamford-area adults, 5% of Bridgeport-area adults, 6% of Norwalk-area adults, and 11% of Greenwich-area adults (2018 DataHaven surveys). Binge drinking among ages 12+ in SW CT is higher than state and national rates (see Figure 2).

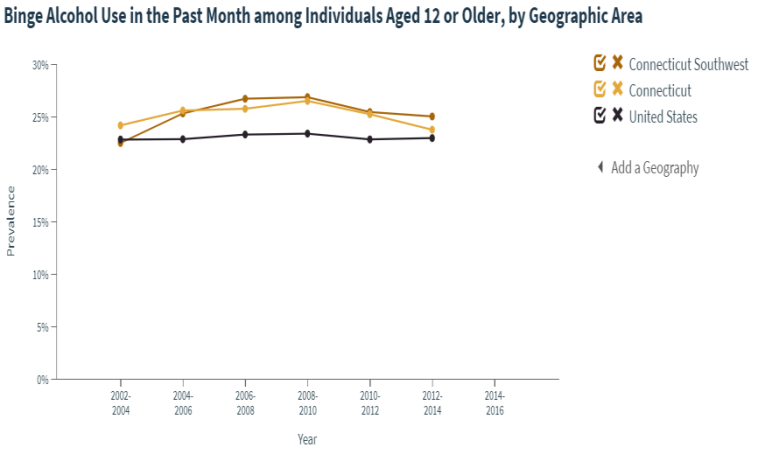



Figure 2: Past Month Binge Drinking in US, CT and SW CT

*Adults:* In 2018, alcohol use rates within SW CT ranged from 24% in Greater Bridgeport to 28% in Greater Stamford and Norwalk to 31% in Greater Greenwich, according to DataHaven surveys. 8% to 10% of adults within the region reported feeling a need to cut down on drinking/drugs in the past 12 months, similar to the state average of 8%, according to the 2015 DataHaven surveys.

*Youth:* Both nationally and within the state, past 30 day use of alcohol among teens is 30%. A sample of five local youth surveys conducted in SW CT during 2018-19 found that between 21% and 50% of high school students reported past 30 day alcohol consumption, with rates increasing each grade. Where racial data was available, Whites reported drinking more than Hispanics or Blacks. One town reported that 14% of middle school students had used alcohol in the past 30 days. In one local suburb, the alcohol use rate had declined from a high of 41% several years earlier to 21%. Binge drinking was reported by 13% of high school

[2] https://pire.org/Home/Resources

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

*Perception of Harm:*

- High school students' perception of harm from alcohol range was high (74%-82% in local surveys). Perception of harm from binge drinking was lower (38% in one local youth survey).
- Adult perception that young people will abuse drugs or alcohol varies significantly: Greenwich area, 18%; Norwalk area, 20%; Stamford area, 22%; and Bridgeport area, 41%.[3]
- Key informants in the 2018 Community Readiness Survey (CRS) for SW CT identified alcohol as the #1 problem substance for teens, young adults, and adults up to age 65. However, they believed that most community residents are less concerned with preventing alcohol abuse than other drug abuse and that many residents feel it is okay for youth to drink alcohol occasionally.

**Risk Factors and Subpopulations at Risk:**

- *Risk factors for alcohol dependence and misuse* include: early initiation of alcohol use; steady drinking over time; family history; mental health problems including trauma; social norms and cultural factors; perception of harm.
- *At risk populations* include: males, though alcoholism has been increasing in females; Hispanics/Latinx; youth.
- Additional risk factors among youth include: academic and/or other behavioral health problems in school; alcohol consumption with peers; lack of parental supervision; parental norms and tolerance; low perception of risk; easy access.

**Burden:**

- Connecticut is well above the national average in the percentage of fatal crashes involving drunk drivers. Of the 278 fatal crashes in the state in 2017, 43%, or 120, involved at least one driver with a blood alcohol level of .08 or higher compared to national rate of 29%.[4]
- In SW CT there were 785 Driving Under the Influence (DUI) arrests in 2016. Figure 3 shows great variation in DUI arrests by town, which may reflect prevalence and enforcement differences.
- In SW CT, alcohol was involved in 26% of the accidental drug overdose deaths in 2018 (30 out of 117), reports the Chief Medical Examiner.

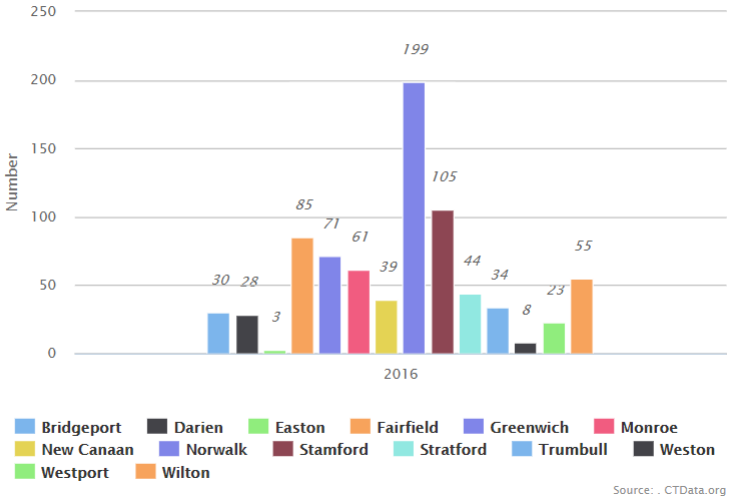



**Figure 3: DUI Arrests in SW CT by Town, 2016`**

[3] DataHaven surveys, 2018

[4] https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812603.

**Capacity and Service System Strengths:**

*Prevention:*

- Local Prevention Councils (LPC) provide education about alcohol to youth and parents, often in collaboration with groups such as MADD and SADD. Several LPCs have created alcohol awareness campaigns. Darien, which has significantly higher rates of teen drinking compared with the country, in in its 3rd year of a high-profile "06820" campaign to educate parents about the impact of alcohol on the teen brain, the importance of parent-child dialogue, social hosting laws that hold adults legally responsible for drinking that occurs under their roof, etc. LPCs and other community partners sponsor post-prom events and encourage the use of Uber, Lyft and Safe Rides to prevent driving under the influence.
- Throughout SW CT, pediatricians, clinicians, family physicians, and counselors are trained in Screening, Brief Intervention and Referral to Treatment (SBIRT) and also Adolescent SBIRT. Colleges, hospitals, and social services agencies also use an integrated Mental Wellness Screening tool for "check-up from the neck up" screenings during Wellness Month and beyond.
- Older adults and others at risk are educated about the dangers of mixing alcohol and medications through the state's Change the Script campaign.

*Treatment:* Treatment for alcohol and other addiction disorders is available through local provider agencies and hospitals, including specialized programs such as Mountainside Treatment Center, the Addiction Recovery Center at Greenwich Hospital, and Silver Hill Hospital.

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

*Enforcement:* Alcohol compliance checks are intended to be conducted every six months; however, some town departments report a lack of capacity to train and deploy youth for sting operations. Police departments continue to educate officers on how to strategically disperse parties.

## 2019 PROFILE: NICOTINE (INCLUDING VAPING) IN SOUTHWEST CONNECTICUT

**Smoking** is the leading preventable cause of death and disease in the United States. Tobacco products, whether smoked (like cigarettes or cigars) or smokeless (like chew), contain various pollutants, particularly nicotine, which is highly addictive. Nicotine is a harmful substance that affects the cardiovascular, respiratory, gastrointestinal and immune systems and most body organs. Nicotine is now also delivered through vapes—also known as e-cigarettes, pens, and by the popular brand name JUULs. All these products are regulated by the Federal Drug Administration (FDA) under the regulatory category of "tobacco."

*Vapes* are battery-operated devices that can resemble a flash drive, pen, or cigarette. Vapes allow the user to inhale aerosol that contains the same harsh chemicals that are in cigarettes (such as acetone and formaldehyde), along with additional chemicals and flavoring. Vapes are popular with teens and young adults and are frequently used to ingest marijuana or THC (the main active ingredient in marijuana). Recent national data suggest that the popularity of vaping is leading to an increase in cigarette smoking, reversing a decades-long drop. Teens who use vapes are 4 times more likely to smoke cigarettes.

### Magnitude of Issue:

*Tobacco:* The National Survey on Drug Use and Health (NSDUH) reports that Southwest Connecticut (SW CT) has greater awareness of the risks of cigarette smoking, lower use of tobacco, and lower use of cigarettes compared to the state and country. (See Figure below.)

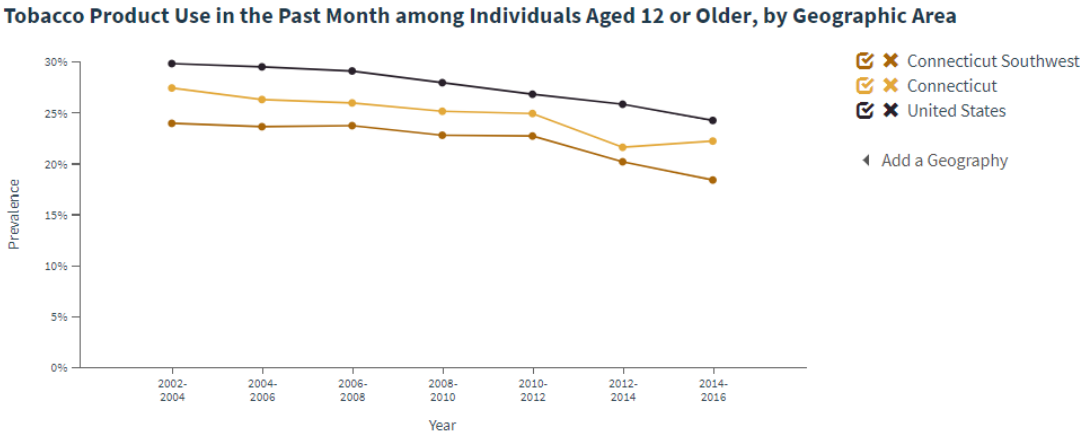



**Figure 4: Tobacco Product Use in US, CT and SW CT Over Time**
*Source: NSDUH*

- The current prevalence of tobacco use among adults ranges from 7% in the Greenwich area to 21% in Greater Bridgeport, according to 2018 DataHaven surveys.
- Although NSDUH data show that tobacco usage in SW CT decreased 6 points between 2002-04 and 2014-16, the more recent DataHaven surveys found that smoking had increased 3 points between 2015 and 2018 in Greater Bridgeport.

*Vaping:* Similar to national and state trends, vaping is increasing dramatically in SW CT:

- 14% to 23% of adults in the region have ever tried vaping, compared with 11% to 18% three years ago. 36% of Hispanic/Latino adults in SW CT tried vaping compared with 22% of Caucasians and 21% of African Americans, according to DataHaven.
- The vaping prevalence is highest amongst teens, though data are not available for all communities. In a 2017 youth survey in a local suburb, 25% of freshmen and sophomores and 45% of juniors and seniors reported vaping during the past month.
- A youth survey in a local city found that 12% of high school students had vaped marijuana in the past month.
- 2018-2019 youth surveys in the region found that teens perceive vapes to be far less harmful than cigarettes.

## Risk Factors and Subpopulations at Risk:

- *Risk factors:* lower levels of education, lower socioeconomic status, males.
- *At risk populations:* Adults with mental health or substance use disorders, who account for 40% of all cigarettes smoked; adults seeking to quit smoking cigarettes; youth.

## Burden:

Smoking creates a burden on individual health as well as societal healthcare costs:

- On average, smokers die 10 years earlier than nonsmokers. Second-hand smoke is a health risk present not only in traditionally cigarettes but also in vapes, due to the chemical and nicotine content.
- Smoking among people with serious mental illness is a major contributor to their premature mortality.
- In CT, 4900 adults die each year from smoking-related causes.
- In CT, smoking accounts for $2.03 Billion in annual healthcare costs, as well as $1.25 Billion in productivity loss.
- Schools in SW CT reported 384 disciplinary actions related to vaping in 2017-2018.

## Capacity and Service System Strengths:

*Prevention:* Tobacco control efforts are largely conducted through Local Prevention Councils, municipal health departments, and school systems, with unequal levels of investment that depend on local community resources and grants. Local communities are all addressing vaping as a growing epidemic; for example, Stamford has created a vaping task force and Trumbull has conducted a vaping education campaign. The Norwalk-based Courage to Speak Foundation is incorporating vaping education into its 2019 school substance abuse curriculum.

*Treatment & Recovery:* Some behavioral health providers have focused on reducing smoking and increasing healthy behaviors. Several years ago Bridge House in Bridgeport was the first psychosocial program in the state to go smoke-free. The local hospitals in Bridgeport, Greenwich, Norwalk and Stamford offer smoking cessation programs. In Bridgeport, St. Vincent's Medical Center runs a vaping cessation program for teens, and in Norwalk, the local SMART Recovery teen group addresses vaping on a regular basis, including encouraging alternatives. SmokefreeTXT and BecomeAnEx.org are apps designed specifically to assist teens with quitting.

*Legislation & Enforcement:* Bridgeport and Trumbull passed local ordinances that raise the age to buy nicotine products (including vapes) from 18 to 21 years of age even prior to the "Tobacco 21" bill being passed at the state level during the 2019 legislative session. To ensure compliance with tobacco legislation, 661 compliance checks were conducted in SW CT during 2018-19; FDA data show that 12% of those retailers received a warning letter and 1% paid a fine for the violations that were found. 4 suburbs in SW CT had no violations.

## 2019 PROFILE: CANNABIS (MARIJUANA) IN SOUTHWEST CONNECTICUT

**Cannabis** (marijuana) is the most commonly used illicit drug both locally, in Connecticut and on a national level. Approximately 10% of users develop an addiction to the drug. Marijuana can be taken orally, mixed with food or drink, vaped, and smoked, including in a concentrated forms such as hashish or honey oil, budder, dabs or wax. The majority of "recreational" use in the U.S. and Connecticut involves smoking in rolled cigarettes ("joints"), pipes or water pipes ("bongs"), or hollowed-out cigars ("blunts"). More recently, methods include vaping, smoking, or eating ("dabbing") different forms of resin extracts: hash oil, honey oil, or shatter.

