Statewide Needs Assessment for Maternal, Infant, and Early Childhood Home Visiting Programs

Connecticut, 2020

A Report to:

Aileen McKenna, PhD, IMH
PI & Manager of Home Visiting Programs
At the Connecticut Office of Early Childhood (OEC)

By

The OEC-UConn School of Social Work Research Partnership

In partnership with the

Connecticut Home Visiting Advisory Board

In partial fulfillment of mandates pursuant to:

The MIECHV authorizing act: Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)).1 Section 50601 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123) (BBA) section 50603 that requires states to conduct a statewide needs assessment under section 505(a) no later than October 1, 2020.

Grant ID: X10MC31131

Authorship:

OEC-UConn School of Social Work Research Partnership:

Kathryn E. Parr, Ph.D.
Megan Feely, Ph.D.

With assistance from:
Ciara Collins, Ph.D., Juliany Polar, MEd., Kyle Pilon, M.A., Harini Buch, B.A., Bonnya Mukherjee, M.B.A., Tea Llakmani, B.Sc., Raul Santiago, Domenic Deluca, B.Sc., Heather Durosko, B.A., and Cluber Marin

Home Visiting Advisory Board Membership:

Name	**Organization/Agency**
Kelly Annelli, MSHV	CT Coalition Against Domestic Violence
Linda Bamonte, PT, DPT	CT Office of Early Childhood
Kim Boulette	CT Department of Public Health – WIC
Deborah Buxton-Morris	Nurse-Family Partnership at Visiting Nurse Association of Southeastern CT
Marc Camardo, MPH	CT Department of Public Health – Title V
Lisa Candels	EdAdvance
Marrijane Carey, MPH, MSW	Maternal and Child Health Consultant
Marjorie Chambers, MS, RD	CT Department of Public Health – WIC
Betsy Cronin	The Connection, Inc
Kareena DuPlessis	Child Development Infoline
Siobhan Feliciano, MS, LPC, LADC	CT Department of Mental Health and Addiction Services
Adriana Fontaine	CT Parent Advisory Center
Emily Frankel, MPA	Nurse-Family Partnership
Bill Halsey	CT Department of Social Services
Pam Langer, MA	PAT
John Leventhal, MD	Yale University
Mary Kate Locke, LCSW	Family and Children's Agency
Allison Logan, BS-ED, MS	Bridgeport Prospers
Darcy Lowell, MD	Child First
Crista Marchesseault, MA	Minding the Baby – Yale University
Shelly Nolan, MS, LPC	CT Department of Mental Health and Addiction Services
Mary Peniston, MPA	Child First
Jessica Sanderson, Ph.D., LMFT	Urban Alliance
Arietta Slade, Ph.D.	Yale University
Louis Tallarita, LMSW	CT State Department of Education
Elizabeth Teller	Birth to Three Program at SARAH, Inc.
Katie Trocin, MPH	Health Resources and Services Administration

And our thanks to the many parents and community members that contributed to this report!

1. Introduction

Since the original 2010 NA, MIECHV home visiting has been brought under the purview of the Office of Early Childhood, that also overseas other home visiting, child care funding, licensing and training, IDEA early-intervention services (the Birth to Three System), and some 2-Gen programs to support parents in providing a stronger and healthier future for their children. Through the state procurement process, MIECHV funds four evidence-based programs through 22 local agencies in all counties in the state.

The purposes of this Needs Assessment (NA) update for the state of Connecticut were to understand the current needs of families and children and identify the high-risk communities. It was also used to support statewide planning for a continuum of home visiting services from prenatal programming through age-5, and it will be used in the implementation phase of that plan. Additionally, this NA was used to identify the high-risk communities so that the planning phase of the statewide process could incorporate strategies to reach those communities with evidence-based and promising home visiting services.

The NA was also conducted to identify unmet needs for home visiting and other services for families, and to disseminate that information to stakeholders. There were a number of important findings that influenced the eventual direction of the program. In addition, needs assessments and other state-wide plans from the Department of Public Health, the Department of Children and Families (DCF) were taken into consideration during the NA and planning process. Information was disseminated through presentations to different groups of stakeholders including home visiting providers, other early childhood service providers, the NA Advisory Board, and to all respondents of the program survey. This needs assessment is an update to the 2010 Statewide Needs Assessment.

This NA assessment pointed toward a system of prevention that was in closer alignment with the DPH goals that also filled identified gaps in HV services among existing DCF services and would also not be covered by the anticipated expansion of DCF-related services allowed under the Family First legislation. The DPH decennial NA was conducted simultaneous to this NA but information from interim presentations was available and utilized. One of their key findings, and a focus for their efforts in the future, was the persistence of health disparities across race/ethnicity. While the MIECHV NA was conducted on a community level, rather than by demographic population like the DPH, the findings are similar. Some areas of the state have a very low prevalence of the risk factors while other communities have a high prevalence of these risk factors.

Although DCF-funded services, including HV, are treatment focused through their differential response program and other post-involvement recommendations families are often referred to community programs. In those community programs including HV families with current or former DCF-involvement were often prioritized for services. While this was a reasonable approach, the result has been that primary prevention was often difficult or unavailable for families to access and HV has been stigmatized as an extension of DCF services.

This dynamic is in the context of a relatively service-rich state with multiple therapeutic home visiting programs offered through DCF and an extensive and geographically dispersed array of SUD and MH treatments available for the same populations who might access HV. While gaps remain, these programs are accessible to many people across the state. Additionally, many adult and children's services have participated in specific trauma-sensitive treatment. and state-funded SUD and MH services have a department dedicated to women's behavioral health and gender-specific SUD and MH needs.

2. Identifying At-Risk Communities (Counties) with Concentrations of Risk

Connecticut (CT) is a New England state of 4,842 square miles[1], neighboring New York City, Rhode Island and Massachusetts. CT has a population of 3,586,677.[2] Roughly 5.1% of the population is under the age of 5. Just over half (51.2%) are women. White, non-Hispanic, are the largest race/ethnicity subgroup at 65.9%. Another 12.2% of people are Black and 16.9% are of Hispanic ethnicity. About 2.5% of the population reports being of two or more races and 3.5% identified as another race. CT has 8 counties but does not have a county level government system. Instead, the next level of government below the state level is the town level. There are 169 towns in CT.

Although CT's per capita income is about 32% higher than the US average,[3] CT has the among the greatest income inequality in the US. In CT, the richest 5% of households have average incomes 14.1 times that of the bottom 20% of households.[4] In addition, People of Color in CT have worse pregnancy outcomes. Pregnant Black women experience an infant mortality rate 3.6 times greater than Caucasian women. Pregnant Hispanic women's infant mortality rate is 1.4 times greater than Caucasian women. These represent some of the inequalities that CT's home visiting system seeks to identify and ameliorate.

a. Adding Data for the Simplified Method / Method for the Data Summary

This NA follows the simplified method. The simplified method has two levels of analysis. First, this method examines indicators for 5 different domains: (1) Socioeconomic Status; (2) Adverse Perinatal Outcomes; (3) Substance Use Disorder (SUD); (4) Crime; and (5) Child Maltreatment. Within each domain are a series of indicators. The number of indicators per domain ranges from 2 to 5 for each geographical subunit. For each indicator, the average and variance is calculated for the geographical subunit and then compared to the state figures. If a subunit is greater than 1.5 standard deviations above the state in a single indicator it is considered an outlier in that indicator. If a geographical subunit is an outlier for at least half of the indicators in a domain, it is considered an outlier for that domain. Looking across the five domains listed above, a geographical subunit is designated at-risk if it is an outlier for at least 2 domains.

i. Description of Added Data

This report made two permitted changes under the simplified method to add to the county level analysis. First, towns were added to the analysis as they are the primary geographical subunit used in CT instead of counties. The town was selected as this unit of analysis because it is the only meaningful sub-state geographic designation in CT. All land in CT is incorporated into 1 of 169 towns. The towns are nominally grouped into eight counties, but there is no county level administration. Data is rarely analyzed at the county level within CT. Local taxes are also assessed at the town level rather than the county level resulting in significant variation in tax rate, tax income and services such as public schools. In addition, county lines do not delineate service boundaries as they do in most states. Instead, state agencies and consortiums of non-profits (e.g. agencies serving people who are homeless) have created their own service regions, each with a varying number of regions (range 5-13 regions). Consequently adjacent towns could be very different in demographics and in service availability because they were in different regions for different service sectors. For example they could be in the same region for the Department of Mental Health and

[1] https://www.census.gov/quickfacts/fact/table/CT,US/PST045219 (accessed Sept 26,2020)
[2] http://data.ctdata.org/ (accessed Mar 15, 2020)
[3] https://www.census.gov/quickfacts/fact/table/CT,US/PST045219 (accessed Sept 26,2020)
[4] https://www.cbpp.org/sites/default/files/atoms/files/Connecticut.pdf (accessed Sept 26, 2020)

Addictions Services (DMHAS) and different regions for the Department of Children and Families (DCF). Because of this unusual geographic service arrangement this NA was conducted using the town as the primary geographic unit.

Results are reported based on the HRSA supplied data for the county as well and counties are identified as the 'at-risk communities' in the Needs Assessment Data Summary.

The second change was to data series collected. Because the data supplied by the national TA was at the county level, this analysis needed to add in town level data. In this way, data were updated to the most recently available data. The second change was to add additional data series because of interest by the local Home Visiting Advisory Team. For instance, parent focus groups and community meetings suggested that birth outcomes were an important domain here in CT. For this reason, the teen pregnancy and infant mortality rates were added to the analysis. Figure 1 below illustrates the relationship between the prescribed NA county data series and the town level data series. A complete Map Appendix is attached to this document with maps identifying each town and their quintile of risk for each indicator and a summary map of high-risk downs by domain.

Figure 1: Domains, and differences in indicators between county- and town-level data

Domain	County Indicator	Town Indicator
Socioeconomic Status (SES)	Poverty	Poverty
	Unemployment	Unemployment Rate
	HS Dropout	Disengaged Youth
	Income Inequality	5-Year Gini Coefficient
Adverse Perinatal Outcomes	Preterm Birth	Preterm Birth
	Low Birth Weight	Low Birth Weight
		Infant Mortality
		Teen Pregnancy (15-19)
Substance Use Disorder	Alcohol	Binge Alcohol Use
	Marijuana	
	Illicit Drugs	
	Pain Relievers	Non-Medical Use Pain Relievers
		Drug Abuse Offenses
		Received SUD Tx by Residence - CT DMHAS
		Received MH Tx by Residence- CT DMHAS
Crime	Crime Reports	Crime Reports
	Juvenile Arrests	Juvenile Arrests
Child Maltreatment	Child Maltreatment	Child Maltreatment Allegations
		Reports of Domestic Violence

*Sources and Series Details are provided in Appendix A and the Data Summary Workbooks

Socioeconomic Status

The data series analyzed at the town level remained similar to the county level analysis. The at-risk analysis substituted Disengaged Youth for High School Dropout rates. The NA team contacted the CT State Department of Education but the state no longer produces a high school dropout rate and has replaced it

with the Disengaged Youth rate. Disengaged Youth are not enrolled in school, not employed and/or not in the labor force and between the ages of 16 and 19. This series comes from the American Community Survey (ACS) 5-year estimates.

Adverse Perinatal Outcomes:
This report incorporated an additional two series into the Adverse Perinatal Outcomes indicator. Because of the notable disparities in perinatal outcomes in CT, the Home Visiting Team placed special emphasis on this domain. The infant mortality rate (IMR) is the number of infant, neonatal, and post-neonatal deaths before 1- year of age per 1000 live births. Additionally, the teen pregnancy rate – babies born to females 15-19 – was included in this section. In both instances, it was felt that early intervention could improve outcomes for children in CT. These indicators were included in the instructions as potential additions to the NA.

Substance Use Disorder (SUD):
The SUD domain had some challenges at the town level. The publicly available National Survey of Drug Use and Health (NSDUH) was not available at the town level. The closest sub-state geographical division was based on the regions used by the CT Department of Mental Health and Addiction Services (DMHAS). In order to use this data, towns were assigned the prevalence rate associated with their region. Unfortunately, the small number of regions led to a lack of statistical variability at the town level for the 'Marijuana Use' and 'Illicit Drug Use' Variables. There were no towns that met the outlier criteria of being more than 1.5 standard deviations above the state average. By identifying no outliers, inclusion of these 2 variables would improperly make the threshold of being an outlier in half of the variables in this domain difficult to reach.

Instead, two additional variables were added. The first was Drug Abuse Offenses per 10,000 population. These are individuals with an arrest related to the possession or sales of illegal drugs; offenses directly related to drug abuse (e.g., stealing to get money for drugs); and offenses related to a lifestyle that predisposes the drug abuser to engage in illegal activity.[5] While not a perfect indicator, this is indicative of general drug us and high risk activities that endanger children. The second variable is the rate of individuals receiving SUD treatment by their place of residence. This data comes from DMHAS. DMHAS is required by state mandate to track treatment provided at all SUD treatment clinics in the state. This variable is also an indicator of local drug use.

Finally, the Home Visiting Team was interested in including a more precise indicator of mental health need. In particular, the Team was interested in understanding the risk posed by maternal depression. While CT does participate in the CDC Pregnancy Risk Assessment Monitoring System (PRAMS), responses are entirely voluntary and are not reflective of the entire population. Instead, the decision was made to use individuals receiving Mental Health services by place of residence as measured by CT DMHAS. The population receiving services reflects a broad array of the population at public clinics. While imperfect, this variable was considered preferable to the PRAMS data that did not allow for a town-level breakout.

The use of SUD and mental health treatment were both suggested by the guidance as additional variables to include in the NA.

[5] https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide/introduction (accessed Sept 26, 2020)

Crime
There were no changes to the crime data except that it was collected at the town level.

Child Maltreatment
In addition to child abuse allegations, this domain also included information on domestic violence. The Connecticut Coalition against Domestic Violence (CCADV) is composed of CT's 18 regional domestic violence service organizations. Together, they serve as the primary resource for legal, shelter, support, counseling, and other resources for families experiencing domestic violence. They shared the unduplicated count of individual receiving services and their town of origin with this analysis. Domestic Violence has historically been a focus of Home Visiting in CT. Children suffering trauma through exposure to DV are one of the populations of focus for the Child First model, which is funded in CT. The NA included this population to see how well they were being served and matches the suggestions provided in the NA guidance.

In summary, this analysis included both county and town level analyses. However, because CT operates on a town-system, the town analysis was more relevant to the Home Visiting Team and was therefore provided. The town-level analysis includes 6 additional series. Two series were 'omitted' only because they did not yield any useful information about high-risk areas when explored at the town level. There is further comparison of the county- and town-level analyses at the end of this section. Outcomes for both analyses are presented in the Needs Assessment Data Summary workbooks included with this report.

Phase I: At-Risk Area Findings: Counties and Towns

Table 1: At Risk Counties with At-Risk Towns and Population Comparisons

			At Risk Towns		
County	# Towns in County	Population per County	# Towns in County At Risk	Population per County in Towns	Towns
Fairfield	23	943,823	1	144,900	Bridgeport
Hartford	29	892,697	5	324,038	Bloomfield, East Hartford, Hartford, Manchester, New Britain
Litchfield	26	181,111	4	48,641	Canaan, Sharon, Torrington, Winchester
Middlesex	15	162,682	-	-	
New Haven	27	857,620	5	329,287	Ansonia, Derby, Meriden, New Haven, Waterbury
New London	21	275,796	2	66,075	New London, Norwich
Tolland	13	150,921	1	29,303	Vernon
Windham	15	117,027	4	66,561	Killingly, Plainfield, Putnam, Windham
Total	169	3,581,677	22	1,008,805	

The simplified, Phase I, county level analysis identified Hartford, New Haven, and Windham counties as high need counties. For reasons discussed above, this analysis has chosen not to concentrate on only the county level geography. Instead, it focuses on the sub-geography of the town level. The town level in CT is the primary sub-state administrative and taxation unit.

Table 1 above provides a comparison of the two approaches. Using the town-level analysis, a total of 22 of 169 towns are designated high need. These towns represent 1,008,805 people or 28.2% of the state population. Focusing only on Hartford, New Haven, and Windham counties identifies 1,867,344 people, which is 52.2% of the state population. However, only 38.6% of these counties' population is actually in towns representing high risk.

Based on this analysis, the at-risk towns were 51.9% female with a high of 54.3% female in Putnam and a low of 47.7% in Winchester. About 6.1% of the population or 61,753 are less than 5 years old. The race and ethnic composition varies across the different at-risk communities. Across the at-risk communities, 21.1% were Black or African American compared to the state average of 9.8%.[6] Putnam had the lowest percent of Black or African American, 0.3% and Bloomfield had the highest percent, 57.0%. People with Hispanic ethnicity comprise 30.4% of the at-risk communities. This percent is higher than the state average of 15.7%. Canaan has the lowest percent of people with Hispanic Ethnicity, 0.8%. Hartford has the highest percent of people with Hispanic Ethnicity, 44.5%. The at-risk communities were less likely to have people of white race only. The at-risk communities had 41.5% white race compared to the state as a whole, 67.5%. The percent of white only people ranged from a low in Hartford of 14.8% to a high of 93.4% in Putnam. Other race proportions were similar to state averages with 3.8% Asian, 0.2% American Indian or Alaskan Native, 2.6% of two or more races, and 0.4% other races. The percent of Native Hawaiian or Pacific Islander was less than 0.1%.

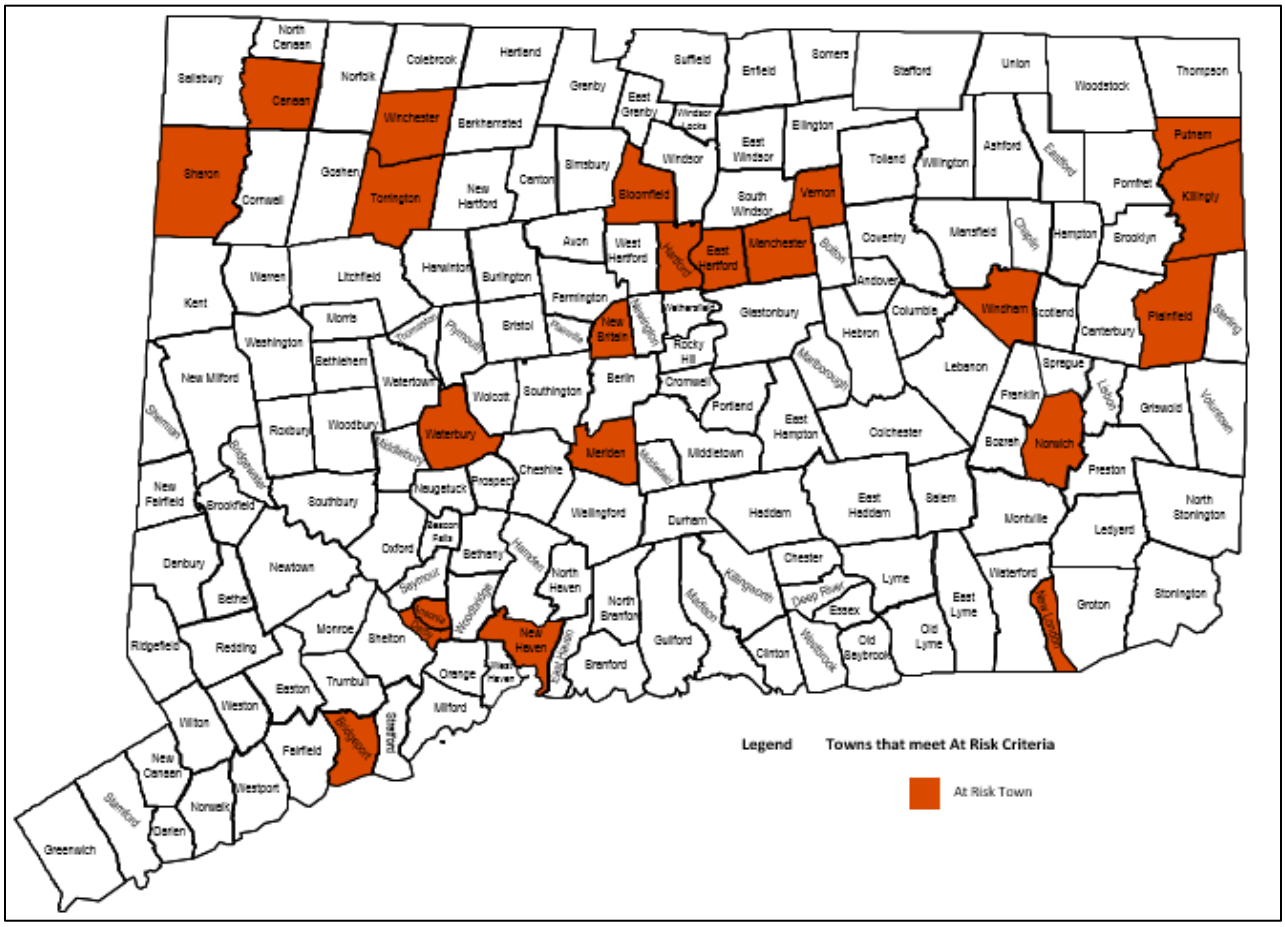
As discussed above, the nature of a town-level system of government means that, within a given county, there can be substantial differences in socioeconomic status and risk. For instance, the median household income in West Hartford is $99,280 while household income in Hartford is $34,338.[7] These differences are reflected through the education systems, social services, and family well-being. This ultimately results in different levels of risk even for neighboring towns like West Hartford and Hartford.

Figure 2 shows the dispersion of at-risk towns in the state. Looking at town findings by a geographic lens, there are clear pockets of need distributed throughout the state. Some are centered around major cities like Hartford, New Haven, Waterbury, and Bridgeport. But there are outlying pockets in the Northwest, Northeast, and Southeast areas of the state. In CT, these areas are less likely to have resources and services for families. Also, CT's limited public transportation system is even patchier in these non-urban areas. Families repeatedly expressed the difficulty they had travelling to access services in these areas. Thus, their experiences emphasize the need to for home visiting services in these parts of the state.

[6] http://data.ctdata.org/dataset/population-by-race-by-town

[7] https://www.census.gov/quickfacts/fact/table/hartfordcityconnecticut,westhartfordcdpconnecticut/INC110218 (accessed 9/26/20)

Figure 2: Summary of At-Risk Towns in Connecticut (2020)



Phase 2: At-Risk Areas Adjustment: Counties & Towns

Based on the Phase I data supplied by HRSA, the following counties were identified as high risk: Hartford, New London, and Windham. The supplemental Phase I analysis was at the town level and added new variables to the analysis. The town level analysis identified pockets of need throughout the state. The only county not to have an at-risk town was Middlesex County. Counties with high-risk towns were considered for inclusion as an At-Risk Area.

The new counties identified through the town analysis align directly with the MIECHV NA statutory criteria for high need. Among the newly identified counties, only the towns of Canaan and Torrington in Litchfield County do not meet the low socioeconomic status criteria. Adverse perinatal outcomes were not an issue in any Litchfield town. Similarly, Norwich in New London County did not meet the criteria for this domain. In part, this finding may be because there is a robust Nurse Family Partnership (NFP) program that serves this region. Substance use was not an outlier in Fairfield and much of Litchfield. However, the SUD domain used NSDUH data that used amalgamated regions to estimate town data resulting in fewer outliers. Both crime and child maltreatment were significant issues in most of the towns. Of the new counties considered, crime was not an outlier in Bridgeport (Fairfield County), Torrington (Litchfield County), and New London (New London County). Child maltreatment was a significant issue in all but Bloomfield (Hartford County). See Table 2.

Table 2: At-Risk Towns and Counties by Domain

Town	County	Population	In Need Families	Socioeconomic Status	Adverse Perinatal Outcomes	Substance Use	Crime	Child Maltreatment	Number of At-Risk Domains
Bridgeport	Fairfield	146,825	2,510	X	X			X	3
Bloomfield	Hartford	20,611	47		X		X		2
East Hartford	Hartford	52,166	571	X	X			X	3
Hartford	Hartford	127,933	2,917	X	X	X	X	X	5
Manchester	Hartford	57,602	482		X		X	X	3
New Britain	Hartford	75,278	1,503	X	X	X	X	X	5
Canaan	Litchfield	1,136	3				X	X	2
Sharon	Litchfield	3,125	16	X			X	X	3
Torrington	Litchfield	37,040	171			X	X	X	3
Winchester	Litchfield	10,655	54	X				X	2
Ansonia	New Haven	19,523	132	X			X	X	3
Derby	New Haven	13,039	106	X	X		X	X	4
Meriden	New Haven	61,287	579		X		X	X	3
New Haven	New Haven	130,088	2,614	X	X		X	X	4
Waterbury	New Haven	112,880	2,304	X	X	X	X	X	5
New London	New London	27,015	504	X	X	X		X	4
Norwich	New London	38,007	381	X		X	X	X	4
Vernon	Tolland	29,528	147				X	X	2
Killingly	Windham	17,332	117			X	X	X	3
Plainfield	Windham	15,382	67		X	X		X	3
Putnam	Windham	9,395	50		X	X	X	X	4
Windham	Windham	24,706	463	X		X	X	X	4

Based on this analysis, this NA finds that New London, Litchfield, Tolland and Fairfield Counties – or at least pockets of them – need to be included as high-risk regions. In some cases, these pockets of need were reflected in the previous NA. For instance, towns centered-around Hartford, New Britain, Waterbury, New London, and Windham have had long standing issues.