Today's cannabis is much stronger than in the past. The average THC (tetrahydrocannabinol) potency of confiscated marijuana in 2013 was 9.6%, 3 times higher than in the 1990s, according to the National Institute on Drug Abuse (NIDA). Most recently, the THC potency used in "dabbing" ranges from 40-80%, according to the U.S. Drug Enforcement Agency (USDEA). Any THC concentration above 10% can cause serious cognitive impairment, and high potency marijuana can lead to panic attacks, paranoia, hallucinations, and psychotic episodes.[5]

The general population has a low perception of harm, particularly since the state of CT has legalized the use of marijuana for 36 health conditions for adults and 10 for children as of 2019. However, the federal government finds only modest evidence of effectiveness for 3 health conditions,[6] and marijuana does pose significant risks to the developing brain. Teenagers who use it several times a week may have a permanent IQ loss of 6 to 8 points.[7] NIDA reports that teens who are heavy users are at greater risk of developing other substance use disorders and teen users with certain gene variants are at risk for developing schizophrenia.

### Magnitude:

As of June 2019, *medical marijuana* certificates have been issued to 33,569 Connecticut residents, including 7,309 in Fairfield County (0.8% of residents), per the state Department of Consumer Protection.

*Illicit use* of marijuana among teens and adults has been increasing for more than 10 years, with higher rates in CT than the rest of the country, as shown below. Consumption in Southwest CT (SW CT) has varied and most recently has been similar to the overall national rate:

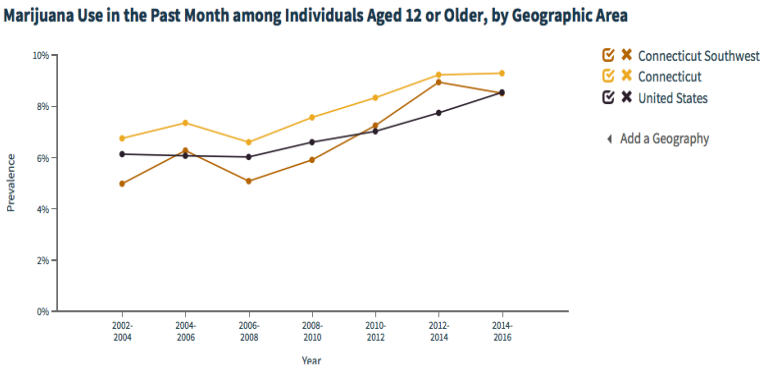



**Figure 5: Past-Month Marijuana Use in US, CT and SW CT**
*Source: National Survey on Drug Use and Health (NSDUH)*

[5] USDEA: JustThinkTwice.gov/facts-about-marijuana-concentrates

[6] http://www.nationalacademies.org/hmd/Reports/2017/health-effects-of-cannabis-and-cannabinoids.aspx

[7] Meier MH, Caspi A, Ambler A, et al. Persistent cannabis users show neuropsychological decline from childhood to midlife. PROC NATL ACAD SCI U S A. 2012;109(40):E2657-E2664.

It is no coincidence that use of marijuana has increased as the *perception of harm* has decreased. In SW CT, the only decrease in marijuana usage in recent years (2006-08) corresponds to an increased perception that marijuana is harmful during that same time period. (See figure below.)

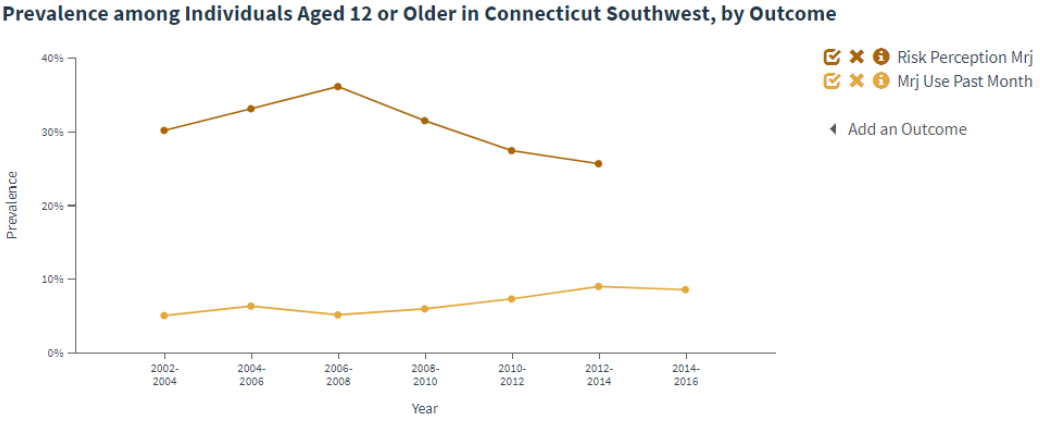



**Figure 6: Marijuana Use and Perception of Harm in SW CT**
*Source: National Survey on Drug Use and Health (NSDUH)*

*Adults:* In SW CT, past-month marijuana use among adults varied from 5% in greater Norwalk to 9% in the Greenwich and Stamford areas to 18% in the greater Bridgeport area, compared with 12% statewide, according to surveys conducted by DataHaven in 2018. (Behavioral health stakeholders in our workgroup believe these numbers to be significantly underreported.) In the Bridgeport area survey, 11% of adults reported using marijuana 10+ days in the past month. 1/3 of Bridgeport-area users reported using marijuana for medical purposes and 1/3 for both medical and recreational.

*Youth & Young Adults:* Young adults are the largest consumer group of marijuana regionally and nationally. Use in this age group is significantly higher in CT and SW CT than in the US as a whole (see figure that follows). The higher use by young adults accounts for the increased overall prevalence of marijuana in CT compared with the nation:

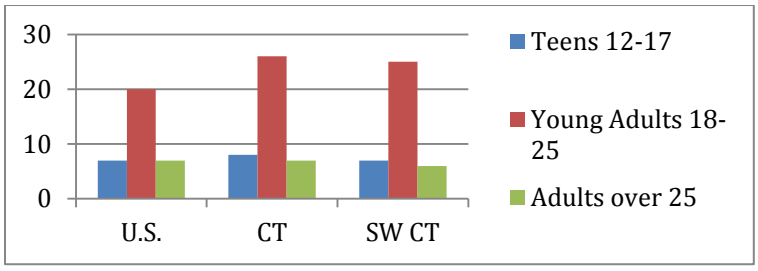



**Figure 7: Past 30-Day Marijuana Use by Age in US, CT and SW CT**
*Source: CT Data Collaborative, based on NSDUH 2014-2016*

Among teens, a sample of four youth surveys conducted within SW CT during 2017-2019 shows that:

- Past-month marijuana use among local high school students varied from 9% to 20% (for all 4 grades combined). Broken down by grade, usage is seen to increase each year, up to almost half of seniors.
- Between 9% and 12% of local high schoolers reported vaping marijuana in the past month.[8]

[8] The 2018 Monitoring the Future study reports that 12th graders in states with medical marijuana laws are twice as likely to "vape" marijuana or consume edibles as students in states without those laws: 16.7% vs 8.3%.

- One city reported that 6% of middle schoolers (grades 6 to 8) had used marijuana during the past month.
- Between 59% and 84% of high school students perceived marijuana as harmful.

## Risk Factors and Subpopulations at Risk:

- *Risk factors include:* Anxiety, depression, PTSD, or other mental health issues; poor academic performance; frequency of usage; early initiation; and low perception of harm. Possible legalization decreases perception of harm: one in four 12th graders admitted that they would more likely try or increase their current use of marijuana if it were legalized.[9]
- *At-risk populations* include: youth and young adults; individuals with schizophrenia (whose symptoms worsen with marijuana consumption); individuals with specific AKT1 or COMT gene variants (who are more likely to develop schizophrenia).

## Burden:

- Youth who are heavy users of marijuana are 3 times more likely to become addicted to heroin, according to the Centers for Disease Control and Prevention.
- Traffic accidents, emergency room visits, and fatalities increase in states that legalize retail marijuana. In Colorado, traffic fatalities increased 48% after legalization.
- Emergency room visits for marijuana-induced psychosis, marijuana overdose and overdose in children who consume marijuana edibles that look like candy are rising.[10]

## Capacity and Service System Strengths:

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

- Dissemination of myths and facts about marijuana with a primary focus on the health related risks
- Implementation of regional public awareness campaigns
- Education on brain development and how marijuana can affect the adolescent brain
- Educating community members on regulations for medical marijuana use
- Educate parents / professionals about signs and symptoms of marijuana use
- Support school policies related to marijuana and other illicit drugs

*Treatment and Recovery:* The state Department of Mental Health and Addiction Services (DMHAS) reported 7569 treatment admissions statewide for marijuana in 2016 (11.3% of all admissions). Of all marijuana treatment admissions, 72.6% were male and half (50.6%) were ages 21-30 years old. In Southwest CT there are public and private addiction treatment providers for both youth and adults. However, there is a question of capacity given that a number of families who can afford it report using out-of-state treatment facilities for their children.

*Medical Marijuana:* In late 2018, two medical marijuana dispensaries were approved for SW CT, one in Stamford and one in Westport, bringing the state's total to 18. Regionally, concerns have been expressed about the stringency of the state's medical marijuana program, since dosage is not scientifically determined but decided by dispensary staff without special training or knowledge of the patient; THC levels are not regulated; and doses are available for smoking as well as in pill form, sending mixed messages about being medical.

[9] 2018 Monitoring the Future Survey

[10] USDEA: https://www.justthinktwice.gov/article/drug-alert-marijuana-edibles

## 2019 PROFILE: PRESCRIPTION DRUGS IN SOUTHWEST CONNECTICUT

*(See also the Profile on Heroin and Illicit Drugs in Southwest CT for more information on other opioids)*

**Prescription drugs** were used by almost half the U.S. population in the past month, with psychiatric medications the leading drug types for adults ages 20-59 and teens ages 11-19.[11] The most common psychiatric medications are *antidepressants* (e.g., Prozac, Zoloft, Effexor, Lexapro, Cymbalta, Wellbutrin, Celexa); *benzodiazepine* (aka "benzos," such as Xanax, Valium, Ativan, Klonopin, used for anxiety and insomnia); and *amphetamines* (e.g. Adderall, used for ADHD). These drugs can have significant side effects and can create dependency. In many cases they are misused, meaning used other than as prescribed: for different symptoms, in higher doses or for longer than as prescribed, or used by someone other than the intended recipient. In 2018, 17% of benzo users reported misuse.[12] Safe storage and disposal practices are strategies for reducing diversion and misuse of prescription drugs.

*Opioids* (e.g., Oxycontin, Percocet, Demerol, Dilaudid, Vicodin) are powerful and addictive prescription drugs used to manage pain. Today's opioid crisis began in the early 2000s, when the medical community identified pain as the "fifth vital sign" and began prescribing opioids aggressively in response. Many individuals who were prescribed opioid medication developed an addiction, turning to illicit opioids such as heroin, which is cheaper and does not require a prescription. Currently, medical professions encourage the use of alternatives for pain management: non-steroidal anti-inflammatory drugs (e.g., ibuprofen), physical therapy, and mind-body therapies. Legislative and practice changes are in place to curb the prescription of opioid medication.

### Magnitude:

*Prescription Drug Use:* Nationally, 12.6% of adults take a benzodiazepine,[12] 11.4% of adults ages 20-59 take an antidepressant, and 6.2% of teens and 3.5% of children under age 11 take an ADHD stimulant.[11] While similar state-level data on use are not available, the top 5 drugs prescribed in Connecticut in 2018 include 3 benzos and 1 stimulant, as well as 1 opioid. (See adjacent figure.)

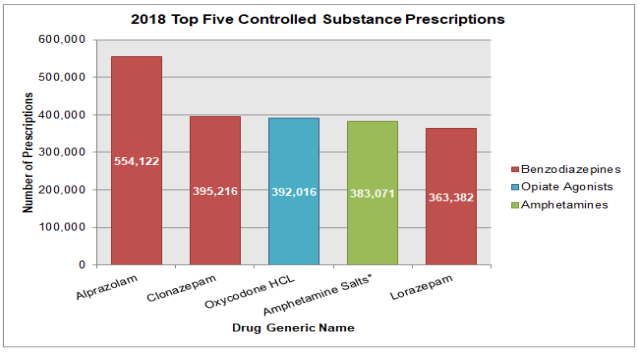



**Figure 8: Top 5 Prescription Drug Types in CT, 2018**

*Source: CT Prescription Monitoring and Reporting System (CPMRS)*

*Prescription Drug Misuse:* Nationally, emergency department visits involving misuse of pharmaceuticals have doubled over the past five years.[13]

Within Southwest CT (SW CT), local youth surveys examined misuse of prescription drugs in 2018, finding:

- 12% of middle and high school students in one city had used prescription drugs in the past 30 days.
- 30% of high school students stole prescription drugs from a family member, and 40% took the pills with a family member's permission.
- 3% of high school students in one suburb reported past-month prescription drug use.
- 6% of high school seniors reported using a stimulant without a prescription.

[11] May 2019 National Center for Health Statistics (NCHS) data brief: https://www.cdc.gov/nchs/data/databriefs/db334-h.pdf

[12] https://www.psychiatry.org/newsroom/news-releases/study-finds-increasing-use-and-misuse-of-benzodiazepines

[13] SAMHSA National Prevention Strategy: Preventing Drug Abuse and Excessive Alcohol Abuse

*Opioid Misuse:* In 2018 surveys conducted by DataHaven, between 21% and 24% of SW CT adults over age 18 report personally knowing someone who struggled with opioids in the past three years. Among these respondents, 2% in the greater Stamford and Norwalk areas and 6% in the Bridgeport area reported that it was they themselves who struggled, leading to a calculation that 0.4% to 1.4% of SW CT residents may have an Opioid Use Disorder (OUD).

In 2018, 1882 individuals from SW CT (0.27% of the region) were treated for OUD, according to the Department of Mental Health and Addiction Services. After rising from 2013 to 2015, the number of residents receiving OUD treatment has decreased for the past two years and is now 4% lower than in 2013. In comparison, the state OUD treatment rate has increased by 7% during this period and only began to decrease in the past year.

*Trends:* The number and percentage of opioids have decreased in CT since 2016, along with an 8% decrease in the strength of opioids prescribed. [14] Figure 9 reflects the success of state policies aimed at curbing the opioid epidemic. In addition, benzodiazepine prescriptions decreased by 5.3% from 2018 to 2019, according to the state Department of Consumer Protection.

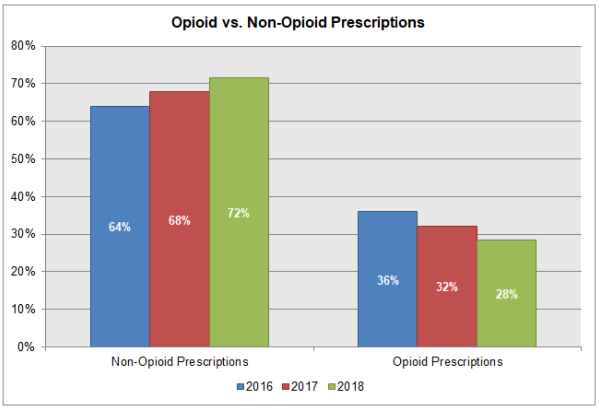



**Figure 9: Change in Opioid vs Non-Opioid Prescriptions in CT, 2016-2018**
*Source: CPMRS*

## Risk Factors and Subpopulations at Risk:

- *Risk factors for prescription drug misuse* include: other substance misuse, including alcohol and tobacco; family history of substance misuse; mental health disorders; peer pressure or social setting involving drug use; access to prescription drugs (e.g., unlocked home medicine cabinets); and lack of awareness about risks and harm.
- *At-risk populations* are non-Hispanic whites, followed by non-Hispanic blacks. Prescription drug use increases with age. Teens and young adults are more likely to misuse stimulants. Individuals dealing with pain are most likely to be prescribed an opioid.

## Burden:

The heavy use of prescription drugs in our society has an impact on individuals, families, and the economy. Financially, the cost of prescription drugs can be burdensome for people who are uninsured, have significant co-pays, or take multiple medications, as well as to employers and insurance plans. Health-wise, people who take psychiatric medications may experience sleep problems, nausea, weight gain, dizziness, and suicidal ideation. Both psychiatric medications and opioids can lead to dependence and misuse.

Most tragically, drug overdoses have led to the deaths of 354 SW CT residents between 2016 and 2018. Among the 117 overdose deaths reported in 2018, 91% involved opioids, with 30% specifically involving prescription opioids, and 34% involved benzodiazepines. The majority of overdose deaths (79%) involved more than 1 drug: 24 deaths involved both opioids and benzos, and 8 deaths involved opioids, benzos and alcohol.

These deaths have a significant impact on families. According to the 2018 DataHaven surveys, 16% to 18% of adults in SW CT know someone personally who died from an opioid overdose. In the Greater Bridgeport survey, 29% of respondents reported that the person who died was their family member. Small subgroups are affected by multiple

[14] CT Prescription Monitoring and Reporting System

deaths within their social circles: 5% to 7% of SW CT adults surveyed know between 2 and 4 people who died from an overdose in the past three years, and an additional 1% to 3% of respondents report knowing 5+ people who died from an overdose in the past three years.

## Capacity and Service System Strengths:

*Prevention:* Local communities are working to reduce demand for prescription drugs by educating about health risks, increasing perception of risk, and disseminating information about prescription drug abuse through multiple channels to different community sectors. Key respondents in the regional 2018 Community Readiness Survey (CRS) identified the elderly as a target for preventing prescription drug misuse. Through the state's Change the Script campaign, communities have been able to educate prescribers about the CPMRS and parents about safe storage of prescription drugs.

*Reducing access:* Prescription drop boxes at 13 police departments in SW CT are successful in reducing access to unused prescription drugs. Statewide, 43,251 lbs of returned prescriptions were burned in 2018, up from 37,541 in 2017, according to the Department of Consumer Protection. As of 2020, drop boxes will be available in big box store pharmacies throughout the state. Many towns in SW CT also participate in biannual Drug Take Back Days, and Local Prevention Councils (LPCs) have used state opioid response grants to purchase and distribute medication lock boxes.

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


**Figure 10: Substance Use Treatment Facilities and Buprenorphine Physicians in SW CT**
*Source: SAMHSA Treatment Locator Map*

*Narcan:* Individuals who overdose on opioids can often be revived and saved from death through the application of Naloxone (aka Narcan), which is carried by first responders. Narcan is available at 58 pharmacies throughout the region as of May 2019, according to CT Open Data. Community stakeholders such as libraries and schools have Narcan on site, and the Greenwich Department of Human Services has piloted an outreach program to distribute Narcan to drug users in the community.

Through several state opioid response grants, all local communities have sponsored educational sessions on opioids and have trained people to administer Narcan, distributing 1243 free Narcan kits to date. During 2019, hospital emergency departments will receive Narcan through the state grant to distribute to individuals who have overdosed and their families.

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

## 2019 PROFILE: HEROIN AND ILLICIT OPIOIDS IN SOUTHWEST CONNECTICUT

*(See also the profile on Prescription Drugs in Southwest CT for more information on opioids)*

**Heroin** is a highly addictive opiate (narcotic) drug processed from morphine and extracted from certain poppy plants. It is a semi-synthetic opioid which is synthesized from naturally occurring opiates. Heroin comes in a white or brownish powder or a black sticky substance known as "black tar heroin." It is often "cut" with other drugs or substances such as sugar or powdered milk. A user is unaware how much actual heroin is being used, creating likelihood of overdose. Street names include Big H, Black Tar, Chiva, Hell Dust, Horse, Negra, Smack, and Thunder. Heroin can be injected, snorted, or smoked. It provides an initial surge of euphoria followed by a twilight state between sleep and wakefulness. Physical symptoms of use include: drowsiness, respiratory depression, constricted pupils, nausea, a warm flushing of the skin, dry mouth, and heavy extremities[15]. Overdose symptoms include slow and shallow breathing, blue lips and fingernails, clammy skin, convulsions, coma, and possible death.

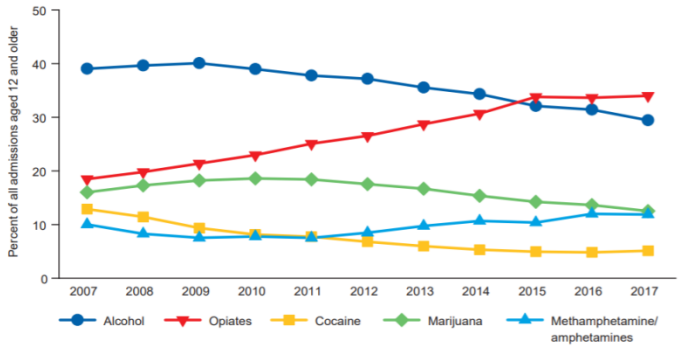
*Fentanyl* is a synthetic opioid, 80 to 100 times stronger than morphine, which was developed for pain management in cancer patients and applied as a skin patch. Due to its potency, fentanyl is often diverted for abuse, sold as high potency heroin or added to heroin to increase its strength. Users can easily overdose and die. Street names include Apace, China Girl, China Town, China White, Dance Fever, Goodfellas, Great Bear, He-Man, Poison, Tango & Cash. Fentanyl gives an intense, short-term high. Effects include slow respiration, low blood pressure, nausea, fainting, seizures, and death.[16] Recently, *carfentanil* is an even stronger opioid that can very easily lead to a fatal overdose.

Most users of heroin and illicit opioids begin with an addiction to a prescription opioid given for pain management, then turn to heroin since it is cheaper and easier to access. Best practice for treating opioid use disorder includes both counseling and Medication-Assisted Treatment (MAT) using an opioid antagonist (usually suboxone or methadone). Naloxone (a.k.a. Narcan) is an opioid antagonist drug that can temporarily reverse an overdose, giving time to transport an individual to a hospital for treatment.

### Magnitude:

The National Survey on Drug Use and Health (NSDUH) first reported past-year heroin use in 2014-16, its most recently published survey, showing that less than 1% of individuals ages 12 or older in Southwest CT (SW CT) had used heroin. Abuse of heroin and other opioids has now increased for over ten years. National data show that admissions for primary heroin use climbed from 14% of substance use admissions in 2007 to 27% in 2017 (see red trend line in adjacent figure). Our calculation based on 2018 DataHaven surveys in SW CT indicates that 0.4% to 1.4% of residents may have an Opioid Use Disorder (OUD).

Nationally, the majority of primary heroin admissions are aged 18-44 (average of 36). Two-thirds are non-Hispanic Whites, 14% are non-Hispanic Blacks, and 13% are Hispanic, according to SAMHSA treatment data.




SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.21.18.

**Figure 11: Primary Drug Use at Admission, 2007-2017 (US)**
*Source: SAMHSA Treatment Episode Data Set*

[15] https://www.dea.gov/factsheets/heroin
[16] https://www.dea.gov/factsheets/fentanyl

Within Southwest CT (SW CT), 1882 unique individuals received treatment for opioids (including both illicit and prescription opioids) in 2018, according to data from the Department of Mental Health and Addiction Services. This represents 0.003% of the region's population. 106 residents of the region died in 2018 as a result of an opioid overdose, with fentanyl involved in 79 deaths and heroin involved in 56 deaths. The majority of these deaths involved more than one drug; when used alone, fentanyl accounted for 5 deaths and heroin accounted for 2 deaths. There were also 2 deaths of individuals who had used both heroin and an opioid antagonist.

## Risk Factors & Subpopulations at Risk:

- *Risk factors* include: marijuana use; heavy tobacco use; previous overdose; personal or family history of substance misuse; history of depression or anxiety.
- *At risk populations:* Individuals with prescriptions for pain management; seniors prescribed multiple medications; women (due to biological factors and an increased likelihood of being prescribed opioids and being given longer term and higher dose prescriptions).

## Burden:

- Heroin is highly addictive. Extreme withdrawal symptoms (e.g. craving for the drug, restlessness, muscle and bone pain, vomiting) make it difficult for users to quit, and cravings lead many users to relapse.
- Heroin use can lead to respiratory arrest and accidental overdose.
- Up to one-third of opioid overdoses are thought to be intentional suicides.
- When heroin is injected, there is a risk of contracting hepatitis, HIV or other blood-borne diseases.
- The impact of addiction on an individual's life and their family is often devastating both emotionally and financially, due to the cost of treatment (often multiple times).

## Capacity and Service System Strengths:

*Prevention & Education:* Awareness about the harmful effects and high potential for addiction continues to be important information for parents and youth. Local Prevention Councils (LPCs) have conducted community education on heroin and other opioids for families and prescribers and supports trainings on the use of Narcan to reverse an overdose. The Hub supports these efforts through information, opioid education, and distribution of Narcan kits, in conjunction with LPCs and through an AmeriCorps PreventionCorps grant. Narcan trainings within SW CT are now incorporating information about the state's newly created Naloxone + Overdose Response App ("NORA") app (available at www.norasaves.com) as well as on the LiveLOUD website also developed by the state.

*Reversals:* As of May 2019, Narcan is available at 58 pharmacies throughout the region. Through state opioid grants, all local communities have sponsored sessions to train people to administer Narcan and a total of 1243 free Narcan kits have been distributed to date. First responders carry Narcan and administer it regularly to reverse overdoses. In 2019, the State Opioid Response grant will provide hospital emergency departments with Narcan to distribute upon discharge to individuals who have overdosed and their families.

*Treatment:* Medication Assisted Treatment (MAT) is available via 12 publicly funded nonprofits, 2 private for profits, and individual providers throughout the region (see map below). Two provider agencies have recently received federal and state grants to do mobile outreach to opioid users from Bridgeport through Stamford, and the Greenwich Department of Human Services is piloting an outreach program by town social workers. There are detoxification facilities in the region, although access is limited and some users have to go to other parts of the state for available

beds. The state Access Line, which provides transportation to detoxes when needed, is reported to be less able to connect people to treatment than in the past.


**Figure 12: MAT in Southwest CT**
***Source: SAMHSA***

*Recovery:* Recently, hospitals have begun hiring Recovery Coaches as an effective way to use people with lived experience to respond to overdoses that come into the Emergency Department, connecting people to treatment and recovery support. In SW CT, Stamford Hospital recently hired a Recovery Coach and Norwalk Hospital expects to hire one in Fall 2019. Other recovery supports in the region include the CT Community for Addiction Recovery (for individuals with a substance use disorder) and The CARES Group, Courage to Speak, SMART Recovery Family & Friends for family support.

**Cocaine** is a nervous system stimulant that is derived from the coca plant (native to South America) or prepared synthetically. In the past it was sometimes used medicinally as a local anesthetic, but today it is used illegally as a stimulant. Cocaine is found in several forms: as a powdery substance, crack (in rock-like form) or freebase. It is commonly snorted, inhaled as smoke, or dissolved and injected intravenously.

Cocaine is highly addictive and carries a risk of overdose and death. There are no medications specifically approved to treat cocaine withdrawal, so treatment focuses on monitoring symptoms and providing a safe environment to limit harm to self and others.

## Magnitude:

Nationally, cocaine use has stayed stable, varying between 1.7% and 2.4% of teens and adults over more than 10 years, according to the National Survey of Drug Use and Health (NSDUH), as shown in the figure below. While cocaine usage appears to be trending upward since 2008-2010, it is still lower than the 10-year high (2004-2006) and remains below 2.5%.

Use in Connecticut has generally been about 0.1% higher than national rates, with increases and decreases typically occurring in CT and in Southwest CT (SW CT) before the rest of the country. Within the SW CT region, the prevalence of past-year cocaine use, according to NSDUH, is 2.13% for teens and adults (over age 12). This rate is somewhat higher than the U.S. rate of 1.8% but less than the state rate of 2.39%.

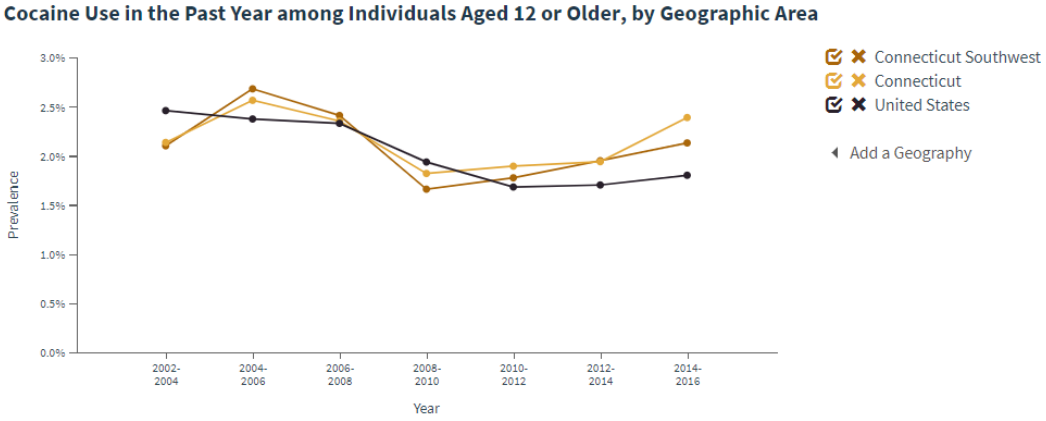



**Figure 13: Cocaine Use in the US, CT and SW CT**

*Source: NSDUH*

Among teens specifically, the 2017 state Youth Risky Behavior Survey (YRBS) found that 3.8% of high school students in Connecticut reported using some form of cocaine in their lifetime. Males were twice as likely (5.1%) to have used cocaine as females (2.5%). By race, 4.2% of Whites, 3.8% of Blacks, 2.1% of Hispanics and multi-racial students, and 1.7% of Asian students reported ever using cocaine.