There were some emerging areas that were less of a concern in the previous needs assessment. With the opioid epidemic spreading in CT, previous wealthier communities to the east and northeast of Hartford have increased in risk. Manchester and Vernon follow the I-84 corridor east from Hartford and East Hartford. These areas have seen an increase in crime and child maltreatment concerns with a population young enough for adverse perinatal outcomes to be a concern. Bloomfield is another 'bedroom community' that has faced an increase in crime and child maltreatment risk.

In the Northeast and Northwest, there has been an expansion of risk out into surrounding areas of what were previously urban problems. For instance, Torrington has had a pocket of adverse outcomes for families historically but this NA finds that Sharon, Canaan, and Winchester – which are suburbs to Torrington – now also face increased risk. This is part of a natural geographic migration to these areas. In the rural Northeast, opioids as well as increased other drug use have expanded the area of concern to towns like Killingly, Plainfield, and Putnam. Being rural, these two areas suffer from twin barriers of fewer service providers and poor public transportation for families seeking services. The physical distance between homes is another barrier for home visiting. Transportation for a home visitor might take 15 minutes between visits in an urban area like New Haven, visitors have to travel an hour or more between

visits in the Northeast and Northwest. This increases the resources needed to serve the same numbers of families in these regions.

There were also some towns that were previous foci of MIECHV funding that were not designated 'at risk' in this statutory-based assessment. In some cases, this reflects a genuine shift in need. Table 3 below lists some of the towns that received higher levels of service in FFY19/20 based on the previous needs assessment. In some cases, the change in designation represents a small geographical shift but the general area remains a focus. For instance, Groton neighbors New London and Norwich which remain focus areas. East Haven, West Haven, and Hamden are all part of the New Haven region and will likely continue to be served through regional/county level system. Sprague is part of the Windham area/County and will receive services. The CT 'gold coast' in the Southwest corner has also seen a reduction in the number of towns at-risk. While the city of Bridgeport and Fairfield County remain foci based on this NA, surrounding towns like Stamford and Norwalk have not been designated at-risk. Neither town reached outlier status on any domains in this analysis. They each had 3 areas of concern that fell just below the required threshold including on substance abuse. In part, the risk maybe reduced because both towns have experienced improved socioeconomic status over the past 10 years. These two towns will continue to receive some services because of the focus on neighboring Bridgeport, and Litchfield County.

However, there are a few towns that have been de-emphasized in this report. Bristol, and Danbury were outliers in less than 1 domain. This represents a shift in focus from the 2010 NA. While the MIECHV funding will continue to serve the counties these towns are in, these towns may yield fewer clients moving forward. The only town that was previously identified that is not part of an at-risk county is Middletown in Middlesex County. A total of 2 families were served in FFY19/20 with MIECHV funds. Middletown is also a very service-rich town in other modalities for families. The MIECHV team will need to consider at what level to fund Middlesex County going forward based on a careful consideration of need and their expert knowledge of the region.

Table 3: Towns Receiving MIECHV Funding but have experienced a reduced relative risk since 2010

Town	County	Population	Socioeconomic Status	Adverse Perinatal Outcomes	Substance Use	Crime	Child Maltreatment	Number of At-Risk Domains
Bristol	Hartford	63,202	0.5	0	0.2	0	0	1
Danbury	Fairfield	78,761	0	0.25	0	0	0.5	1
East Haven	New Haven	29,611	0	0.25	0	0	0	0
Groton	New London	47,704	0	0.25	0.4	0.5	0	1
Hamden	New Haven	59,888	0	0	0	0	0	0
Middletown	Middlesex	45,423	0	0	0.2	0.5	0	1
New Milford	Litchfield	28,538	0	0	0	0	0	0
Norwalk	Fairfield	87,286	0.25	0.25	0.4	0	0	0
Sprague	New London	3,128	0.25	0.25	0.4	0	0.5	1
Stamford	Fairfield	123,203	0.25	0.25	0.4	0	0	0
West Haven	New Haven	55,098	0.5	0	0	0	0	1

3. Identify Quality and Capacity of Existing Programs

Programs Offered

In general the Office of Early Childhood, that oversees both the MIECHV-funded and state-funded home visiting programs aims to serve the entire state. This may be because with just 8 counties; it is a small state. In Table 7 of the NA Data Summary, all of the at-risk counties (7 of 8), and all of the at-risk towns (22 of 169), currently receive evidence-based home visiting services. Every model that is overseen by the OEC is on the HOMVee List.

Figure 3 :Families Served by Home Visiting Models
Federal Fiscal Years 2019, 2020

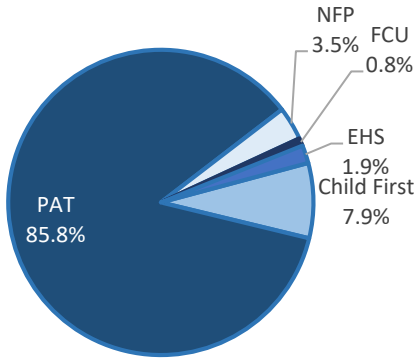


Figure 3 shows the distribution of people served by different models funded by MIECHV and the OEC State-Operated programs. Analyzing this data is challenging because the home visiting models have been in transition the past two years. The data presented for the state-funded models were from FFY19. In this year, there was a transition to funding Family Check-Up (FCU), Minding the Baby (MTB) and Nurse Family Partnership (NFP). As programs came online, their service reporting was spotty. As a result, the State-Funded data includes only families served in Child First (CF), Parents As Teachers (PAT), and a few families for FCU. The MIECHV-funded programs are also in transition. CF and NFP started in July of 2018. As a result, their service data was incomplete for FFY19. To get a better sense of who was served by these programs, data was pulled for FFY20. The two other MIECHV-funded models, PAT and Early Head Start – Home Based Option (EHS-HBO) are longer-standing programs and their service data from FFY19 was complete and used.

The model serving the biggest share of home visiting families is PAT (85.8%). Child First is second most common serving 7.9% families. Also, CF is the most expensive model per family and serves fewer families for a shorter period of time with the same funding as other projects. Both the State-funded and the MIECHV-funded programs are going to be re-procured this year. It is likely that the models will once again change across the state.

Table 4: State-funded, families served by program by county

County	State - Funded FY19			
	Child First	PAT	FCU	State Total
Fairfield	12	258	0	270
Hartford	7	576	0	583
Litchfield	0	90	0	90
Middlesex	0	29	0	29
New Haven	1	635	24	660
New London	0	42	0	42
Tolland	6	13	0	19
Windham	0	41	0	41
Total	26	1684	24	1734

Although the data is somewhat disjointed, every county is covered by MIECHV funding in part as well as State-funded evidence-based programs. (See Tables 4 and 5).

Every county, including Middlesex, is partially served by both streams of funding. Hartford County has the most families receiving home visiting through both funding streams. Middlesex and Tolland counties have the least amount of families served. PAT serves the most families under both funding streams. In the MIECHV funding, it serves 68.9% of families served and CF serves 17.6% of families. The state-funding stream data finds that 97.1% of families served in FFY19 were served by PAT. This finding is somewhat of an artifact of the changeover in programs that occurred that year. Despite this, all counties in CT were served by HOMVee approved models, both State-funded and MIECHV-funded. The town level data is available in the NA Data Summary. Again, all at-risk towns are served by evidence-based models with both funding streams.

Table 5: MIECHV-funded, families served by program by county

	MIECHV -Funded FY19* /FY20^				
County	PAT*	NFP^	Child First^	EHS*	MIECHV Total
Fairfield	195	0	33	5	233
Hartford	264	0	74	0	338
Litchfield	64	0	36	0	100
Middlesex	5	4	0	0	9
New Haven	121	0	50	50	221
New London	54	98	0	0	152
Tolland	29	0	0	0	29
Windham	68	0	11	0	79
Total	800	102	204	55	1161

Population in Need

County Level Analysis

The population in need approximates the number of families / individuals who might be eligible for services. The estimates of this population supplied by HRSA appear to be the total population of the County. This analysis selected the option of developing its own estimates. These estimates were used to assess what portion of the eligible population is served by OEC sponsored home visitors.

To estimate the number of eligible families, the analysis retrieved the number of families with children under the age of 6 per town.[8] This data is from the US American Community Survey (ACS) using the average values for 2014-2018, In addition, the number of teenage pregnancies per town were added to this figure. This data is from the CT DPH based on their provisional 2018 vital records statistics.[9] Once the base number of families was calculated, the rate of children in poverty by town was applied to this number. This yields an approximation of the number of families with young children or pregnant parents with low socioeconomic status in the County. This county-level analysis does not account for the limited

[8] http://data.ctdata.org/visualization/children-by-family-type?v=table&f={%22Town%22:%20%22Connecticut%22,%20%22Age%20of%20Child%22:%20%22Total%22,%20%22Family%20Type%22:%20%22Total%22,%20%22Measure%20Type%22:%20%22Number%22,%20%22Year%22:%20%222014-2018%22,%20%22Variable%22:%20[%22Children%20Under%2018%22,%20%22Margins%20of%20Error%22]} (accessed Sept 20,2020)

[9] https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports (accessed Sept 20, 2020)

number of towns in each county that are designated high-risk. However, the analysis is also performed at the town level. There were some limitations because of the need for town-level data.

Another consideration is that this is a somewhat lose definition of 'at-risk'. CT has indicated that it might prioritize families with infants and toddlers in the next round of funding. This would reduce the total number of eligible families to those with children under 3. Additionally, this approach considers only teen pregnancy and low income as 'risk-factors'. If additional family attributes were known, such as educational attainment, SUD / MH needs, etc., then this estimate could be further refined. The consequence of this is that these estimates of eligible families are both likely overestimates.

Table 6: Population Served: County Level Analysis

County	Families Served	HRSA Eligible Population	% HRSA Eligible Served	Optional Method Eligible Families	% Optional Eligible Served
Fairfield	503	944,177	0.1%	5,718	8.8%
Hartford	921	892,389	0.2%	7,325	12.6%
Litchfield	190	182,571	0.2%	540	35.2%
New Haven	881	856,875	0.2%	7,511	11.7%
New London	194	269,801	0.2%	1,992	9.7%
Tolland	48	151,118	0.1%	301	15.9%
Windham	120	116,192	0.2%	767	15.6%

Table 6 shows the at-risk counties, families served, eligible population, and eligible population served by both methods. The number of families served by the OEC home visiting programs range from 921 in Hartford County to 48 in Tolland County with a total of 2857. HRSA's estimate of need appears to represent most of the population in these counties. The total number of eligible families is most of the population of the state, 3,413,123. Assuming an average of 2.3 people per family, between 0.1-0.2% of these individuals have been served; with an average value of 0.2%.

Using the optional estimate, the number of eligible families ranges from 7,511 in New Haven and 301 in Tolland; with a total of 24,254. While still likely an overestimate, this population is closer to the number served. The percent of eligible families served ranges from 35.2% in Litchfield County to 8.8% in Fairfield County; with an average value of 11.8%. It is important to remember that even this estimate is likely an overestimate of the number of families who would be considered high priority moving forward.

Town Level Analysis

Table 7, below, looks at the same information for the 22 towns that were found to be at risk. Within these towns at total of 1999 families were served. This represents 70.0% of all families receiving home visiting services from the OEC funds. This suggests that as currently allocated the funds are going to the high-risk areas. Overall, 1999 of an eligible 15,738 families in these 22 towns were served reflect a 12.7% penetration rate. For the HRSA designated population estimate, only 0.4% of families in these towns were served.