Within SW CT, local youth surveys do not ask specific questions about cocaine. Among adults in the region, anecdotal reports from social services providers indicate an increase in cocaine usage in the past year.

### Risk Factors and Subpopulations at Risk:

- *Risk factors for cocaine use* include: Prior use of other illicit substances, such as cannabis (marijuana) and heroin; academic failure
- *At-risk populations* include: young adults ages 18-25, who are twice as likely to use cocaine compared with other adults; males, compared with females

### Burden:

Cocaine is associated with a variety of health effects, from malnutrition to heart damage to stroke. Long-term neurological effects can include seizures, cognitive impairment, and movement disorders such as Parkinson's. People who inject cocaine are at risk for HIV/AIDS, Hepatitis B virus and Hepatitis C infection through sharing of needles and drug preparation equipment. The CT Department of Health reports that those who inject drugs represent 31% of the new estimated HIV infections. People who snort cocaine can damage their nose and throat, and those who smoke it can experience lung damage and worsen asthma.

Cocaine can also lead to accidental death. Within SW CT, 123 individuals (an average of 41 per year) died from a cocaine overdose between 2016 and 2018, according to the Office of the Chief Medical Examiner (OCME). In 94% of these cases, other drugs were also involved, but in 8 cases, the death was due to use of cocaine alone.

Social consequences of cocaine use include property loss, crime, unemployment, disruptions in family environments, and homelessness.

### Capacity and Service System Strengths:

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

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

## 2019 PROFILE: ILLICIT DRUGS IN SOUTHWEST CONNECTICUT

*See also: profiles on marijuana, heroin, cocaine, and prescription drugs in Southwest CT*

**Illicit drugs** is a term that includes both *illegal substances*, such as cannabis (marijuana and synthetic marijuana), cocaine (including crack), ecstasy, hallucinogens, heroin, inhalants, ketamine, and methamphetamine, and also *prescription drugs that are used illicitly*, such as prescribed opioids, sedatives, tranquilizers, stimulants, steroids, and over the counter medications that are used other than as prescribed or by someone without a prescription. Depending on the substance, the effects will vary; however, most illicit drugs carry health risks, including addiction, overdose and even death. Some illicit drugs can be easily obtained from a person's own home, which can increase the likelihood of addiction and misuse among family members or youth (e.g., babysitters).

### Magnitude:

Nationally, around 3% of teens and adults report past-year illicit drug use disorder, according to National Survey of Drug Use and Health (NSDUH) data. The prevalence of illicit drug use disorder has been a bit higher in the state but lower in Southwest CT (SW CT), as shown in the adjacent figure, "Illicit Drug Use Disorder in US, CT and SW CT."

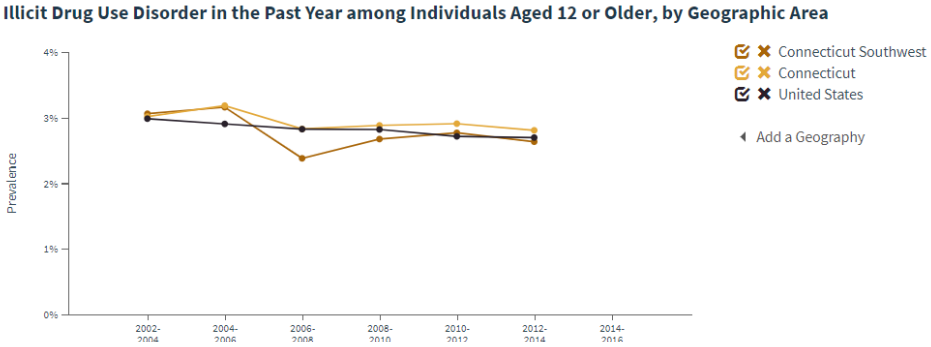



**Figure 14: Illicit Drug Use Disorder in US, CT and SW CT**

*Source: NSDUH*

The following figure, "Illicit Drug Use in SW CT by Drug," shows the prevalence of illicit drug use in the region from 2002 to 2016:

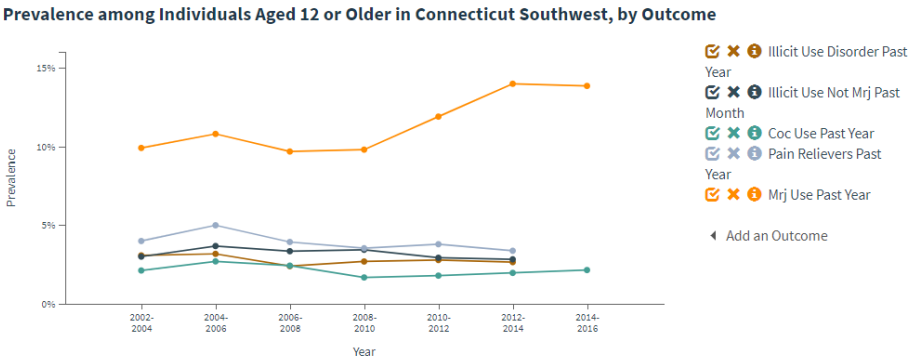



**Figure 15: Illicit Drug Use in SW CT by Drug**

*Source: NSDUH*

- Marijuana (in yellow) has consistently been the most used illicit drug in the region, with 14% of teens and adults reporting in 2014-16 that they had used marijuana in the past year. Consumption of marijuana has been increasing as the use of other illicit drugs (in black) has decreased.
- The next most used illicit drug within the region during this period, shown in gray, was pain relievers (which decreased from 2004-2012), followed by illicit drugs other than marijuana, shown in black, which have remained mostly stable at around 3%.
- The least used illicit drug was cocaine (shown in green), with 2% of teens and adults reporting past-year use of cocaine in 2014-16. Cocaine consumption has been relatively flat since 2008.

In focus groups conducted within SW CT in the past year, social services providers indicated that PCP was as or more prevalent than opioids among adults and that cocaine and spice were increasing. Regional youth data on illicit drugs is limited, but the statewide 2017 Youth Risky Behavior Survey (YRBS) found that among CT high school students, 34% ever tried marijuana, 10% ever took prescription medicine illicitly, 6% ever used inhalants, 6% ever used synthetic marijuana, 4% ever used cocaine, 3% ever used methamphetamines, 3% ever used ecstasy, 2% ever used heroin, and 2% ever injected an illegal drug.

While there is no reliable data on the extent of polysubstance use in SW CT, data from the Office of the Chief Medical Examiner (OCME) show that polysubstance use is the norm among those who die from accidental drug overdoses:

- In 92% of the 117 accidental drug overdoses within SW CT in 2018, multiple drugs (up to 6 at one time) were involved. The average was 2.4 drugs per overdose death.
- The most commonly involved drugs were fentanyl, heroin and other opioids (involved in 90% of deaths); benzodiazepines and cocaine (each involved in 34% of deaths); and/or methamphetamine (involved in 9%).
- 26% of the drug overdose deaths in the region in 2018 also involved alcohol.

A few other illicit drugs account for a very small number of deaths in SW CT over the past 3 years (2016 to 2018). In every case, these drugs were used in conjunction with other drugs:

- PCP - involved in 7 deaths.
- Buprenorphine - involved in 5 deaths. (Buprenorphine is an opioid antagonist and was present along with heroin in several deaths.)
- Carfentanil – involved in 4 deaths, all in 2017.
- U-4770 – involved in 3 deaths.
- Ketamine - involved in 2 deaths.
- Diphenhydramine (Benadryl) – involved in 1 death.

## Risk Factors and Subpopulations At-Risk:

- *Risk factors for illicit drug use* include: Early initiation of any substance; genetic factors, including family history of mental illness or substance use; nature of the drug; delivery mechanism; individual metabolism.
- *At-risk populations* include: Individuals with high stress, anxiety, depression or other mental illnesses; individuals in peer groups that use illicit drugs.

## Burden:

Drug dependence and abuse usually impact the lives of both the individual affected and their family. The impact can include: school dropout, loss of workplace productivity, treatment and hospitalization costs, criminal justice involvement (thefts, arrest and/or imprisonment), increased accidents, and increased mortality. The following statistics show some of the burden within SW CT:

- 1044 drug arrests were made in 2016.
- 748 individuals were admitted to DMHAS substance use treatment in one illustrative month (June 2016).
- 117 residents of SW CT died from accidental drug overdoses in 2018.

According to the National Institute on Drug Abuse (NIDA), substance abuse costs in the U.S. reach more than $600 Billion per year. NIDA notes that drug treatment is much cheaper than alternatives: for example, one year of methadone maintenance costs ~$4,700 per person compared with $24,000 per person for one year of incarceration.

## Regional Capacity & Service System Strengths:

Within SW CT, there are public, nonprofit, and for-profit addiction treatment centers that treat both substance use and co-occurring mental health disorders, although cost / insurance can be barriers. More education and treatment is needed in languages other than English. There is a choice of free support groups based on several models (12 step, CT Community for Addiction Recovery, LifeRing, SMART Recovery, Refuge Recovery, Women in Sobriety, etc.). With state funding focused on opioids, communities are working to educate the public about the risks of legalizing marijuana. There has been little consistency in drug education in schools but there is regional interest in aligning educational campaigns.

**Problem Gambling** is defined by the National Council on Problem Gambling (NCPG) as "behavior that causes disruptions in any major area of life" but does not meet the criteria for a diagnosis of Disordered Gambling (behavioral addiction, per the 2013 American Psychiatric Association Diagnostic and Statistical Manual V criteria).[17] Disordered Gambling was previously classified as an impulse-control disorder. The revised classification as an addiction has helped clinicians to better understand and treat it, and also helped researchers to redefine addiction. Once thought of as dependency on a chemical, addiction is now defined as "repeatedly pursuing a rewarding experience despite serious repercussions."[18]

A new area of concern is online videogaming. With the introduction of loot boxes in videogames, the lines between gaming and gambling are becoming blurred. Loot boxes, which can be bought or offered as rewards for achieving certain goals within a game, have come under fire over concerns that they encourage addictive behavior, especially by children.[19]

## Magnitude:

According to the CT Council on Problem Gambling (CCPG), 8% of the population in CT is at risk of developing a problem with gambling in their lifetime and up to 2% will meet the clinical criteria for Disordered Gambling.[7] Gambling activity is high in Connecticut, according to a November 2018 survey by the NCPG. Past-year gambling rates for 14 of 15 activities were higher in Connecticut than nationally, including any activity (83% vs 73%), lottery games (74% vs 66%), and casino activity (48% vs 37%).[20] Within the state, Fairfield County had the second lowest gambling rate compared with other counties on a 2013 profile; however, more updated information is not available at the county level.[21]

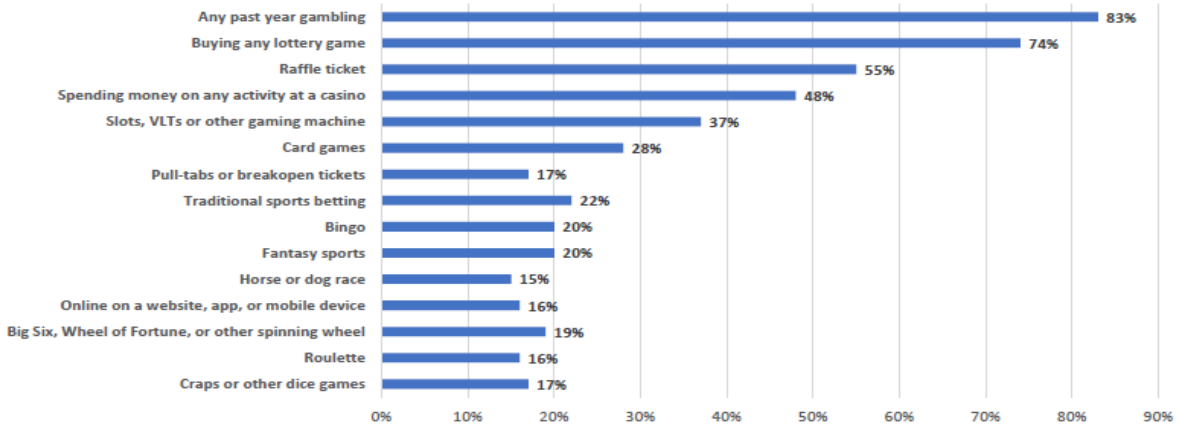



**Figure 16: Rates of Past Year Gambling Activity in Connecticut**

***Source: NPGC***

Data from Department of Mental Health and Addiction Services, Better Choice Gambling Treatment Programs indicate the most concerning gambling behaviors for clients admitted into treatment were scratch tickets (29%), sports betting

[17] Kagan R, et al. 2014. Problem gambling in the 21st century healthcare system. National Council on Problem Gambling. Available at: https://www.ncpgambling.org/wp-content/uploads/2014/07/ACA-brief-web-layout-publication.pdf

[18] Jabr F. 2013. Gambling on the brain. *Scientific American.* 309 (5): 28-30.

[19] *Washington Post,* May 8. Available at: https://www.washingtonpost.com/technology/2019/05/08/video-game-loot-boxes-would-be-outlawed-many-games-under-forthcoming-federal-bill/?noredirect=on&utm_term=.ebabcd50a4eb.

[20] National Council on Problem Gambling. 2018. National Survey on Gambling Attitudes and Gambling Experience. Available at: https://www.ncpgsurvey.org/.

[21] Lower Fairfield County Regional Action Council. 2013. Epidemiologic profile of substance use, suicide & problem gambling. CT Department of Mental Health & Addiction Services. Available at: https://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/lfcrac.pdf.

(29%), slot machines (18%), card games (12%), lottery games (6%) and dice games (6%).[22] Clinicians in southwest CT treating those with problem or disordered gambling have noted trends, including a slight increase in numbers receiving treatment, an increase in electronic gambling use, and an increase in the number of women receiving treatment.[23] In addition, people in intensive outpatient programs for substance use disorder purchase many lottery and scratch-off tickets.[6]

Youth prevalence data in one community showed that, among high school students, the percentage of males participating in a sports fantasy league or gambling on a sporting event was 2.5 times higher than for females. CCPG's fact sheet states that college students also have a greater likelihood of past-year gambling and more money gambled by males than females.[24]

## Risk Factors and Subpopulations at Risk:

- *Risk Factors for problem gambling:* Having an early big win (leading to false expectation of future wins); easy access to the preferred form of gambling; having a recent loss or change, such as divorce, job loss, retirement or death of a loved one; feeling bored or lonely, or having a history of risk-taking or impulsive behavior; having financial problems; having a parent with a history of problem gambling.
- *At-risk populations include:* Women progress to a gambling disorder 2X faster than men after beginning to gamble. Youth who are more at risk of developing a problem are those who gamble at an early age, experience a win on their first time, and have a family history of problems with gambling problems. Rates of problem gambling are doubled among persons living within 50 miles of a casino.[25] (Although there is presently not a casino in Fairfield County, there is ongoing consideration for one to be built in Bridgeport.[26])

## Burden:

Comorbidity with problem gambling is common. A national telephone survey revealed that 75% of all problem gamblers have had a problem with alcohol and 38% have had a problem with other drugs.[27] There are several health issues related to Disordered Gambling including anxiety and depression, sleep disturbances and chronic tiredness, back problems, and migraines.[28] Overall, those with Disordered Gambling are more likely to rate themselves in poorer health.[4] In addition, no other addiction has as high a suicide rate as gambling. The NCPG estimates that one in five gambling addicts will attempt to kill themselves, about twice the rate of other addictions.[29]

## Capacity and Service System Strengths:

Connecticut has two state organizations to support treatment and prevention in the state. They are the CCPG, which runs the Problem Gambling Help Line, and DMHAS Problem Gambling Services, which oversee DMHAS-funded treatment providers and 5 regional gambling awareness teams and initiatives. Both organizations provide expertise and resources to strengthen the capacity of the regions to increase gambling education and awareness.

In Southwest Connecticut (SW CT), Positive Directions and CT Renaissance are the two "Better Choice" programs funded by the state to provide treatment for problem gambling at little to no cost.

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[22] Key informant interview. 2019. CT Department of Mental Health & Addiction Services, Problem Gambling Services.

[23] Key informant interview. 2019. Southwest Connecticut clinicians.

[24] Connecticut Council on Problem Gambling. 2018 update. Fact sheets. Available at: http://www.ccpg.org/resources/.

[25] CT Department of Mental Health & Addiction Services, Problem Gambling Services. 2019 update. Expansion of legalized gambling fact sheet. Available at: https://www.ct.gov/dmhas/lib/dmhas/pgs/gamblingexpansion2.pdf.

[26] Munson E. 2019. New sports betting proposal, Bridgeport casino clear first Connecticut legislative hurdle. *CT Post*, Mar 19. Available at: https://www.ctpost.com/politics/article/New-sports-betting-proposal-considered-by-13699940.php.

[27] Romm T and Timberg C. 2019. Video game 'loot boxes' would be outlawed in many games under forthcoming federal bill. Petry NM et al. 2005. *J Clin Psychiatr*. 66: 564-574.

[28] 12 CT Department of Mental Health & Addiction Services, Problem Gambling Services. 2002. Co-occurring Disorders Problem

[29]Gambling Integrated Treatment Workbook,https://www.ct.gov/dmhas/lib/dmhas/pgs/Cooccuringworkbook.pdf.

Data collection on gambling has increased in SW CT. At college and health fairs, a three-question survey is asked to determine gambling prevalence and awareness. It identifies whether someone has gambled in past 12 months, whether they are concerned about someone who has gambled, and whether they are aware of gambling support resources that exist. In October 2018, the Brief Biosocial Gambling Screen (BBGS) was integrated into the Mental Wellness screening tool used throughout the region during Wellness Month, as well as by several towns, colleges and providers throughout the year. Use of this tool allows for assessment of potential problem gambling at any screening event for mental health and substance use.

Within SW CT there are two primary teams focused on strengthening gambling awareness. They are the Regional Gambling Awareness Team, whose members presently represent 14 different organizations, and the Caribe Gambling Awareness Youth Team, whose members range in age from 14-18 years. Both teams annually plan and implement a number of initiatives to increase awareness, including infusing gambling awareness into existing opportunities (e.g. integrating gambling screening and discussions with mental health), developing social media (e.g. youth PSA), planning and coordinating events during PGAM (Problem Gambling Awareness Month), hosting opportunities to educate elected officials and organizing forums on "hot topics" such as sports betting and using interactive activities to demonstrate key messages about gambling. A more recent initiative in our region is the Congregation Assistance Program/Community Awareness Program (CAP), which is a community-based training program available to interested faith communities or other groups through The Hub. A CAP training provides awareness not only about problem gambling but also substance misuse, suicide and mental health.

**Mental health** refers to psychological, social and emotional well-being. A person's mental health status is critical as it has an impact on thinking and decision making, work or school performance, physical health, and relationships. Mental health disorders are very common, affecting almost one in five people each year, as a result of biological factors such as genetics and family history, situational factors such as stress and trauma, and/or physical health problems. Serious Mental Illness (SMI)—including major depression, bipolar disorder, and schizophrenia—can lead to financial burdens on individuals and families, loss of livelihood and home, and incarceration.

Types of mental health disorders include:

- anxiety disorders
- psychotic disorders (e.g., schizophrenia)
- eating disorders
- obsessive-compulsive disorder
- mood disorders (e.g., depression or bipolar)
- personality disorders
- post-traumatic stress disorder
- hoarding disorder
- and others, including a combination of these.

Co-occurrence of a mental health and a substance use disorder (SUD) is very common; SAMHSA reports that 1 in 4 people with a Severe Mental Illness also have an SUD. While some disorders are chronic and may recur, recovery is possible. Treatment can involve wellness practices (exercise, nutrition, stress management, mindfulness), therapy, medication, peer support, or a combination.

Half of mental illness begins by age 14 and three-quarters by age 24, per the World Health Organization.

## Magnitude:

*Prevalence in adults:* According to SAMHSA, 16.22% of adults in Southwest CT (SW CT) experienced some form of mental illness in the past year—somewhat lower than the state and national averages. As shown in the figure below, the percentage of adults in the region who experience past year depression (5.7%), serious mental illness (3.1%), or suicidal ideation (3.5%) has remained fairly consistent, with suicidal ideation rates correlating closely to rates of serious mental illness:

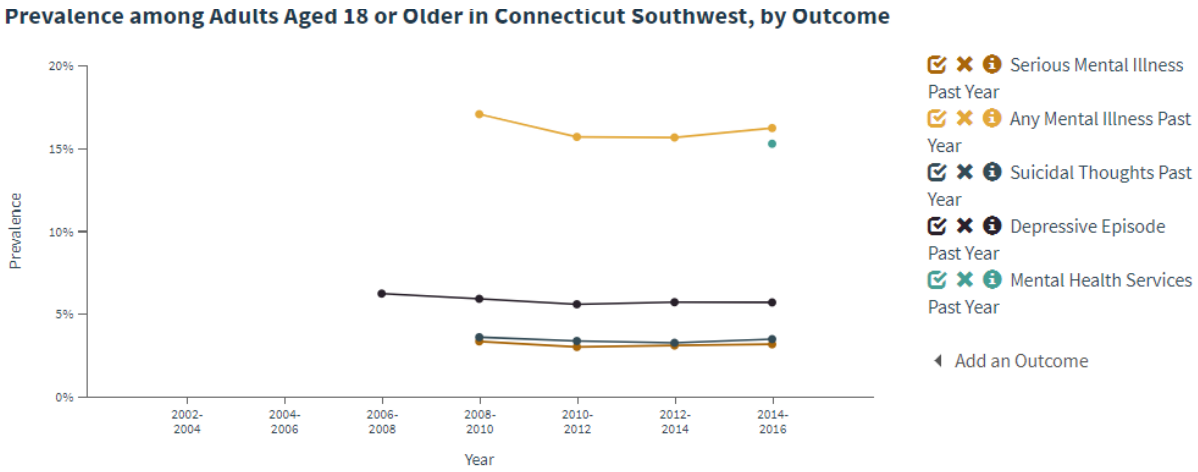


Figure 17: Prevalence of Mental Illness among Adults in Southwest CT

In 2018, DataHaven conducted surveys of adults in 4 metro areas within the region: greater Bridgeport, greater Greenwich, greater Norwalk, and greater Stamford. These found:

- The percentage of adults reporting *feeling satisfied with life* has dropped by 5 points statewide and by 2 to 13 points in SW CT since 2015.
- The percentage of people reporting anxiety or depression has increased by 1 to 2 points since 2015. In 2018, at least one in ten respondents felt *"completely" or "mostly" anxious yesterday* (10% in Greenwich and Stamford, 13% in Norwalk, 17% in Bridgeport) compared with 12% statewide. Between 5% and 14% of respondents reported feeling "*down, depressed or hopeless" more than half the days in the past two weeks* (5% in Greenwich, 7% in Norwalk and Stamford, 14% in Bridgeport), compared with 9% in CT.
- A majority of respondents (69% in Norwalk, 71% in Stamford, and 75% in Greenwich) report that they *"always" or "usually" get the social and emotional support* they need, compared with 70% statewide. In Bridgeport, 82% responded that they have "relatives & friends they can count on."

*Prevalence in youth:* Mental illness in teens and young adults has increased nationwide since the mid-2000s. Depression rates rose by 52% among teens and by 63% among young adults, and serious psychological distress (including suicidal ideation, attempts, and deaths) rose by 71% among young adults. Increased use of digital communication and social media and decrease in sleep are contributors.[30] Students who compare themselves poorly on social media are prone to depression and anxiety.[31]

Statewide, the 2017 Youth Risk Behavior Survey (YRBS) found that 26.9% of CT high school students reported symptoms of depression. Within SW CT, 14% of high schoolers in a suburban community and 23% of high schoolers in an urban community reported signs of depression on Search Institute youth surveys conducted in 2018, up from 10% and 17% in prior surveys.

Depression is linked to suicidal ideation (see also *Profile: Suicide in SW CT*): in the 2017 YRBS, 13.5% of CT high schoolers reported seriously considering attempting suicide in the past year and 8.1% had attempted suicide at least once. Within SW CT, findings are quite varied (possibly based on the impact of municipal funding for prevention): one suburb reported a decrease in teen suicide attempts from 9% in 2016 to 5% in 2019, while a 2018 survey in an urban community found that 16% of 7th graders, 14% of 9th graders and 11% of 11th graders had made a past-year attempt.

## Risk Factors and Subpopulations at Risk:

- *Risk factors for mental illness* include family history, stressful situations such as financial hardship or personal loss, and chronic physical conditions (e.g., depression often occurs following a heart attack or stroke). Substance misuse often indicates an underlying mental health concern.
- *Subpopulations at risk* include youth and young adults; individuals with lower income and educational levels; individuals reporting two or more races, followed by Whites; and women compared with men.

## Burden:

Mental illness takes a toll on an individual's personal and professional life and on family members who may have to leave the workforce to take care of a loved one. The burden includes:

[30] 2019 Twenge & Cooper
[31] March 5, 2018 presentation to Wilton Youth Council by Dr. Suniya Luthar

- Co-occurring substance use disorder.
- Increased risk of suicide.
- Economic burden of $400 million per year to the state for SMI in adults, with over half due to lost productivity: unemployment, lost compensation for caregivers, or early death.[32]
- Increased risk of school suspensions and expulsions.[33]

## Capacity and Service System Strengths:

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

The state's Infoline is a resource for the region and handled 7664 calls for mental health and addiction referrals from SW CT residents in 2018-19. Half of these calls were to the 2-1-1 crisis intervention & suicide program, which connects youth under age 18 to mobile crisis services. Many calls are from schools, which are the front line for adolescent mental health. Some school districts (Stamford, Norwalk) are redesigning their school counselor program. Several contract with Kids in Crisis to embed Teen Talk counselors (3 local middle schools and 5 high schools). 3 local districts have contracted with Effective School Solutions for in-school support. The Fitch Academy, Spire School, and Newport Academy provide therapeutic alternative school programs for those with mental health disorders. Most school systems are building social-emotional programming into their curriculum, including teaching mindfulness and DBT skills and using GoZen, GoHackify, Wingman, 2nd Steps and others.

Dozens of free peer support groups are available throughout the region, including Depression Bipolar Support Alliance (DBSA), National Alliance for Mental Illness (NAMI), SMART Recovery, The C.A.R.E.S. Group, and more, providing support to individuals and families for mental health, substance use, hoarding, gambling, suicide loss, bereavement, and other issues. There are also many trained Recovery Support Specialists in the region, and there is a need for more program and funding mechanisms to connect these peer specialists to those in need.

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

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

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

Regional stakeholders also collaborate on legislative advocacy efforts, with recent wins such as the task force on the psychiatric workforce, behavioral health parity, and Tobacco 21.

[32] April 2018, USC Schaeffer
[33] May 20, 2019 CT Mirror: Almost one-third of students with emotional disturbances are suspended or expelled, far more than students with any other disability.

**Suicide** does not discriminate but affects all ages, races and sexes, creating a ripple effect that can devastate families and communities. Suicide is the 11th leading cause of death for Connecticut residents[34], yet it is largely preventable. According to the American Foundation for Suicide Prevention (AFSP), approximately 10 million people seriously consider suicide ("suicidal ideation") each year, with about one-third of those moving on to making a serious plan for an attempt. Just over one-third of those who have a plan do complete suicide. At any stage it is possible to intervene to provide help.

Suicide is tied to mental illness in 90% of cases, although often the mental illness may go unrecognized. Major life triggers such as a significant loss, death of a loved one or postpartum depression can be triggers. Self-harm is often misconstrued as an attempt but is not usually suicidal behavior. Efforts to identify people who are struggling with depression and other behavioral health disorders and connect them to treatment are critical; however, the National Institute of Mental Health reports that up to half of people who are dealing with a mental health disorder go untreated.

## Magnitude:

The number of suicides in CT first climbed above 1 per day in 2011 and has increased every year since then except for a drop in 2013.[35] As shown in the adjacent figure, the state suicide rate of 10.01 per 100,000 is still lower than the U.S. rate of 13.42. In Southwest CT (SW CT), the suicide rate by town ranges from 0 to 12 per 100,000, with a regional average of 7 deaths per 100,000 population.