Table 7: Town-level comparison of eligible population

Town	County	Families Served	HRSA Eligible Population	% HRSA Eligible Served	Optional Method Eligible Families	% Optional Eligible Served
Bridgeport	Fairfield	250	146,825	0.4%	2,510	10.0%
Bloomfield	Hartford	23	20,611	0.3%	47	48.9%
East Hartford	Hartford	103	52,166	0.5%	571	18.0%
Hartford	Hartford	462	127,933	0.8%	2,917	15.8%
Manchester	Hartford	57	57,602	0.2%	482	11.8%
New Britain	Hartford	120	75,278	0.4%	1,503	8.0%
Canaan	Litchfield	3	1,136	0.6%	3	100.0%
Sharon	Litchfield	0	3,125	0.0%	16	0.0%
Torrington	Litchfield	105	37,040	0.7%	171	61.4%
Winchester	Litchfield	21	10,655	0.5%	54	38.9%
Ansonia	New Haven	42	19,523	0.5%	132	31.8%
Derby	New Haven	26	13,039	0.5%	106	24.5%
Meriden	New Haven	98	61,287	0.4%	579	16.9%
New Haven	New Haven	323	130,088	0.6%	2,614	12.4%
Waterbury	New Haven	131	112,880	0.3%	2,304	5.7%
New London	New London	52	27,015	0.4%	504	10.3%
Norwich	New London	59	38,007	0.4%	381	15.5%
Vernon	Tolland	25	29,528	0.2%	147	17.0%
Killingly	Windham	13	17,332	0.2%	117	11.1%
Plainfield	Windham	7	15,382	0.1%	67	10.4%
Putnam	Windham	8	9,395	0.2%	50	16.0%
Windham	Windham	71	24,706	0.7%	463	15.3%

The range in estimated eligible families being served goes from 100% in Canaan to 0% in neighboring Sharon. The estimated number of families is low in both of these towns- 3 in Canaan and 16 in Sharon. These towns represent outliers. Overall, an average of 12.7% of families in need are being served. Among the major towns in each county, the percent served ranges from 10.0% in Bridgeport (Fairfield County) to 61.4% in Torrington (Litchfield County). In general, the Northwest corner near Torrington is well served despite no one being served in Sharon. The other parts of the state are closer to the average. In New Haven, 323 families were served, which is about 12.4% of the estimated eligible. In Hartford, 15.8% of eligible families were served. Towns in New Haven County and Litchfield County are well served.

To understand the quality and capacity of existing home visiting programs, several different methods were used to collect data from programs, professionals and families.

Family Focus Groups. Focus group data was collected from 12 focus groups of families comprised of 116 individuals. Ten communities were selected to have representation from different regions of the state along with metro and nonmetro communities. The communities were also selected using available

information on child maltreatment and poverty rates. The communities represented were Bridgeport, Danbury, Derby/Ansonia, Hartford, Killingly, New Britain, New London, Stamford, Torrington, and Waterbury. Additionally, a focus group was held at an inpatient substance use disorder treatment facility for women with young children and a focus group was held in New Haven that was specifically for fathers. We intentionally recruited families with and without home visiting experience and approximately half of the families had some experience with a home visiting or home-based program. Spanish translation was available at all groups, with some of the focus groups being solely conducted in Spanish. Many of the participants were mothers (91%) but there were fathers (9%) in many groups along with other caretakers, such as grandparents.

Community Focus Groups, also referred to as Community Listening Sessions. In collaboration with the Preschool Development Grant, we held meetings in ten communities and on two webinars. These were attended by home visiting providers, providers of other types of child- and family-serving programs, and other community stakeholders. We called these "Community Listening Sessions" but they were a more rigorous method than a meeting and were structured more like focus groups with consistent questions, note takers, and recordings. At each session, part of the time the larger group was divided into five smaller groups for discussion. Each table's discussions were recorded and transcribed. There were five specific topics that were discussed: awareness and communication, meaningful family partnerships, services provided, feedback and data, intake and referrals coordination.

Provider Survey: Surveys were sent to agencies that provided home visiting and/or home-based services from any funding source. Some of the information is at the agency level and some is at the program level. The survey was based on the North Carolina Landscape Survey and included questions about agency staffing, client characteristics, outreach, collaborations with other agencies, referral sources, barriers to services, community needs, home visiting program priority populations, outcomes of interest, funding sources, service area and service completion. The survey was sent to over a 100 agencies and programs, 16 MIECHV-funded programs responded and 48 other programs responded including 17 Birth to Three (IDEA early intervention programming), 16 programs funded by the Department of Children and Families and 15 programs that were not in any of these categories.

Advisory Board. The Advisory Board of approximately 30 members met four times throughout the process of the needs assessment. The board represented experts from home visiting and other agencies that serve a similar population and/or may refer to home visiting programs. They provided invaluable institutional knowledge and perspectives, subject matter expertise, and a different viewpoint on the direct service process.

Existing Programs

In addition to the MIECHV and state-funded programs described above, there are other home visiting programs in the state. The programs available in Connecticut that serve families with children 5 or under that can be considered a home-visiting program (Triple P and Circle of Security have home-visiting options but are often delivered in an office), their level of evidence and the type of funding they receive are presented in Table 8.

Table 8: Early childhood home visiting programs, level of evidence and funding sources

Program Name	HomVEE approved	Other evidence-based support	Receives MIECHV – Funding*	Receives State Funding	Receives DCF – Funding*
Child First	X		X	X	X
Early Head Start-HBO	X		X		
Family Check-Up	X			X	
Minding the Baby	X			X	
Nurse-Family Partnership	X		X	X	
Parents as Teachers	X		X	(previously recieved)	
Family Based Recovery		Research studies suggests "promising practice"			X
Intensive In-Home Child and Adolescent Psychiatric Network Support (IICAPS)		Medicaid eligible			X
Triple-P		California Evidence-based Clearninghouse, Well-supported			X
Circle of Security (not HV-version)		Insufficient evidence			X

* Models may receive funding from multiple sources

There are also a number of families with young children receiving home visiting or home-based services funded through the Connecticut Department of Children and Families (DCF). Child First is the only home visiting program that is funded by both agencies. In the 2019 state fiscal year, 546 children were served by DCF-funded CF programs. In-Home Child and Adolescent Psychiatric Services (IICAPS), an intensive psychiatric diversion program is also funded by DCF and served 2,853 children, although IICAPS serves youth up to age 18.

DCF also funds Family Based Recovery (FBR) program a substance use disorder recovery program that is delivered in-home for families with a child 0-36 months, also described in section 4. There are also a number of therapeutic programs that are targeted at families with children older than 5 years. Triple P and Circle of Security are also offered to families in the state through a Parent Support Services program and 2,053 families received one of those programs in a single quarter. Most of these programs are offered through the child welfare program of DCF, but Triple P and Circle of Security are partially funded by the children's mental health program that is also operated by DCF. Across all programs, more than 10,000

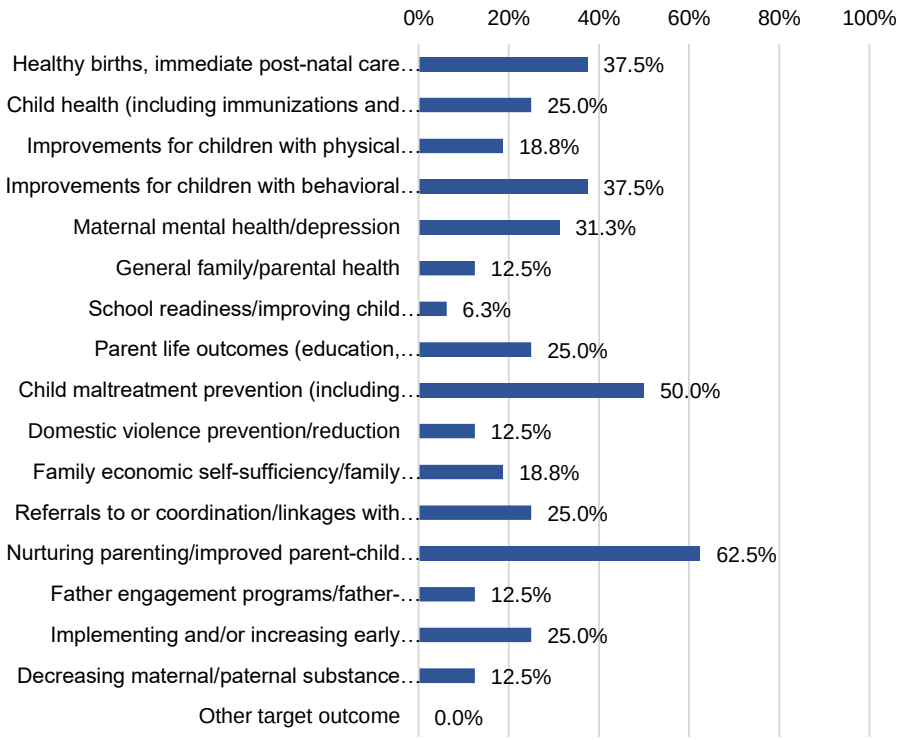
children and youth (up to age 17) receive a therapeutic service from DCF-funded programs and many of these services may be offered in the home.

Outcomes

Sixteen different outcomes were included in the survey along with the opportunity to identify *Other targeted outcomes* (Figure 4). The graph illustrates the wide variety of foci of the MIECHV home visiting programs with at least some respondents identifying each outcome as one of their program's top three priority outcomes.

Nurturing parenting/improved parent-child interactions was the most common outcome and was identified by 62% of respondents. *Child maltreatment prevention* was the next most common with half of programs identifying this as a targeted outcome. *Improvements for children with behavioral or social-emotional problems* and *healthy births/post-natal care* were each identified by about a third of programs.

Figure 4: Percent of MIECHV-Only Respondents Across All Home-Visiting Models Who Selected Each of These Target Outcomes as One of the Top 3 (N=16)



The number of different targeted outcomes echoes the findings from the family and community focus groups that it is unclear to other types of providers (i.e. who might be referring to HV) what families would benefit from home visiting services because the focus or goals of the programs were often unclear.

The programs that are currently supported by MIECHV funding provide a range of prevention and treatment services (Table 9). Some of the programs are primary prevention, such as PAT, although they are generally delivered to a selective population with one or more risk factors for poor health or delayed development. Other programs provide treatment for identified problems such as CF for trauma exposure.

Most towns only have one type of program. Consequently, this means some towns only have a treatment option, many only have a more primary and more general support program, and only a few towns have a health focused program such as NFP or Family Check-up. This results in towns that are covered by HV services with only one or two types of programs, but not a consistent combination of programs. This patchwork of different types of coverage by town boundary is also confusing to many service providers who are potential referral sources.

Table 9: Types of Programs and Focus Ages	
Prevention Programs	
	Child Age
Nurse-Family Partnership	Prenatal – 2 years
Parents as Teachers	Prenatal – 5 years
Early Head Start-HBO	Prenatal – 3 years
Treatment Programs	
	Child Age
Child First	6 mo – 5 years

i. **Gaps in the delivery of home visiting.**

The NA uncovered some important gaps in the delivery of home visiting services in Connecticut. Some of the key findings were the inaccessibility of HV programs that focus on prevention, the lack of availability of programs in some of the non-metro areas, and the problems with the commonly used approaches to referring families.

MIECHV home visiting programs encompassed prevention and treatment programs, but there are also treatment programs available to families with DCF involvement. DCF offers several treatment programs for families with children in the age-range of home visiting. Additionally, the majority of MIECHV programs use DCF as a referral source (see section 3.iii for more discussion of referral sources) and many programs prioritized families with current or prior DCF-involvement. Consequently, sometimes there are few programs or few slots at programs that are accessible to families without DCF involvement.

Additionally, many towns did not have any home visiting programs. Most of these unserved towns were in non-metro areas where driving distances between families are far and there are fewer families to serve. About two-thirds (600 of 880 in a quarter) of families with a MIECHV program are located in one of ten towns, all of which were identified as high-risk towns. This suggests that the largest concentrations of MIECHV funding are in high-risk areas. However, a number of other towns identified as high-risk have few families being served through MIECHV funding. ere are three towns that are identified as high-risk who have no families served by MIECHV-funding. Some of these towns may have HV services through other funding sources, but there are some towns that are entirely unserved.

Another gap that was identified through the NA was in determining eligibility for programs. Families and providers talked about the challenges experienced by families who made just a little more than the federal poverty level. These families are often ineligible for services and benefit programs or may be considered a low priority when they are technically eligible for services; however, the families are far below an income level that would allow them to privately purchase similar services.