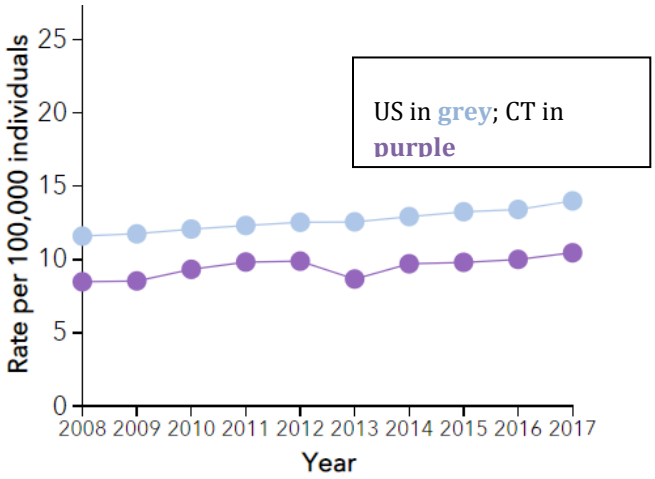


Figure 18: Suicide Rates in the U.S. and CT over Time. (Source: AFSP)

Between 2016 and 2018, there were 157 suicide deaths in SW CT, an average of 52 deaths per year. The average age was 50.5, with suicides ranging from age 16 to 85. Males accounted for 70% of the deaths. By race, the majority were Whites (80%), with 9% Black, 6% "Hispanic, White," and 4% Asian. [36]

Suicidal ideation and attempts in youth are of concern. Statewide, 13.5% of teens seriously considered attempting suicide in the preceding 12 months (16.8% of girls, 10.3% of boys) and 8.1% attempted at least once. More than one in five teens identifying as LGBT made at least one suicide attempt. Black and Hispanic teens attempted suicide more frequently than Whites.[37] The National Institute of Mental Health recently reported that in the month after the release of the Netflix show *13 Reasons Why,* about a teen's suicide, suicide rates among 10 to 17 year olds increased 28.9%. Within SW CT, local youth surveys do not consistently capture suicide-related data. One 2018 survey in a local urban school district found that 16% of 7th graders reported a past-year suicide attempt, with attempts decreasing to 14% of 9th graders and 11% of 11th graders.

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[34] American Foundation for Suicide Prevention 2018 state report, https://afsp.org/about-suicide/state-fact-sheets/#Connecticut

[35] Office of the Chief Medical Examiner (OCME) 2016-2018 suicide deaths

[36] Office of the Chief Medical Examiner (OCME) 2016-2018 suicide deaths

[37] CT Youth Risky Behaviors Survey 2017

## Risk Factors & Subpopulations at Risk:

- *Major risk factors for suicide* include: mental health disorders, especially depression; addiction disorders, especially gambling; a prior suicide attempt; and family history of suicide. Access to firearms increases the risk. Up to one third of opioid overdose deaths are thought to be intentional suicides.
- *Populations at high risk,* according to the Centers for Disease Control and Prevention (CDC), include: males (4x higher suicide rate than females); middle-aged individuals; African-American children under age 12; American Indian and Alaskan Natives. LGBTQ individuals are at significantly higher risk.
- While the suicide rate among pre-teens remains lower than the rate among adolescents, it has been rising. Suicide is the second leading cause of death for ages 10-14 nationally.

## Burden:

Each completed suicide has a lifelong, traumatic impact on family and close friends. The burden includes:

- "Devastating" effects on an average of 11 people and a ripple effect on approximately 115 individuals who are exposed, according to a University of Kentucky study.
- A contagion effect where one suicide may trigger others, particularly in high-profile cases.
- A 4 times higher risk of dying by suicide for children who lost a parent to suicide, according to the QPR Institute.
- An estimated 6,747 years of potential life lost before age 65 and an average of $1,163,740 in combined lifetime medical and work loss per suicide death in CT, according to AFSP's 2018 report. The estimated total loss for 2010 was $410,800.

## Capacity and Service System Strengths:

*Hotlines:* The national Suicide Prevention Lifeline, 1-800-273-TALK, routes callers to the local mobile crisis line. The state's 2-1-1 Infoline continues to be under-recognized. The national Crisis Text Line, accessed by texting 741741, is more likely to be used by youth or young adults than telephone crisis services, therefore all youth-serving organizations are encouraged to raise awareness of this resource. SW CT also benefits from the Greenwich-based Kids in Crisis, which has a 24/7 hotline for youth as well as emergency shelter beds for ages 0-18. Warmlines include a statewide Young Adult service that operates daily from 12-9pm and the regional Soundview Warmline, staffed by people in recovery from 5-10pm nightly.

*Mobile Crisis:* Connecticut is currently reorganizing its mobile crisis intervention services, but at present adult mobile crisis is distinct from children's mobile crisis. Adult mobile crisis operates with a limited staff (and no Spanish capacity) during work hours, serving SW CT from Bridgeport. Children's mobile crisis is available 24/7 but is not mobile after 10pm. In the past year, 2-1-1 received 3843 calls for Crisis Intervention and Suicide from SW CT, representing 50.1% of all behavioral health-related calls. Police departments are often called instead of or by mobile crisis. The increase in Crisis Intervention Trained (CIT) officers is cited by families as invaluable.

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

*Treatment:* Individuals with suicidal ideation are usually sent to hospitals. There is a need for alternative models, such as a peer respite, which provides a safe space for people experiencing a mental health crisis. One relatively new treatment resource is providers who are using ketamine for treatment-resistant depression. Recent research indicates that ketamine can be effective in those experiencing chronic suicidality, although it is not covered by insurance in most cases.

*Support Groups:* There are 2 support groups in the region for people who have lost someone to suicide: one in Greenwich and one in Westport. Additionally, AFSP holds an annual Survivors of Suicide event each November in Fairfield or Westport. At present, there are no "alternatives to suicide" support groups in the region for people who are personally experiencing recurrent suicidal ideation.

*Awareness / Prevention:* Prevention efforts in the region include: community mental health screenings during "Wellness Month," providing gatekeeper prevention training (e.g., Question-Persuade-Refer in English and Spanish or safeTALK) as well as ASIST suicide intervention training, raising awareness about local resources, teaching coping skills, and removing barriers to behavioral health treatment. AFSP's annual Out of the Darkness Walk in Westport raises significant funds and awareness and offers support for suicide loss survivors. It is important for community groups to follow safe messaging protocols (download at www.preventsuicidect.org) after a completed suicide to avoid a contagion effect.

## EMERGING ISSUES

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

1. Vaping is increasing dramatically each year, particularly among teens and young adults.

2. Vaping marijuana is common, although not captured in all surveys, which often ask about vaping and marjiuana separately. Anecdotal reports from some clinicians indicate that vaped marijuana is the most commonly used substance by teens. The use of "dabs" in vaping can deliver extremely high concentrations of marijuana that are associated with neurological risks.

3. The perception of harm from marijuana continues to decrease as more conditions are added to the list approved for medical marijuana. Meanwhile, providers indicate that there is an increase in marijuana-induced psychosis. Youth reports indicate that perception of harm from other substances may be decreasing as well.

4. Mental health disorders are increasing dramatically among teens and young adults. Suicide is increasing generally, and attention to suicidal ideation even in young children is essential. Adults surveyed in the region report less life satisfaction and higher levels of anxiety and depression than in the past.

5. The use of psychiatric medications continues to increase, with benzodiazepines (benzos) and antidepressants commonly prescribed. Among providers and consumers concern has been expressed that dependence on benzos requires attention and may be seen as the next epidemic after opioids.

6. Prescription of opioids has decreased; as a result, social services providers note that other drugs may be starting to come back, with slight increases in PCP and cocaine cited by Community Care Teams since last year. The primary drugs in the region continue to be cannabis and alcohol.

## RESOURCES, STRENGTHS, ASSETS

The region has many strengths and assets to draw upon, including partnerships among many community stakeholders; a wide treatment continuum; many varied recovery supports; peer support specialists; and new vans to provide mobile outreach and resources in the community. These are described below.

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

- the hospital-led Community Health Improvement Projects (CHIPs) in the Bridgeport, Norwalk, Stamford and Greenwich areas, which survey community health needs every three years and develop and implement plans to meet the priority needs;

- the Community Care Teams (CCTs) in Stamford, Norwalk and Bridgeport, which meet weekly to coordinate care across sectors for a limited number of high-need clients;

- the Catchment Area Councils (CACs), which meet subregionally six times per year, with behavioral health consumers, family/friends, and providers at the table, to identify concerns and make recommendations about treatment and recovery services;

- the System of Care Community Resource Collaboratives (CRCs), which bring together families of children with behavioral health challenges and their providers to address service needs;

- the Local Prevention Councils (LPCs), which meet most months at the municipal level to plan and implement prevention strategies in their community; several of which have Drug-Free Community grants, CT Strategic Prevention Framework Coalition, and Partnership for Success grants that have allowed them to use staff and resources to create impressive campaigns and services;

- the Communities 4 Action (C4A) coalition, active in Greenwich, Stamford, Darien and New Canaan, which has pioneered prevention initiatives such as dropboxes and blister packaging;

- the Local Interagency Service Teams (LISTs), which meet sub-regionally on a monthly basis to address juvenile justice concerns;

- the Opening Doors Fairfield County (ODFC) coalition, which seeks to end homelessness in the region, and its Health and Housing Committee, which addresses the intersection of housing, mental health, and substance use.

For those seeking behavioral health care, **treatment providers** are located throughout the region, making geographic access to services possible, even though transportation is often a challenge. Individuals who are eligible or have insurance or private pay capability can make use of a continuum of care, from outpatient through hospitalization, including residential programs and Medication Assisted Treatment programs. Treatment services in the region include the following[38]:

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

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

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

- 2 very active NAMI affiliates operate a large number of monthly support groups as well as offering free speaker meetings and book clubs.
- The CT Community for Addiction Recovery (CCAR) operates the Bridgeport Recovery Community Center, which offers a wide range of daily meetings as well as the Telephone Recovery Support (TRS) program.
- Support groups exist for a number of specific issues, from brain injury to hoarding, bereavement to sex addiction, and co-occurring mental health and substance use. Individuals can seek support through multiple pathways, since there are groups available that use a variety of models: SMART Recovery, LifeRing, Women in Sobriety, Refuge Recovery, Double Trouble in Recovery, Depression and Bipolar Support Alliance, The C.A.R.E.S. Group, Courage to Speak, etc.
- Family and friends can also access a large number of free support groups and training programs.[39]

**Peer support specialists**—Recovery Support Specialists (RSS's) and Recovery Coaches—are trained and available throughout the region, although they are significantly underutilized and many are seeking employment. Currently a number of DMHAS-funded providers and one CCT are employing peers, and the local hospitals are hiring Recovery Coaches to meet with patients in the emergency departments to address opioid overdoses. Some Recovery Coaches are able to work with patients privately. The TurningPointCT project based at The Hub recently offered a Recovery Coach Academy for young adults and hopes to offer drop-in recovery support hours at the Norwalk young adult drop-in center, located at Triangle Community Center, beginning this fall.

**New resources** in 2019 are several vans that are just being launched, which will complement existing mobile outreach efforts (such as the medical bus run in Norwalk by the Community Health Center and a pilot program using social workers in Greenwich). The new grant-funded vans are the following:

- The "Vehicle for Change" purchased by Supportive Housing Works, which does outreach to homeless and at-risk youth in the Bridgeport region.
- A van run by Recovery Network of Programs, operating from Bridgeport to Norwalk to engage opioid users and do suboxone induction.
- A van run by Liberation Programs in the Stamford area to engage opioid users and connect them to services including methadone.

## RESOURCE GAPS AND NEEDS

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

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

## PREVENTION

To create and sustain a robust prevention infrastructure capable of effectively promoting mental health and preventing substance misuse, problem gambling, and suicide, much more **funding** is necessary. A dollar invested in prevention has an estimated return on investment of $10.[40]

Until recently, the state's infrastructure for implementing community-level prevention efforts consisted of 13 Regional Action Councils (RACs) supporting Local Prevention Councils (LPCs) around the state. The role of the LPCs is to build coalitions and develop local capacity to plan and implement prevention strategies in their individual communities to the extent possible given their funding. However, the following factors are significant limitations:

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

As community members have pointed out, campaigns by Big Tobacco, Big Pharma and other lobbying groups are extremely well funded and able to make their products and messages constantly visible to their target audiences. With increased resources, prevention in CT can provide alternative messaging to better educate the public and seek to change social norms.

## TREATMENT

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

- **Supportive and affordable housing** is cited as a critical factor to achieving or maintaining recovery and has been a top priority in the region for years.
- **Case management** is essential for individuals with complex and interconnected challenges to be able to navigate the variety of services and benefits that are possible, as well as for insured families seeking care for a loved one whose needs go beyond a therapist and/or psychiatrist.

In terms of *resource gaps*, the number one challenge continues to be **accessing prescribers** (psychiatrists and/or APRNs) for medication.[41] Currently, as a result of the lack of psychiatrists (not to mention the lack of bilingual psychiatrists and psychiatrists who take insurance), key informants report that one hospital has not been able to accept new clients in psychiatry for several years; psychiatrists at another hospital have

[40] Community Prevention Initiative: Power of Prevention

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

caseloads above 400; and providers who do street outreach are frustrated that there is no immediate access during the short window that a client may be engaged and ready to accept treatment.

The following treatment gaps have also been identified:

- no **First Episode Psychosis** program in the region;
- no **respite beds** or **peer respite** for those with suicidal ideation or experiencing psychosis, which results in expensive hospitalization and rehospitalization;
- no equivalent to DMHAS **Young Adult Services** for young people who are not DMHAS eligible;
- not enough **longer-term treatment beds** for addiction.

## RECOVERY

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

- support for postpartum depression
- support for those with suicidal ideation (e.g., Alternatives to Suicide support group, respite beds)
- SMART Recovery groups for adults over 25, since existing groups are aimed at teens, young adults of family and friends
- more supports for those with co-occurring disorders
- help in training and sustaining support group facilitators
- job opportunities for certified peer specialists and funding for providers to hire them.

## UNDERSERVED POPULATIONS

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

- The undocumented, who will face new challenges in 2020 with stricter documentation requirements.
- Those with cultural/ language differences.
- Middle-class individuals and families continue to face cost barriers in accessing services since they may be neither poor enough to qualify for state funded programs nor rich enough to pay out of pocket. (For example, psychiatrists may charge a rate of $500/hour; co-pays for therapy can add up to $200+ in a month.)
- Individuals with autism are often overlooked in the behavioral health system and assumed to be under the care of a developmental disabilities provider; however, many may have co-occurring mental health issues, and there are very few services available for adults on the spectrum.

# RECOMMENDATIONS

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

## KEY FINDINGS

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

### TOP PRIORITIES FOR THE REGION

With this understanding, our regional workgroup identified **Mental Health** as the top priority for the region. It emerged as the most important area to address for multiple reasons: mental illness affects the most people, it creates a significant burden, it is associated with all the issues the behavioral health community is trying to prevent (suicide, drug misuse, problem gambling), and it is getting worse, with anxiety and depression increasing dramatically among young people as well as increasing among adults. Addressing people's mental health struggles improves their health and reduces their need for unhealthy coping skills such as alcohol and other drugs.