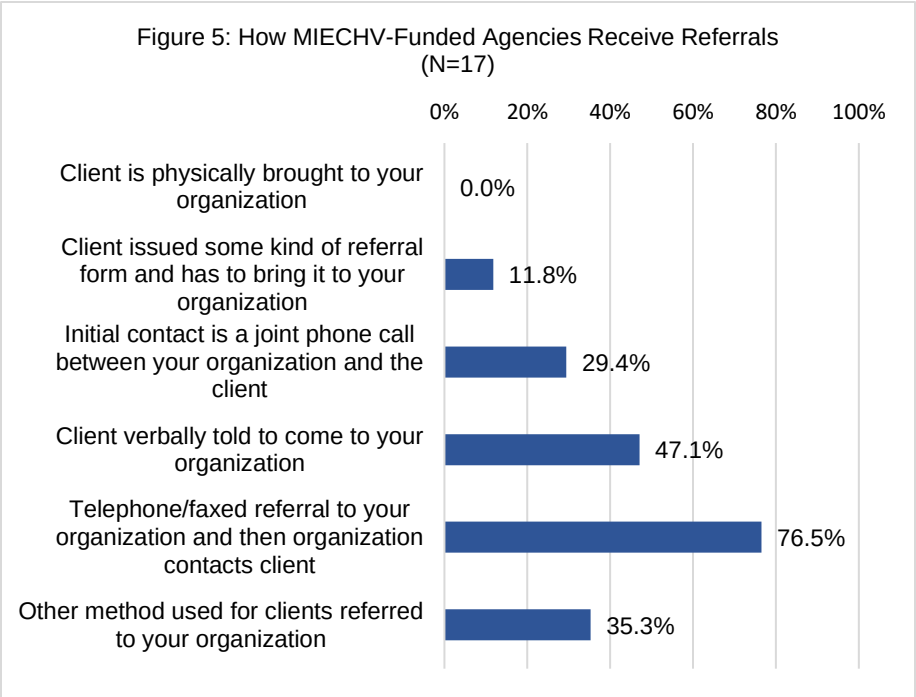
Families who are eligible using financial guidelines are often eligible for many other social support services but if they increase their wage-income they may lose their eligibility for some programs or services. This situation if often referred to as the “benefit cliff”. Families in our focus group spoke of having to balance their wage-income with the eligibility guidelines for programs they needed, such as healthcare. For HV specifically, there was a perception that families who were already eligible for and receiving many services were also prioritized by and provided with HV services.

These practices often leave families who are above the income threshold without any means of accessing support services. Eligibility should not be confused with focus populations which are discussed in a later section.

ii. **Extent Home Visiting Meeting Current Needs.**

Numerically, many families which could benefit from HV cannot be served because of a lack of funding. However, according to the families in our focus groups, families were generally very satisfied with their home visiting program. They liked what they learned in the programs and particularly liked learning about their child's development. They appreciated their relationship with their home visitor and expressed that they thought their family benefited in many different ways from the programs.

In their focus groups professionals expressed that when families were matched to the right program that the home visiting programs met family needs. In addition to identifying other types of services that were needed in the state, such as more infant mental health, they also identified a need for more lighter-touch home visiting programs. They wanted programs that could work with families before significant problems developed, i.e. more prevention focused programs. They also identified a logistical need for shorter programs when a multi-year commitment seemed too long or for families who were anticipating a housing change that would move them out of the service area.



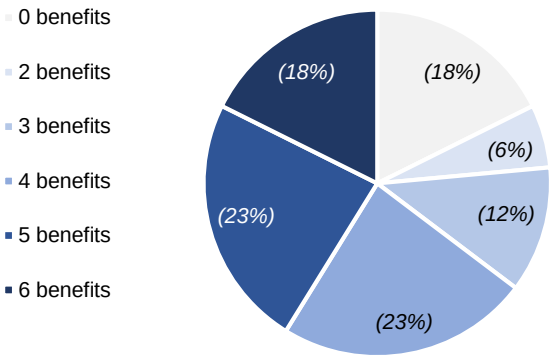
In our focus groups, families recognized the value of HV services but expressed that families were often unable to access services without DCF-involvement. This results in some towns effectively having no prevention services for families with young children. Families wanted to be able to enroll in services when they identified a need for support or additional information, rather than waiting until the family situation had devolved into a crisis and DCF was involved.

A key part of this finding was that families wanted more ability to self-refer. They described their initial perceptions of HV as a program for families who were struggling which made it a very stigmatized program. However, once parents learned more about the programs they realized that most of the programs were focused on positive parenting and engaging in HV was something good that parents could do for their families. However, when referrals came through professionals, they often felt judged by those referring sources.

There were professional sources that were less-stigmatized and these tended to be services that were more universally used such as pediatricians and OB/GYN doctors. There were also locations such as the library, which is a universal location, or a WIC office, where HV could be presented as a general benefit families were eligible for rather than something they needed because of a problem.

The survey results illustrate a different aspect of this situation (Figure 5). The most common method of referral to HV is for other providers to telephone/fax a referral form and then the HV program contacts the parent. While we do not know how much the referring provider explained HV to a parent or whether the referral was more of a joint decision, it is obvious why some parents would feel like their parenting is being judged after they were contacted by an agency for a parent support program. Additionally, a minority of programs receive families through a warm-handoff (29%) which is usually considered the most effective referral method.

Figure 6: Number of benefits offered to home visitors at agencies receiving MIECHV funding who do not have a specialized degree. (N=17)



ii. **Gaps in staffing and other requirements.**

Each town in the state is located close enough to an existing program that it should be reachable by at least one evidence-based HV model. However, in the provider focus groups, the problem of long distances between homes in some non-metro areas was raised as a service barrier. They reported it was difficult to meet the capacity requirements from the contracts because a home visitor served fewer families once travel times were accounted for.

The final data point on Table 7 in the NA Data Summary is the estimated vacancy rates. This information was derived from the Provider Survey conducted for the NA. The data was not broken out by region, but examine vacancy by position type. Nursing positions were most in demand and hardest to fill. Across all types of providers, vacancies represented 18.8% of desired positions across the state. In general, Hartford and New Haven Counties have the most resources and are most likely to be able to hire needed staff.

According to the survey, nursing jobs and positions for home visitors with clinical skills had the highest vacancy rates, with, respectively, 33% and 24% of positions vacant at the time of the survey. One caveat is that many agencies have few positions for these specialized home visiting jobs so one open position could result in a high vacancy rate. Through the home visiting survey we identified that some of the HV positions that required more training were more difficult to fill. The difficulty in filling clinical positions was consistent with MIECHV state-level staff's experience with some programs.

Overall, 35% of MIECHV agencies reported medium turnover and 52% reported low turnover. Table 10 provides specific information on HV positions and vacancy rates.

Table 10: Vacancy Rate (%) by Staff Position as Reported by Survey Respondents from MIECHV-Funded Organizations/Agencies

Position	Mean Vacancy Rate (%)	Standard Deviation (%)	Median Vacancy Rate (%)	Minimum	Maximum	Range
Full-Time Home-Visiting Supervisors	12.5%	31.1%	0.0%	0.0%	100.0%	100.0%
Part-Time Home-Visiting Supervisors	20.0%	44.7%	0.0%	0.0%	100.0%	100.0%
Full-Time Home-Visitors--No Specific Degree	22.6%	34.6%	8.1%	0.0%	100.0%	100.0%
Full-Time Home-Visitors--Trained as Nurse	33.3%	57.7%	0.0%	0.0%	100.0%	100.0%
Full-Time Home-Visitors--LCSW, LMFT, or Other Counseling-Related Degree	24.2%	33.6%	16.7%	0.0%	100.0%	100.0%
Part-Time Home-Visitors--No Specific Degree	6.3%	12.5%	0.0%	0.0%	25.0%	25.0%
Part-Time Home-Visitors--Trained as Nurse	50.0%	57.7%	50.0%	0.0%	100.0%	100.0%
Part-Time Home-Visitors--LCSW, LMFT, or Other Counseling-Related Degree	25.0%	50.0%	0.0%	0.0%	100.0%	100.0%

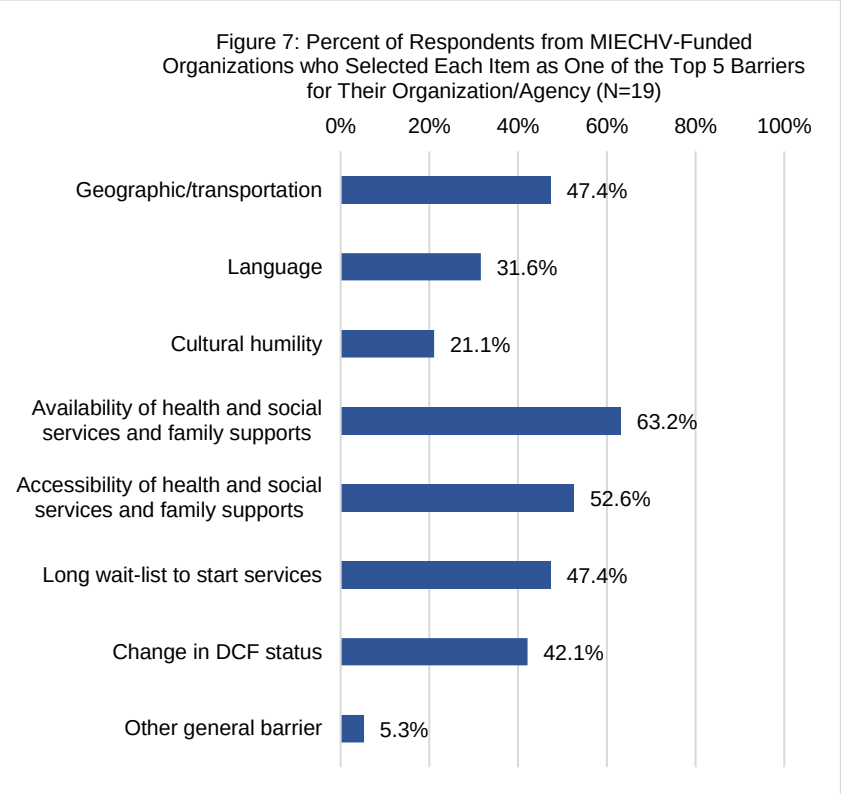
The quality of employment situations available to HV who did not have a specialized degree (i.e. excluding nurses or those with clinical degrees) was of particular interest. While more than half of the agencies provided four to six different types of benefits to this job classification, about a quarter of agencies provided no benefits or only one (Figure 6). Most agencies (76%) offered health insurance or other medical benefits and almost as many (70%) offered dental benefits. The least common type of benefit was employee assistance programs with less than half of agencies (47%) offering that benefit.

Need for clearer communication about the goals and focus populations for home visiting

There was not a clearly and consistently understood message of what the purpose of home visiting was, but there were many different ideas of what it was supposed to be. One consequence of this confusion was that there were many very different ideas of the goals and outcomes of home visiting programs and therefore many disparate ideas of what could be improved.

Community resources

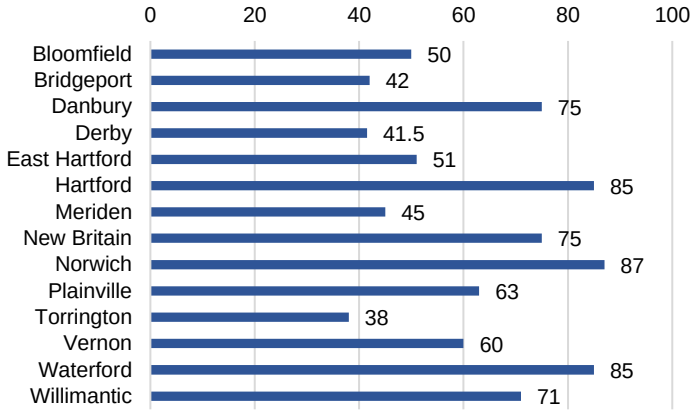
Providers and families identified some gaps in community resources and some resources that had an insufficient supply. Providers identified a dearth of infant mental health services as a needed resource. They also pointed to long waiting lists for the Early Childhood Consultation Partnership that works with families and caregivers to support children with mental health or behavioral problems ages 0-5 years old. They identified a need for more awareness of mental health problems across many contexts including more schools that were trauma-informed schools. Additionally, they identified a need for more mental health services for parents so that parents could better engage with home visiting without their mental health problems impacting their day-to-day functioning as significantly. Some providers described parent's mental health problems becoming the focus of the home visits. This leaves the home visitors unable to work with parents on the home visiting curriculum because the parents are often in crisis.



In the provider survey, the barriers to services that were most commonly identified as one of the "top 5 barriers" were availability (63%) and accessibility (53%) of health and social services and family supports, geography or transportation (47%), long waiting lists (47%), and a change in DCF status (42%) (Figure 7). When asked to identify the number one need in their community, the top three needs were all material needs. Fifty-two percent (53%) of agencies identified housing related services, 32% affordable childcare, and 21% basic needs providers such as food or transportation. Mental health providers were identified by 16% of respondents as the top community need. When asked to identify the top 3 needs in their communities, the same needs of housing (84%), affordable childcare (63%), and basic needs providers (53%) were the needs most frequently endorsed.

On the positive side, many other services were identified as *not a need* in their communities. These included 63% of agencies reporting that early intervention services were not a need, 63% that prenatal care providers were not a need, 52% that access to child health and development information was not a need, and 42% identifying school readiness services, SUD treatment, pediatricians and public benefit programs as not a need.

Figure 8: Average estimated awareness of the organization among professionals who could refer families? (N=16)
(0=No One Aware, 100=Everyone aware)



In summary, while there are many services in Connecticut; some are not available or accessible in all parts of the state; there is an insufficient number of providers or available slots for some services; and material needs are the most common issues across communities.

Informed referral networks

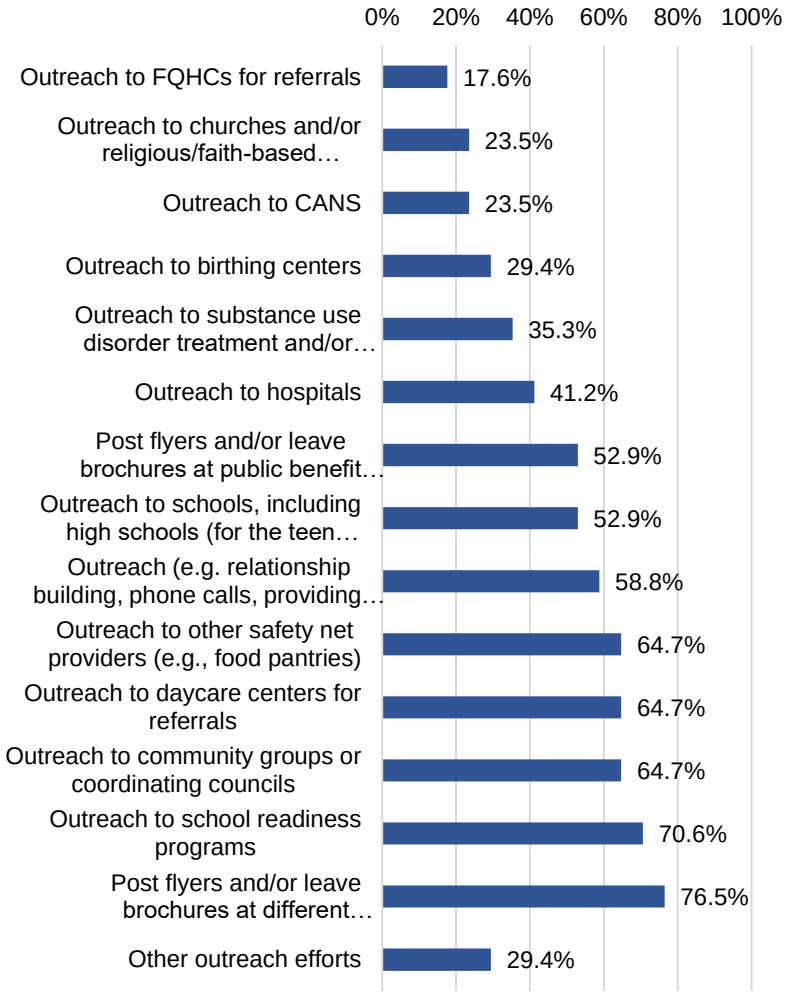
In the provider focus groups, that included many other types of professionals, many people expressed confusion over what types of family needs were appropriate for different HV programs or what outcomes the HV programs were working toward. Home visiting can develop different types of family strengths and address so many different types of family challenges. Thus with different types of programs available in different parts of the state it was difficult for professionals to know which to refer families to. In the provider focus groups, professionals reported that this confusion resulted in inaccurate, limited, or simply no referrals to HV programs. In the survey, current MIECHV programs identified DCF, mental health providers, schools, hospitals, health centers and childcare or preschools as common referral sources (Figure 9).

Across the 16 programs, 60 referral sources were identified, and 72% of these relationships were rated as 'strong' or 'somewhat strong'. When asked to rate the awareness of the organization among professionals who could refer families the responses ranged from 33% to 95% of professionals being aware of the organization, with a mean of 62 (Figure 8). However, that question was at the organizational level. Larger organizations may be generally visible in the community even while other professionals are not aware of their home visiting program.

Priority populations

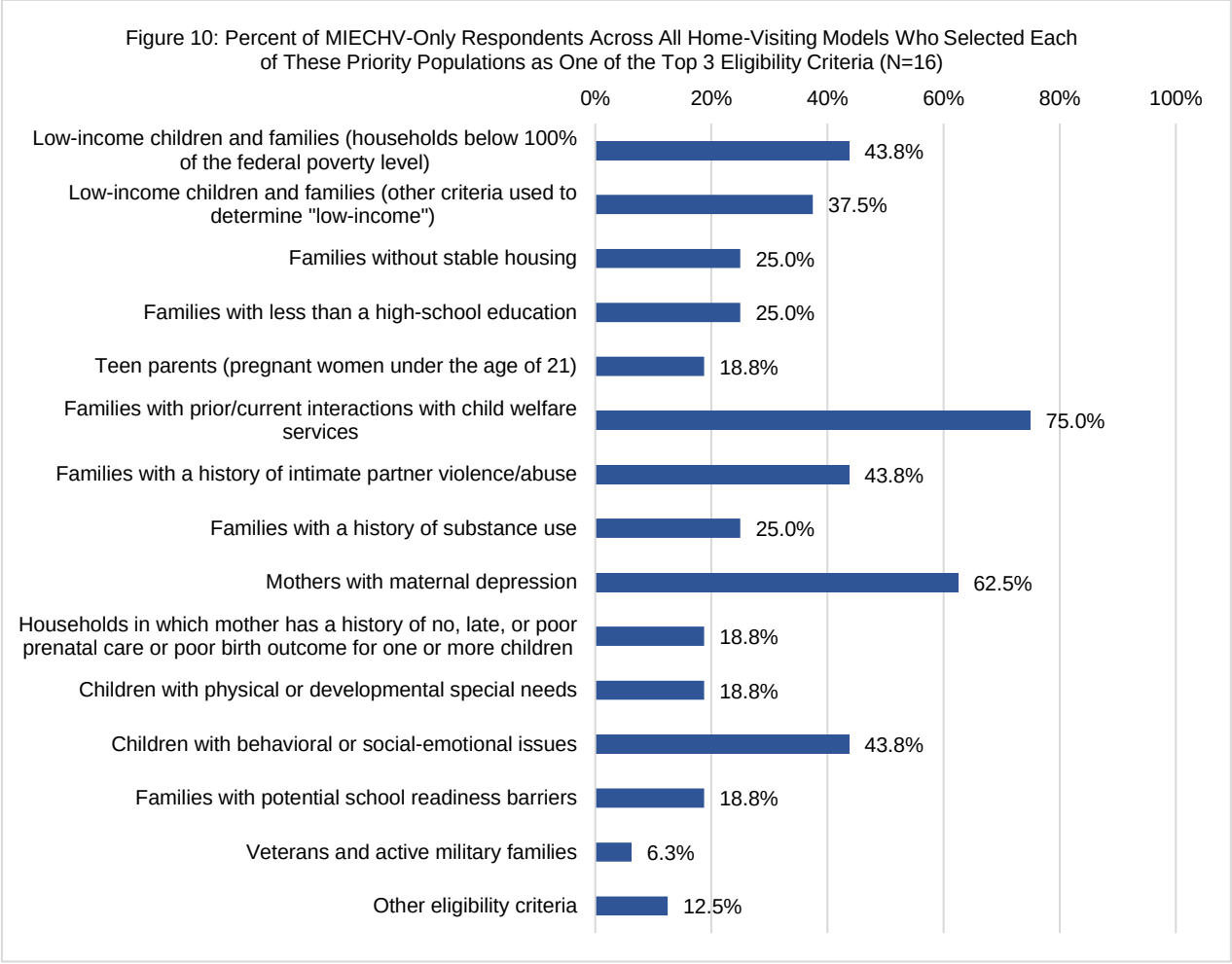
Across the MIECHV-funded programs, there were many different populations identified as a priority population (Figure 10). Three-quarters of programs (75%) identified families with *current or prior interactions with child welfare services* as a priority population. This was consistent with the findings

Figure 9: Percent of Respondents from MIECHV-Funded Organizations/Agencies who Selected Each Outreach Strategy For Their Organization/Agency (N=17)

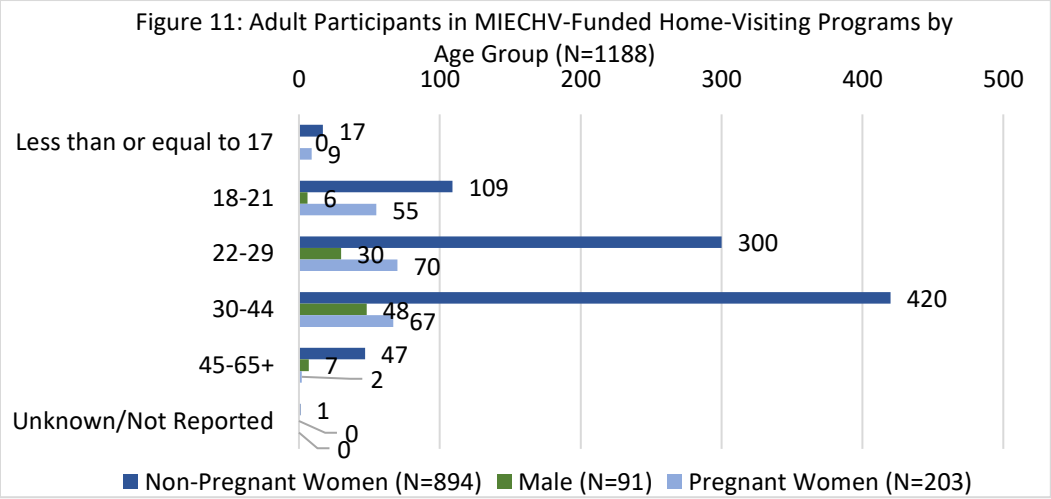


from the family focus groups that it could be difficult to access services without DCF involvement. *Mothers with maternal depression* were also a common priority population with more than half of programs (62%) identifying them as a priority. *Low-income children and families*, *families with a history of intimate partner violence*, and *children with behavioral or social-emotional issues* were also common priority populations with 43% of programs selecting each of those populations as a priority.

However, other than Veterans/active military families which was only selected by one program, at least two programs selected each of the population groups as a priority for their program. There is some obvious overlap in these populations, with many families with DCF-involvement also experiencing intimate partner violence and living in poverty. Additionally, child maltreatment is a risk factor for children's behavioral or social-emotional problems. Given the range of populations it is apparent why those outside of the HV system might be confused as to whom the programs were aiming to serve.



iv. **Optional topics**

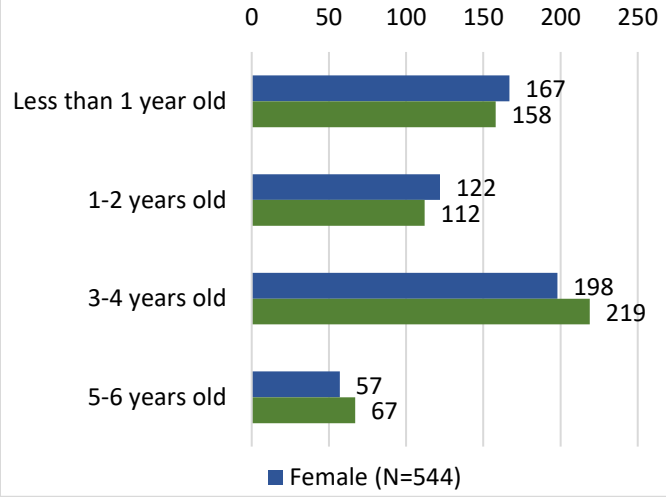


Demographics of Families Receiving Home Visiting

The majority of participants in MIECHV-funded home-visiting programs across the state were non-pregnant women and pregnant women were the second-most common demographic group (Figure 11). About 45% of all 1188 participants are between the ages of 30-44, while 34% are ages 22-29. Less than ten percent of home-visiting participants were teen parents or were over 45 years of age. About a third of parents only had a high school diploma, but 40% have some college/technical training/associates degree. About

10% of parents had a bachelor's degree or higher. Children in MIECHV-funded programs are fairly evenly distributed between the ages of 0 and 4 years old. Among the 1100 children participants in MIECHV-funded home-visiting programs across the state, almost 38% of participants are 3-4 years old (Figure 12). On the lower end of the early-childhood age range, almost 30% participants are less than 1 year old. Slightly more than ten percent of participants are 5-6 years old. The number of children is lower than the number of parents because of the number of pregnant women. Out of the 1100 children participants currently in a MIECHV-funded home-visiting program, slightly more participants are male (51% versus 49%). When comparing gender differences with age, slightly more 0-2 year-olds are female (52% versus 48%), while slightly more 3-6 year-olds are male (53% versus 47%).