**Prescription drugs** were identified as the second priority for the region. This area is important because reducing the prescription and misuse of legal opioids helps reduce the number of people who turn to illicit opioids such as heroin. While the overall number of people addicted to opioids is relatively small, they often suffer tragic consequences such as death or incarceration. New laws in this area are beginning to show an impact, with the proportion of opioid prescriptions showing a slight decrease (see epidemiological profile earlier in this document). However, that progress must be maintained, despite an increase in the overall number of all prescriptions. Benzos and stimulants are commonly prescribed (and commonly misused) prescription drugs. With more than 1 in 9 adults taking a prescription psychiatric drug, despite short-term side effects and long-term risks ranging from addiction to Alzheimer's, it is important to reduce the healthcare system's reliance on drugs and to help people develop coping skills. Encouraging providers to recommend alternatives to drugs is a strategy that can help reduce addiction and side effects and improve social emotional health.

**Alcohol** was identified as the third priority for the region, due to its widespread use at all ages. Among underage youth, alcohol is commonly used, particularly in dangerous situations such as binge drinking and drunk driving. In addition, approximately 1 in 10 adults in the region feeling they should cut back on their drinking. Because alcohol lowers inhibitions, its use can contribute to the use of other drugs.

## OTHER PRIORITIES AND CONCERNS

The other priorities identified in our regional process included:

**Vaping**, which as mentioned earlier, has emerged rapidly in the region and nationally. Many youth and young adults are using their vapes as a delivery system for marijuana.

**Suicide** is increasing nationally. In our region as many as 16% of 7th graders in one community reported past-year suicide attempts.

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

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

# RECOMMENDATIONS FROM PRIORITIES PROCESS

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

## TABLE 2. RECOMMENDATIONS FOR SOUTHWEST CT (REGION 1)

| Problem/Issue | Prevention | Treatment | Recovery |
|---|---|---|---|
| **Substance Abuse/Misuse** | Adapt and share locally developed campaigns throughout the region to address common priorities (e.g., alcohol, prescription drugs, vaping). Priorities include raising awareness among families about the social hosting law and working to reduce binge drinking in young adults and across the lifespan.<br><br>Support development of a regional pool of youth trained to conduct alcohol compliance checks.<br><br>Provide education about the impact of marijuana on the developing brain and safer alternatives for coping with stress. Monitor consequences associated with use of marijuana (including vaping) and CBD oil.<br><br>Convene prevention specialists and providers to discuss expanding their SUD screening program to incorporate MH, suicide, tobacco, vaping and problem gambling using the regionally developed screening tool.<br><br>Support community-level prevention around Alcohol, Tobacco / Vaping & Other Drugs (ATOD) based on CADCA's 7 strategies for change. | Work with key stakeholders (e.g. CHIPs, Community Care Teams, housing providers) to problem solve around alcohol abuse, particularly among people who are not ready for treatment.<br><br>Educate physicians and community members about the value of Medication Assisted Treatment and other evidence-based practices and resources, as well as on non-medication alternatives for treatment (e.g., yoga, reiki, massage therapy, acupuncture, etc.).<br><br>Create a work group of stakeholders and legislators to discuss improvements to medical marijuana program including reviewing operations of regional dispensaries and giving feedback.<br><br>Encourage providers to expand treatment for children/teens. Expand teen vaping cessation supports.<br><br>Raise awareness about use and risks associated with benzodiazepine medications, including supports for those wishing to discontinue their use and alternatives for coping with anxiety. | Encourage sober houses to meet national standards for recovery residences and be listed on the CT Addiction Services website.<br><br>Raise public awareness about the CT Addiction Services website.<br><br>Continue to provide Naloxone trainings throughout the region.<br><br>Expand access to peer supports such as Recovery Coaches and SMART Recovery groups in both community and provider settings. |

| Problem/Issue | Prevention | Treatment | Recovery |
|---|---|---|---|
| **Mental Health (suicide and mental illness)** | Coordinate and expand regional suicide network of care to address pre- and postvention, including exploring creation of an Alternatives to Suicide support group. Train new QPR trainers, including Spanish speakers, to increase regional capacity to provide suicide prevention training.<br><br>Advocate for social-emotional initiatives, such as Free Play, coping skills curricula (e.g., 4 What's Next), and anti-bullying programs, starting in elementary school. Promote social-emotional supports and coping skills to the general public through media campaigns, community outreach, and expansion of support groups.<br><br>Ensure that all schools (K-12) and colleges in the region publicize the Crisis Text Line.<br><br>Coordinate & promote Mental Health First Aid, QPR, SafeTALK, ASIST, and other educational programs. | Support regional efforts to address timely access to treatment, including access to medication (e.g., open access models, telehealth, cooperative agreements among providers, evening/weekend hours, co-locating clinics at shelters).<br><br>Improve discharge planning and community connections from hospitals by providing client feedback about the handoff process, reviewing facility protocols about informing clients, and educating inpatient BH providers about community resources for treatment, housing, supportive services, case management, and peer supports. Consider incentives to agencies for following up on client referrals and successfully connecting clients to care.<br><br>Support education for primary care providers and shelter/housing providers to better understand and serve mental health and trauma.<br><br>Explore options to create First Episode Psychosis program for the region. | Identify mechanisms to create sustainable source of facilitators and facilitator training for MH and SUD support groups such as NAMI, SMART, etc.<br><br>Coordinate efforts to create postpartum depression supports in the region.<br><br>Expand use of Recovery Support Specialists, including exploring using RSS's for a mobile MH outreach program (similar to / following on Homeless outreach Team model).<br><br>Continue to advocate for a peer respite in the region to divert people from hospital stays. |
| **Problem Gambling** | Promote public awareness of CT Problem Gambling hotline.<br><br>Build capacity in the region to prevent problem gambling. Improve outreach to those at high risk and to a broader range of cultural groups.<br><br>Instill gambling awareness into BH activities throughout the region, including disseminating gambling PSA that was created by Caribe Youth in Bridgeport.<br><br>Provide awareness and education about gaming addiction for parents and youth. | Educate providers about gambling and gaming.<br><br>Encourage screening for problem gambling using the Brief Bio-Social Gambling Screening tool (which is incorporated in the regional integrated screening tool). | Explore expanding gambling support groups. |

| Problem/Issue | Prevention | Treatment | Recovery |
|---|---|---|---|
| **Systems: Integration across Behavioral Health** | Coordinate region-wide educational efforts--including videos and digital toolkits--that integrate messaging around MH, SUD and PG.<br><br>Invest in social media buys to reach a bigger audience on youtube & Facebook.<br><br>Encourage use of integrated BH screening tool.<br><br>Make recommendations for improved and/or integrated data collection around MH, SUD and PG, to include hospital / emergency room data, self-injury data, information on non-fatal overdoses, etc.. | Ensure info about language support (e.g., Language Line) is posted visibly in multiple languages and with graphics in hospitals and provider agencies.<br><br>Update "Get Help" poster and disseminate throughout region.<br><br>Advocate for increased dissemination and explanation of client rights information at provider facilities.<br><br>Provide information and education to pharmacists about behavioral health resources in the region.<br><br>Explore with treatment providers the resources for and needs of pregnant and parenting clients. | Encourage and plan for increased use of peers and Community Health Workers to provide community outreach and supports around BH.<br><br>Advocate for legislation to make certified peer support a reimbursable service.<br><br>Create SMART Recovery group for adults.<br><br>Explore creating new support groups for those with COD, such as Double Trouble in Recovery.<br><br>Work with interested towns or cities to become Recovery-Friendly Communities. |

## TABLE 3. RECOMMENDATIONS FOR THE STATE

| Problem/issue | Prevention | Treatment | Recovery |
|---|---|---|---|
| **Substance Abuse/Misuse** | Provide training and supports for youth compliance inspections in the region, including point-of-sale ID checks, to prevent youth under age 21 from purchasing tobacco products and alcohol.<br><br>Support legislation to require blister packaging to prevent diversion of medications (initiated by Communities 4 Action). | Increase available resources, especially longer-term programs, detox beds, drug and alcohol counselors.<br><br>Ensure that treatment providers are fully capable of addressing co-occurring mental illness.<br><br>Increase in-network MAT providers. | Support efforts to ensure safe and affordable sober homes throughout the state.<br><br>Review functioning of Access Line and make recommendations to improve its service. |

| Problem/issue | Prevention | Treatment | Recovery |
|---|---|---|---|
| **Mental Health (suicide and mental illness)** | Assist in compiling local data about the nature and extent of suicidal attempts and self-injury.<br><br>Support legislation to ensure social-emotional curriculum and positive school climate K-12. | Ensure that treatment providers are fully capable of addressing co-occurring substance misuse.<br><br>Support the recommendations of the task force on the psychiatric workforce (to begin meeting in FY20) to address shortages of providers and provider caseloads.<br><br>Consider converting one of the region's Community Support Program (CSP) teams into an ACT team.<br><br>Address the lack of state-funded youth beds in the region.<br><br>Develop a First Episode Psychosis program in the region. | Develop peer respite programs throughout the state to reduce hospitalizations. |
| **Problem Gambling** | Continue to offer training programs for community prevention specialists. | Continue research to measure changes in prevalence and to better understand the impact of problem gambling on CT's communities. | Ensure that problem gambling supports are available in multiple languages. |

| Problem/issue | Prevention | Treatment | Recovery |
|---|---|---|---|
| **Systems: Integration across Behavioral Health** | Integrate messaging about MH, SUD, and PG to fight stigma, raise awareness of the interrelatedness of these issues, and promote wellness.<br><br>Develop videos, webinars and digital tool kits that can be disseminated statewide.<br><br>Invest in social media buys to reach a bigger audience statewide on youtube & Facebook.<br><br>Revisit SBIRT screening program to integrate MH, Suicide, Tobacco, Vaping and Problem Gambling; consider using integrated Mental Wellness screening tool developed in region 1. | Increase support for Co-Occurring Disorders treatment by removing eligibility barriers (both in DMHAS-funded programs and at CVH) where individuals are told their MH needs are too severe for a SUD program and vice versa. Also expand capacity to treat individuals with BH disorders and physical co-morbidities.<br><br>Create incentive programs or other meaningful policy changes to increase the number of bilingual / multilingual providers as well as staff cultural competence.<br><br>Conduct statewide campaign to raise awareness of available treatment resources and physician understanding of MAT.<br><br>Improve Veyo or find another transportation service.<br><br>Explore ways to incentivize providers to accept private insurance and Medicaid. | Increase supportive housing services for the BH population. Current housing policies and programs aimed at ending homelessness do not always best serve individuals with a mental illness or addiction.<br><br>Expand case management resources across programs, including making existing programs less restrictive (e.g., open CSP to those with an SUD primary diagnosis).<br><br>Revisit benefits policies and job programs to reduce barriers to employment.<br><br>Conduct an external evaluation of existing peer support training programs by Advocacy Unlimited, the CT Coalition for Addiction Recovery and Mental Health America to cross-walk the content areas and develop a best-practices training.<br><br>Support legislation in FY20 to make peer support a reimbursable service. |

| Problem/issue | Prevention | Treatment | Recovery |
|---|---|---|---|
| | Remove siloes and integrate programs and structures, for example:<br>• Ensure that all relevant state agencies are represented on the Behavioral Health Planning Councils and involved in cross-agency planning.<br>• Work creatively with housing providers to address the need for affordable, supportive housing.<br>• Expand the Alcohol and Drug Policy Council (ADPC) to include and address mental health and problem gambling.<br>• Coordinate suicide and opioid response across DCF, DMHAS and DPH.<br>• Use DPH training materials about the NORA app and the CPMRS rather than develop separate training modules.<br>• Merge the children's and adult mobile crisis services to increase mobility, availability after hours, and foreign language capacity.<br><br>Work with DOC and DMV to develop legitimate alternative form of identification in order to remove barriers to care for the undocumented.<br><br>Explore creating slots for case management from the General Funds (as is done in Maryland), to be allocated for individuals with very high need regardless of ability to pay. Such funds could be used to support individuals with multiple comorbidities or young adults presenting with complex issues but ineligible for DMHAS's Young Adult Services program due to their insurance or family status.<br><br>Ensure information and websites are available in multiple languages.<br><br>Make use of video conferencing technology and webinars to reduce meetings and travel time. Regionalize conferences and trainings to maximize participation across the state. | | |

# APPENDICES

## PRIORITY RANKING MATRIX FOR REGION 1

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

| PROBLEM | Magnitude | Impact | Change-Ability | Capacity/ Readiness | Consequence of Inaction | Mean Ranking Score: | RANK |
|---|---|---|---|---|---|---|---|
| **Alcohol** | **5.0** | **4.0** | **3.0** | **3.0** | **4.0** | **3.8** | **#3** |
| **Tobacco (Nicotine) / Vaping** | **3.0** | **4.0** | **2.0** | **4.0** | **5.0** | **3.6** | **#4 TIE** |
| **Marijuana** | **4.0** | **4.0** | **2.0** | **1.5** | **5.0** | **3.3** | **#5** |
| **Rx Drug Misuse** | **3.2** | **4.2** | **3.9** | **4.2** | **4.2** | **3.9** | **#2** |
| **Heroin** | **1.6** | **4.5** | **3.7** | **3.8** | **4.6** | **3.6** | **#4 TIE** |
| **Cocaine** | **1.7** | **3.2** | **2.6** | **2.6** | **3.1** | **2.6** | **#6 TIE** |
| **Problem Gambling** | **2.1** | **2.8** | **3.0** | **2.2** | **2.9** | **2.5** | **#6 TIE** |
| **Mental Health Issues** | **5.0** | **4.5** | **4.0** | **4.2** | **4.5** | **4.4** | **#1** |
| **Suicide** | **2.3** | **4.5** | **3.6** | **3.2** | **4.1** | **3.6** | **#4 TIE** |

## REQUIRED STAKEHOLDER QUESTIONS

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

Appropriateness of services to needs:

- Positives: There are both public and nonprofit treatment agencies (including 6 hospitals) throughout the region, along with many individual therapists, offering a wide range of services from outpatient to inpatient using different treatment modalities and often supporting a holistic / wellness approach. Providers go above and beyond to serve their clients' needs, despite very high caseloads (40 to 60 clients per social worker, hundreds per psychiatrist). There are also specialized for-profit agencies in areas such as eating disorders, anxiety, and failure to launch. Many treatment providers are able to address co-occurring mental health and substance use disorders, although there is little awareness about problem gambling and only 2 gambling treatment providers in the region. There is a wide range of recovery supports such as NAMI, AWARE, SMART Recovery, Depression and Bipolar Support Alliance, The CARES Group, etc.
- While an extensive range of services is available, care is fragmented across a variety of provider agencies. For example, clients report that when they are hospitalized, their medications are often changed significantly without communicating with their existing prescribers to identify previous experiences with the new meds. In addition, their community providers often do not receive information about the changes after the client is discharged. It is important to ensure that care is coordinated.
- Clients with both mental health and medical needs often require specialized services. While DMHAS offers the Behavioral Health Homes program to eligible clients within its population, and some provider agencies offer integrated care, many people go underserved (particularly the elderly). Individuals with Severe Mental Illness report that their medical needs are often discounted due to a provider's assumption that the symptoms must be psychological.
- Specialized services for young adults suffering from trauma, mental illness and/or addiction exist for the DMHAS population. However, such services are not available to the majority of the region's population who have private insurance. Relatedly, there is a need for a First Episode Psychosis program for the region.
- In terms of Medication Assisted Treatment (MAT), progress is being made to ensure that multiple MAT methods are available. However, there is a perception among some clients that "addicts want to recover, not trade one drug for another." There is also a perception among some doctors that MAT is a continued reliance on an addictive drug, which points to a need for physician education.
- CAC members recommend that behavioral health programs ensure that clients are educated about their rights frequently, given opportunities to ask questions, and given written copies of their rights.