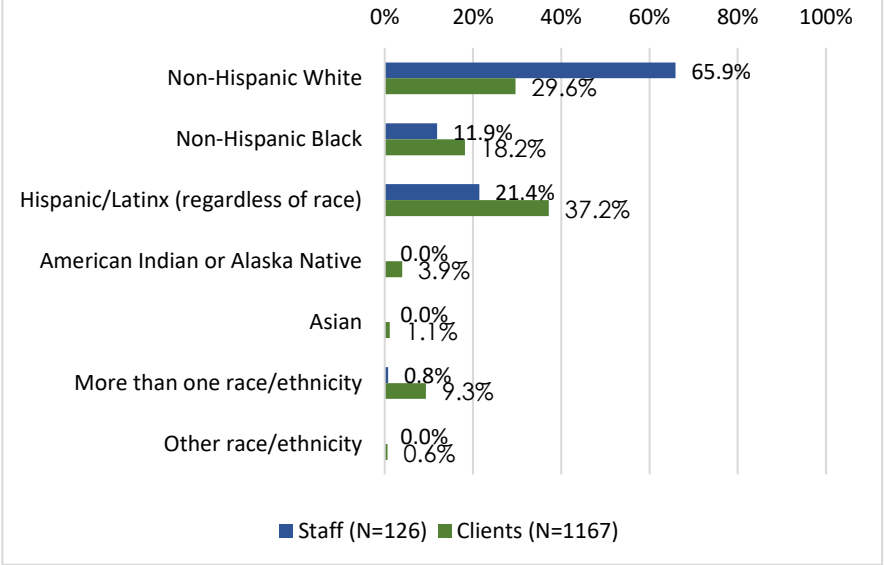
Figure 12: Children in MIECHV-Funded Home-Visiting Programs by Age Group (N=1100)



Cultural and language needs

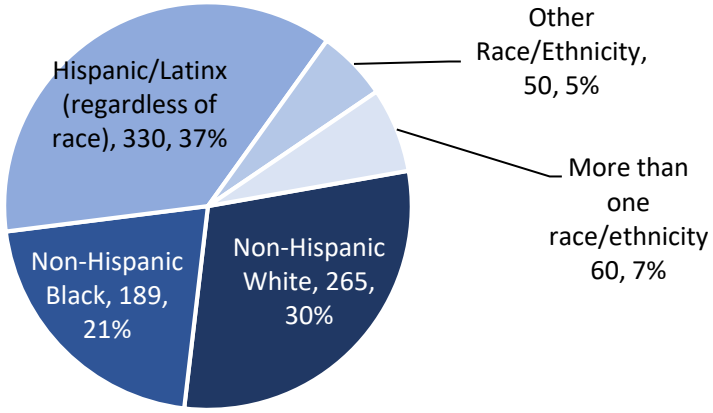
Even though agencies have been making an effort to have staff who reflect the communities they serve, there is still a difference between the proportion of families of each race/ethnicity and the staff who work with them. There are more White staff than families, and more Black, Hispanic/Latinx, Native peoples, Asian, or another race or ethnicity families than staff (Figure 13). Families in high-risk communities were more likely to be Black or Latinx/Hispanic than the rest of the state. The race and ethnicity of HV families in high-risk towns is similarly imbalanced (Figure 14). The geographic segregation of the state results in significant health and other disparities by race/ethnicity and consequently geography. The Title V MCHBG NA identified significant and ongoing health disparities by race/ethnicity, particularly between Black and Latinx/Hispanic individuals and White residents. Additionally, within the Latinx/Hispanic community there are distinct cultural groups that also have their own health and other outcome trends. About half (53% in 2016) of Hispanic/Latinx residents identified as Puerto Rican which is 8.3% of the total population of Connecticut. Puerto Ricans have a particular

Figure 13 : Percent of Clients and Staff from MIECHV-Funded Agencies by Each Race/Ethnicity Category



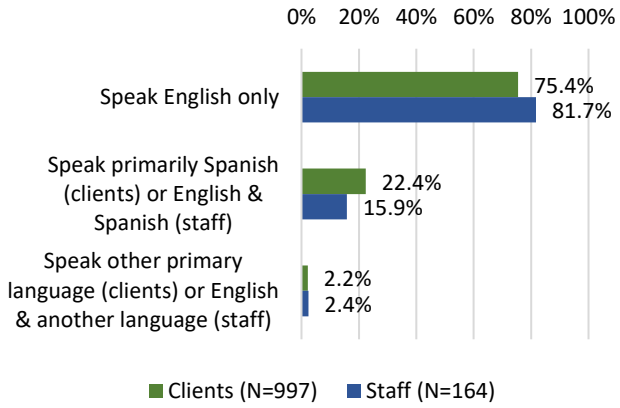
history of migration within the U.S., and tend to have worse health outcomes than those of Latinx/Hispanic ethnicity from other countries of origin.

Figure 14 : Race/Ethnicity of Clients in MIECHV-Funded Home-Visiting Programs in At-Risk Communities (N=894)



There are also many families that have other home languages besides English and Spanish. The percent of HV who speak Spanish 16% which is relatively close to, although still below, the 22% percent of families for whom Spanish is their home language (Figure 15). However, in the family and professional focus groups the lack of cultural adaptations to different cultures was noted. Particularly in the family focus groups, participants noted that the HV program models were not always consistent with their (the family's) cultural norms of child-rearing. This resulted in families feeling judged by the HV or concerned that the HV curriculum would not accommodate their cultural parenting practices.

Figure 15 : Percent of Clients and Staff from MIECHV-Funded Organizations/Agencies by Primary Language

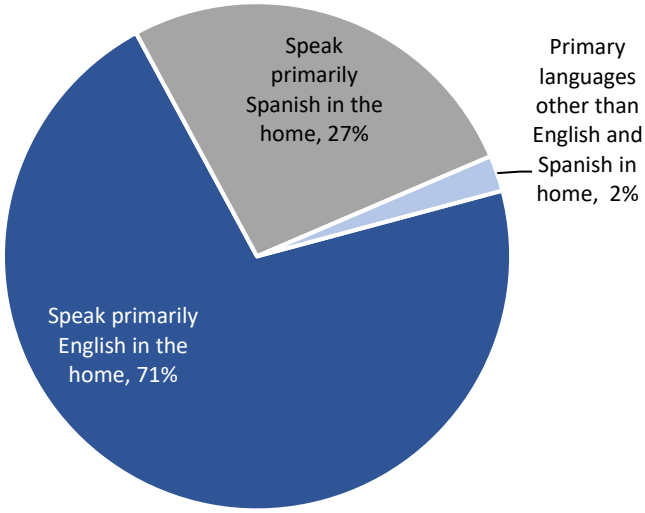


Cultural barriers were raised in some of the community listening sessions but it was not a major topic of discussion among those participants. When it was brought up, the lack of materials and capacity in languages besides Spanish and English was mentioned along with the assumption that increasing the number of Spanish-speaking HV would address the barriers to serving different populations. In contrast to the families, while 21% of programs identified cultural humility as one of their top 5 barriers as an organization, the majority of programs (68%) reported that "cultural humility" was not a barrier the organization faced.

In the provider survey, based on what providers reported about the clients they serve, the majority of clients identified as Hispanic/Latinx regardless of race. This was true for the overall total of clients reported and for the clients in at-risk communities (both about 27%). Specifically from the survey, these communities included Bloomfield, Bridgeport, Derby, East Hartford, Hartford, New Britain, Norwich, Torrington, and Windham (Willimantic, specifically).

Respondents in the 'Other Race/Ethnicity' category identified as either Native American/Alaska Native, Asian, or Middle-Eastern.

Figure 16: Primary Language of Clients in MIECHV-Funded Home-Visiting Programs in At-Risk Communities (N=703)



In terms of primary languages spoken by clients, similar percentages were found for clients overall (Figure 15) and clients in at-risk communities (Figure 16). The majority of clients spoke English as their primary language, although more than 20% were monolingual Spanish speakers. The percentage of monolingual Spanish speakers in at-risk communities was slightly more than the percentage of monolingual Spanish speakers overall (27% versus 22%). Other languages reported included Arabic, French, Russian, American Sign Language, Polish, Hungarian, Ghanian dialects, Swahili, Vietnamese, French Creole, and Nepalese.

Waiting Lists

Most of the HV programs reported no waiting list or a relatively short waiting list with families being served within a few weeks of referral. However, some of the Child First programs reported an extensive list with as many as 55 families and an average wait of 6 months. Some models or programs do not allow a waiting list to be used making it difficult to estimate the actual number of families who could be on a waiting list. Waiting lists were brought up in the family focus groups as well. Some families had been waiting lists for long periods of time and for some programs families were required to reapply for the waiting list periodically. Some programs used an assessment process to determine which families on the waiting list would receive services. This leaves some of the less-severe families on the waiting list for extended periods of time as there were consistently families with more severe needs.

Providers talked about the challenges with waiting lists and making referrals. Some HV programs that they were aware of, and would have liked to refer clients to, had long waiting lists and so were less appealing to refer to. They wanted families to receive services quickly, and referring a family to a 9-month waiting list was not a good option. In some cases, providers reported stopping referring to programs with extensive waiting lists because families were effectively not going to receive the service. Providers wanted a system that would provide better triaging or distributing of families to appropriate and available services.

Specifically in the provider survey, as reported by providers, most MIECHV-funded programs did seem to maintain a waitlist for all families (Table 11), but an almost equal number of respondents stated that their program was not currently at capacity.

Table 11 : Number of MIECHV-Funded Respondents by Home-Visiting Model and Waitlists (N=16)					
Waitlist options	**Early Head Start—Home-Based Option (EHS-HBO)**	**Child First**	**Nurse-Family Partnership**	**Parents as Teachers (PAT)**	**Total Respondents by Waitlist Option**
No (not allowed to have waitlist by funder or model)	0	0	0	2	2
No (not at capacity)	1	1	0	4	6
Yes, for ALL families	0	5	0	2	7
Yes, for all families EXCEPT those referred by DCF	0	0	1	0	1
Total Respondents by Home-Visiting Model	1	6	1	8	16

As shown in Table 12, the average number of families on the waitlist varied greatly by model. Child First reported the highest average number of families on the current waitlist. While two PAT programs reported a waiting list, the lists were five or fewer families.

Table 12: Number of Families at MIECHV-funded programs on the Current Waitlist by Home-Visiting Model					
Model	**Mean**	**SD**	**Minimum**	**Maximum**	**Range**
Parents as Teachers (N=2)	2.50	3.54	0	5	5
Child First (N=5)	23.20	19.45	7	55	48
Nurse-Family Partnership (N=1)	0.00		0	0	0
Total Respondents Who Indicated That Their Home-Visiting Model Had a Waitlist (N=8)	15.13	18.51	0	55	55

Providers were also asked about the length of time families spent on the waiting list. Again as Table 13 shows, there was significant variation even from the few providers that reported their information. The PAT programs are able to move families off the waiting list in 3-6 weeks while some Child First programs have families on the waiting list for six months.

Table 13: Average Length of Stay in days on the waitlist before Enrollment in DAYS by program model					
Model	**Mean**	**SD**	**Minimum**	**Maximum**	**Range**
Parents as Teachers (N=2)	21.000	29.70	0.0	42.0	42.0
Child First (N=5)	114.000	64.17	45.0	180.0	135.0
Nurse-Family Partnership (N=1)	0.00	-	0	0	0
Total Respondents Who Indicated That Their Home-Visiting Model Had a Waitlist (N=8)	76.500	72.12	0.0	180.0	180.0

Use of data

Data was one of the topics in the provider focus groups. Several themes emerged from these groups including the frustrations of home visitors with the duplicate data entry. Many providers entered data into three separate systems: one for their agency, one for the model, and one for the OEC. Sometimes

these data were very similar, but other times they were required to collect different pieces of information or administer similar measures for each entity.