Barriers:

- Some provider agencies require clients to switch prescribers in order to use their services even if they have long standing relationships with their prescriber and despite long waits to see a new prescriber. One Region 1 client moved to a new community not far away (though in Region 2) and was willing to travel back to her existing prescriber and therapist. However, when she found herself in a suicidal crisis and went to the local crisis services, they would not treat her unless she switched to their services and saw their psychiatrist.
- Discharge from hospitals continues to be reported as inadequate. Multiple clients report that they exit without a follow-up therapy appointment or appointment with a prescriber and no info on how to get a script for their refills. Clients are not referred to support groups.
- The shortage of psychiatrists continues to affect provider ability to meet clients' needs. One hospital is still not taking new clients (as reported in past priority reports) because they can't hire a psychiatrist. However, the state task force on the psychiatric workforce legislated based on a bill proposed by the Region 1 CACs has recently been staffed and will begin working.
- Clients continue to report issues in accessing timely appointments at provider agencies due to heavy caseloads of staff.

- DMHAS bureaucracy can get in the way of timely treatment. One example is a client with severe suicidal ideation who was referred for ketamine treatment but the appointment took several months during which time the client had to be hospitalized.

Insurance issues:

- Positive: The Behavioral Health Parity bill that passed during the 2019 legislative session should begin to help individuals and families with private insurance to access services.
- When clients switch from Medi-Medi to Medicare only, they lose services and lose access to their existing providers.
- Many clients point to the "slow erosion of the Medicare Savings Program."
- A lack of inpatient facilities that take Medicare was reported.

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

General prevention strategies for all behavioral health topics:

- State-wide and region-wide coordination of campaigns and messaging, including sharing locally developed campaigns across communities, on a variety of BH related topics.
- Integration of messaging about mental health and substance use. Awareness about how the two are connected (and also linked to problem gambling). Improvements in mental health will reduce substance misuse.
- Budgeting for social media buys (e.g., paid ads region-wide or statewide) to more effectively reach target audiences.
- Widespread interest in increasing development and social media dissemination of short videos.
- Digital toolkits from the CT Clearinghouse: gifs, social media posts, short videos, etc. on a wider range of topics, especially mental health and especially in other languages.
- Continue to fight stigma, raise awareness of treatment availability.
- Need for communities and providers to provide more comprehensive screenings so as not to miss critical opportunities. While the SBIRT initiative continues to emphasize screening for substance use disorders, in Region 1 there is growing use of the Wellness Screening Tool developed by SWRMHB and the Primary Care Action Group, which was developed several years ago to screen for both mental health and substance use. In 2018 it was revised to include screening for problem gambling and nicotine use.
- Providers recommend promoting frequent use of screenings so clients can self-assess their progress and providers can check back in on issues that may be emerging (e.g. gambling, if casino comes to Bridgeport). In Region 1, SWRMHB and now The Hub promote a month-long community screening initiative each October, called Wellness Month.
- More buy-in from different stakeholders who can make change. i.e.school districts, police departments etc.
- Evidence based curriculum that supports children in social / emotional learning.
- Health class offered throughout middle and high school. In some school districts, high school students only have 2 marking periods of health class out of 4 years.

Substance Use:

- Blister packaging to reduce diversion of prescription drugs (an initiative of Communities 4 Action)
- Physician education about MAT
- Stigma reduction around MAT
- Drug Recognition Experts (DREs) to provide ongoing training
- Well-supported evidence regarding Marijuana and E-Cigarettes

Mental Health:

- Awareness of crisis resources, including the Crisis Text Line (posters in all MS, HS and colleges).
- Integration of evidence-based social-emotional health and coping skills curriculum into K-12.
- Increasing wellness practices such as mindfulness.
- Addressing social isolation among at-risk populations (youth, elderly, immigrants).
- Continuing to provide evidence-based trainings to the general population (Mental Health First Aid, QPR, ASIST, etc.) and promoting trauma-informed practices among providers.

Problem Gambling:

- Any kind of awareness efforts about problem gambling for the public and for providers
- Awareness about gaming for parents and youth

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

Substance use:

- Need longer-term programs as well as more detox beds.
- Not enough grant beds.
- Need for more drug & alcohol counselors (especially in CSP programs).
- Need for more COD treatment.
- Not enough MAT providers or not enough in-network.
- Need alcohol & marijuana tx programs for teens.
- Need more treatment programs for teens for vaping/nicotine addiction.

Mental health:

- Continued lack of access to psychiatrists/prescribers - both due to nationwide shortage as well as the fact that most don't take insurance. Prescribers should have lower caseloads. Need for bilingual prescribers. On a positive note, the task force to address shortages in the psychiatric workforce has just been fully staffed. (This task force was created as a result of a legislative initiative from the CACs in Region 1.)
- Crisis services should be available when you need them (after 5pm) and should be truly mobile. Crisis services must have bilingual capability.
- Missing levels of care:
    - Ongoing need for respite beds, especially a peer respite, as mentioned annually. Multiple clients with SMI cite the expense and trauma of going to the hospital when suicidal, knowing they will not receive any services of benefit other than to stay safe, when they would prefer to go to a respite for a few days.
    - A First Episode Psychosis program continues to be unavailable to individuals from Region 1. Strong interest in having a program in Southwest CT as indicated in the past.
- Ongoing shortage of psych beds. Lack of appropriate care for those needing a psych eval or with suicidal ideation, with clients reporting "you just get an overnight hold and then get sent home").
- Need for Assertive Community Treatment team(s).
- Need for mobile outreach team to do client engagement. Many clients don't know about / don't take advantage of many options (e.g., Wellness Center at Greater Bridgeport).
- Need for more / better treatment for co-occurring disorders (MH + SUD).
- Need for youth shelter beds in Region 1. The only option is Kids in Crisis and the state doesn't fund those beds any more.
- Need for providers who accept private insurance and providers who accept Medicaid.
- Integration with primary care is important. Clients report that visits are less than 15 minutes and seek longer patient interaction.

- Need for better client psychoeducation about asking for help, therapy, diagnosis. As one client noted, "Knowledge is power, but it took me 20 years to be empowered."
- Need better medication education for clients: answer questions, explain side effects, etc.

Problem gambling:

- Only 2 Bettor Choice providers in the region, which limits geographic access although they are able to meet current demand for service.
- Lack of provider awareness about problem gambling. Providers are not screening for gambling.

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

Basic needs:

- **Housing** continues to be a top priority for a huge proportion of Behavioral Health clients, as noted in past priority reports. There is a lack of affordable housing, supportive housing, and sober housing throughout the region. This is a social determinant that underlies many behavioral health concerns and affects clients' ability to maintain recovery; as such it should be better incorporated into treatment planning.
- **Case management** is a critical need reported by both clients and providers that continues to be one of the most undersupplied areas. People often fall through the cracks, unable to access benefits they are eligible for or to navigate the system without a case manager. In other cases, social workers and Recovery Support Specialists fill in the gap, providing basic case management (identifying social services, transport, coordinating with other providers, etc.) instead of the counseling or emotional support the client needs.
- **Transportation:**
    - **Veyo** continues to be very problematic: No shows, long waits, taking people to the wrong place, not providing wheelchair-accessible vans. Providers can no longer provide bus tokens to get to IOP.
    - **Access Line** service has decreased. Providers report that the Access Line has told callers to call 211 instead. Callers have been told that transport will only be provided if they have already gone to detox. Callers have also been told that they can only get transportation to an inpatient facility if they call by 3pm the day before, despite the fact that beds are not always available with prior notice and that clients may need urgent same-day access.
    - **Access To Recovery** (ATR) funding was cut.
- **Benefits System**: As observed by one client, "It's so hard to get off disability and out of the public system." Providers concurred that the system fosters built-in helplessness. Employment issues identified include:
    - People in recovery are encouraged to volunteer or do internships but are not provided opportunities for real paid work. They can get trained as peer specialists but few peer jobs exist.
    - When behavioral health clients get a job, they lose their benefits and often their providers. Clients observed that "When you start to work, you should be eligible for 9 months of benefits but you have to know about it and you have to apply."
    - Income threshold: Clients lose cash benefits once they have substantial gainful activity (defined as $1000/month); this should taper off slowly to allow for a safety net.

General Behavioral Health:

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

Substance use:

- Need for affordable and responsible sober housing. Some sober homes in Region 1 provide very limited services yet cost up to $8000/month. Most houses cost ~$1500/month (though Pivot Lighthouse in Bridgeport is $500.)

Mental health:

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

Problem gambling:

- Need more awareness about the state's problem gambling hotline. There are 2 gambling support groups in the region (Darien and Stamford).

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

Prevention:

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

Mental health:

- Providers use a "no wrong door" approach, helping to connect clients to care.
- The inclusion of peers (RSS's) on teams has begun within some DMHAS-funded programs. The use of peers should be expanded. Legislation around insurance coverage for peer support was again initiated during the 2019 session from Region 1 and will be revisited again next year.
- There are a variety of hotlines, warmlines, and peer support options at all levels (national, statewide, and within the region).
- The state provides significant support for young adult services.
- Consumer input is valued and sought after through the Catchment Area Councils.

Problem gambling:

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

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

- Continued attention to developing cultural competence in working with non English speakers.
    - Info about Language Line and client rights should be posted in visual format as well as in various languages in all provider agencies and hospitals.
    - Education, treatment, supports in Spanish should be the norm.
- LGBTQ supports, including treatment for the transgender community.
- Youth with Autism Spectrum Disorders or other developmental disabilities, especially when co-occurring with mental health disorders, were identified by providers.
- More services / supports for pregnant and parenting youth were identified by young adults in recovery.
- Substance use issue: The location of liquor stores targets low-income and often predominantly minority neighborhoods.

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

Substance use:

- Increase in crack, PCP.
- Worsening of the Access Line.
- Marijuana:
    - "Huge increase in ER visits" due to marijuana
    - No maximum amount of THC in "medical marijuana"
    - No protocols for dosage at cannabis dispensaries
    - More pregnant woman smoking marijuana in their first trimester (JAMA)
- Prevention professionals report, "now that we're asking about mental health, it's the top priority."

Mental health:

- Continued increase in anxiety, depression, and suicidal ideation in adolescents. Recent death by suicide of a 14 year old in the region.
- Uptick in children with suicidal ideation with reports of a 5 year old and 9 year old that had just been identified at the time of the focus group.
- In 4 sub-regional surveys conducted in 2018, adults in each of the surveyed areas (greater Greenwich, greater Stamford, greater Norwalk and greater Bridgeport) showed a decline in life satisfaction and increase in reported anxiety and depression since 2015.

Problem gambling:

- Youth surveys in the region indicate an increase in gambling in high schools.
- Gambling treatment providers in the region report more people receiving treatment and more women receiving treatment.
- Gambling treatment providers in the region report an increase in electronic gambling.

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

Technology:

- There is a continued need for DMHAS and other state meetings (e.g. ADPC, CT SAB) to use video-conferencing technology to reduce time and travel while also maximizing participation.
- It would be useful for DMHAS to develop more webinars and digital toolkits that could be disseminated statewide.
- DMHAS and other state agencies should invest in social media buys to reach a broad audience statewide on youtube and Facebook.

Integration:

- At the RBHAO level, DMHAS encourages the integration of mental health and substance use services, and now problem gambling. At the same time, separate programs at the central level continue to foster silos. Co-planning and integration of policies / funds at the central level would be helpful in making these efforts more efficient at all levels. For example:
    - Problem gambling plans, funds and required activities are separate from other regional activities despite the overlap in stakeholders and populations served.
    - Regional suicide networks were created at the same time as the RBHAOs yet in parallel to them. These are now being reorganized to be run through the RBHAOs.
    - RBHAOs were asked to develop regional suicide profiles at the same time that these were being developed through the suicide network of care.
    - ADPC efforts such as the Recovery Friendly Communities model could incorporate mental health along with substance use.
    - Contracts funded through specific grants, such as opioid money, should encourage the integration of general behavioral health efforts while still ensuring that the primary focus is on the targeted subject.
- Screening initiatives such as SBIRT should integrate mental health, substance use and problem gambling using existing tools.
- The existing peer specialist training curricula used by the CT Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU) should be evaluated by external stakeholders and integrated so that *all* certified peers are given adequate training related to mental health, substance use, and problem gambling and can competently provide support and referrals as needed. Consideration should be given to use of the national peer certification curriculum developed by Mental Health America.
- Mobile crisis should be integrated across the lifespan. (Recommendations have been made in this regard by CACs in the past.) We realize that the mobile crisis system is currently being reorganized statewide but are not yet aware of specific decisions that may have been made.

Partnerships:

- Coordination across state agencies, such as the Department of Children and Families (DCF) and DMHAS, is critical to reduce duplication of efforts, improve efficiencies, and maximize funding. The CT Suicide Advisory Board is a very successful example. Other opportunities include:
    - The Joint Behavioral Health Planning Council should serve more of a planning function and less of a report-out function. It should ensure that all parties serving individuals with behavioral health needs are represented across state agencies.
    - DCF and DMHAS could seek to integrate their treatment of youth in the 16 to 18 year old age group.
    - The Department of Public Health (DPH) and DMHAS are both working on suicide and opioids. These efforts could be jointly planned and coordinated at the state level, with the plans and resources be disseminated to the regions through the RBHAOs, which would then coordinate with local health departments.

    - The NORA app developed by DPH has a training of trainers and handouts that could be used in all the regional Narcan trainings, rather than different regions and communities developing their own. NORA will be translated into Spanish and should be used throughout the state.
    - CDC is piloting an Academic Detailing program for Health Districts. They will educate prescribers on modules related to CT Prescription Monitoring and Reporting System (CPMRS), Narcan, & Communication (patient, prescriber, dispenser). This education should connect with the work of the RBHAOs and LPCs.
- Materials developed for community use should involve community stakeholders in the planning and review. For example, some Change the Script materials did not provide sufficient space for local resources and phone numbers.