Another issue that was raised was the feedback loop of collected data. Home visitors collected a lot of information from families and on families, but they rarely saw how that information was applied in the agency or presented to frontline workers as part of their own improvement of practice. They wanted a clearer understanding of how the different pieces of data were used. From their statements, it seemed that workers were not always clear which pieces of information were clinically meaningful, such as a midpoint assessment of a parenting domain; which data represented quality indicators, such as timeliness of a particular assessment; which were key outcomes for different programs, such as a referral to a needed provider; and so forth. This left home visitors scrambling to enter a significant number of data fields that felt meaningless and arbitrary.

Table 15 : Average Length of Stay for Participating Families in MONTHS by Home-Visiting Model

Model	Mean	SD	Minimum	Maximum	Range
EHS-HBO (N=1)	12.00	-	12.00	12.00	0.00
PAT (N=5)	33.00	6.00	24.00	39.00	15.00
Child First (N=6)	9.75	1.99	6.00	12.00	6.00
Total (N=12)	19.63	12.44	6.0	39.0	33.0

Family Engagement and Attrition in Home Visiting

To benefit from the home visiting program, families need to participate for a long-enough period of time to learn from the program and to receive a sufficient number of visits. Keeping families engaged throughout the service period is an important component of reaching the intended outcomes.

Eleven MIECHV-funded programs reported their average number of home visits in the survey (Table 14). The numbers, with some exceptions, were relatively close to the number that would be expected by the model. The average number of home visits reported was highest for the PAT programs and lowest for CF. This suggests that generally the programs are delivering the appropriate dose of services to maintain model fidelity.

Table 14 : Average Number of Visits Per Family Per Year by Home-Visiting Model

Model	Mean	SD	Minimum	Maximum	Range
EHS-HBO (N=1)	46.00	-	46	46	0
PAT (N=5)	113.40	128.57	12	280	268
Child First (N=5)	53.80	23.78	38	96	58
Total (N=11)	80.18	88.63	12	280	268

Programs were asked about the average length of stay to assess engagement in the survey (Table 15). Of the MIECHV-funded programs that responded, the EHS-HBO program reported families stayed for about 12 months or one year. Families spend on average between two to more than three years with PAT programs. Child First has a length of stay of almost 10 months. The average time spent across models is 19.6 months. The NFP program did not report average length of stay.

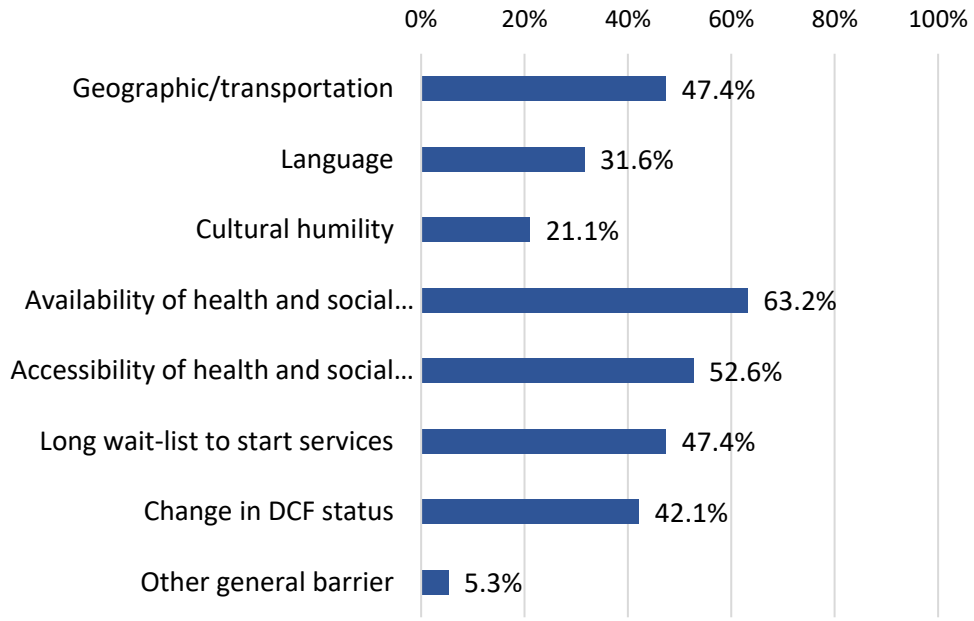
Barriers faced by home visiting programs

The accessibility or just lack of a sufficient number of supporting services was an identified barrier in the surveys and in the provider focus groups. The full results of barriers to service identified by MIECHV-funded agencies is in Figure 17. As noted in a prior section, lack of other social services and challenges in meeting material needs was a barrier to services in many communities. While these families may have

been interested in HV, mental health needs, children's special healthcare needs, specialty medical services, and substance use disorder treatment could prevent families from being in a position to take in the information from a HV. Providers spoke of the challenges of working with families with an untreated or under-treated MH problem where family crises continually took precedence in HV sessions. Many parents reported trusting their HV, often more than other professionals, and spoke of relying rely on them for emotional support in times of crisis. However, HV are not always trained in clinical care and they are there to work with families on child-related topics. This was a frustrating situation for some home visitors.

Material needs including housing, childcare, and food — in addition to the untreated mental health needs of parents presented barriers to services. Families spent significant amounts of time trying to provide basic necessities. Families who had reached a severe crisis, such as homelessness, were often overwhelmed by the number of programs they were offered. Providers suggested, for example, that allowing families to stabilize in housing before offering home visiting was beneficial to families to prevent them from feeling overwhelmed by all of the different tasks (such as finding employment) and services they were offered.

Figure 17: Percent of Respondents from MIECHV-Funded Organizations/Agencies who Selected Each Item as One of the Top 5 Barriers for Their Organization/Agency (N=19)

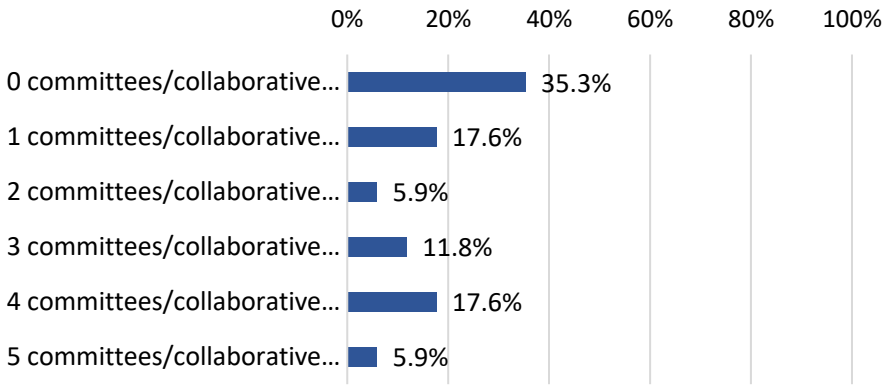


Geography presents another challenge in the state. One of the hardest to staff areas in the state is the Northeast. This area is primarily rural. In the community meetings and the Advisory Board meetings, providers expressed that they would have to hire staff who lived in other parts of the state and pay them time and expenses to travel 1-2 hours each way. In addition, the Northeast does not have many family service providers so there are few resources for home visitors to link families too. Another area that is challenging to serve is the Northwest. In this instance, the families in the focus groups expressed difficulty accessing services rather than the HV providers. Local providers did acknowledge higher costs in terms of travel time to reach families' homes.

Presence of coordinating councils

Home visiting programs participate in council and collaboratives across the state. In the survey of home-visiting programs for MIECHV-funded agencies, a third of programs (35%) reported not being involved in any councils but almost 25% were involved in 4 or more council-type groups. See Figure 18. In addition, 18% of respondents stated that they were only involved in one council.

Figure 18: Percent of Respondents from MIECHV-Funded Organizations/Agencies by Number of Home-Visiting Committees/Collaborative Councils Their Organization/Agency Participates In (N=16)



These councils are groups that are in addition to the provider network through MIECHV or other state-wide groups that the agencies participate in as a part of funding from the OEC. The expected pattern was for programs in metro areas to report more council involvement simply because they were in a denser service network with more possibilities. This was not the case and some of the programs reporting zero councils were in metro areas. In towns with more than one program there was a noticeable difference in the number of councils the different programs were involved in. For example, in Derby, one program reported being involved in one council while the other was involved in five. It is unclear from the survey whether the programs that reported no council involvement were because the agency was isolated from other early-childhood service providers or because they were in a large agency that provided extensive services and therefore the programs had little incentive or perceived need to join other councils.

An additional thing to note is that several respondents reported participating in councils that were based in towns/cities quite far from their organization/agency. As an example, a respondent from Lower Naugatuck Valley Parent and Child Resource Center (LNVPCRC), which is in southwest-central CT, stated that they participated in school readiness councils in Groton, Norwich, New London, Ledyard, and Sprague—all of which are in the southeastern portion of the state. It is unclear if organizations/agencies are participating in councils far from their base due to lack of councils in their area, the respondent's own personal connections and network, or other reasons.

4. Capacity for Providing Substance Use Disorder Treatment and Counseling Services

Introduction

Connecticut has a range of publicly-funded mental and behavioral health treatment options through the Department of Mental Health and Addictions Services (DMHAS). These services are primarily available to residents with state Medicaid health insurance (Husky). The Husky coverage for mental and behavioral health is extensive and, unlike many states, Husky has one of the high reimbursement rates relative to private insurance for behavioral health. These programs include a range of gender-specific facilities and programs and an approach that is attuned to the gendered dimensions of problems, particularly of substance use disorder. In recognition of the impact of parental substance use disorder on children, pregnant and parenting women are prioritized in service allocation and delivery across types of services.

MIECHV-funded home visiting agencies reported barriers to SUD and MH treatment services in the survey. Transportation and physical location were the two most commonly identified barriers to these services. This suggests that for most HV families who need SUD or MH services, they are eligible for services and have insurance coverage but that there are still physical barriers to accessing treatment. Connecticut does not have a robust public transportation system and outside of the metro areas it is virtually nonexistent with extremely limited routes and schedules. A state medicab program is also available, but long waits and limitations on transporting children may limit the utility of this services.

State agencies have worked to provide appropriate and accessible services to the community. While there is still room for progress, some of the remaining significant barriers may lie outside of the types of services that can be provided by these agencies.

Range of treatment and counseling services

Through two different state agencies, Connecticut has an extensive range of gender-specific treatment and counseling services for pregnant and parenting women. The Department of Mental Health and Addiction Services (DMHAS) has a robust mental and behavioral health system. Maps of the prevalence of MH and SUD service use are in the Map Appendix. In addition to DMHAS, the Department of Children (DCF) and Families has an intensive in-home substance use disorder treatment program called Family Based Recovery.

Through DMHAS, a wide range of SUD and MH services are available and the department has worked to develop a system that is accessible and efficiently connects clients with the appropriate services. To facilitate clients accessing more intensive services as quickly as possible, DMHAS maintains a website with the current bed availability at in-patient programs. The available beds are updated daily by programm. For SUD the programs include detox, residential treatment, recovery houses and sober houses including which facilities are gender-specific, which are for pregnant and parenting women, and which are intensive versus intermediate residential.

For MH treatment, the types of facilities include inpatient, intensive, group homes, supervised, transitional, and respite. In a small state that is only 70 miles from southern to northern border and 110 from western to eastern, there are 8 state detox facilities, 10 intensive residential programs (counting separate men's and women's at the same facility as two programs), three additional intensive programs for men and women with co-occurring disorders, seven other programs

specifically for pregnant and parenting women, 10 intermediate residential six of which are gender-specific, two long-term residential programs and seven transitional/halfway house programs.

The Young Adult Services (YAS) division and the Women's Behavioral Health Services (WBHS) program provide appropriate services to young adults and women. In addition to providing developmentally appropriate mental and behavioral care, the YAS has a perinatal support program for young adults between 18-25 who are DMHAS clients and pregnant or parenting. The program provides in-home support during pregnancy, Duala services during the birth, and intensive post-partum support until the youngest child's 4th birthday. As appropriate, the perinatal program connects these young parents to home visiting programs.

The Women's Behavioral Health Services program funds gender-specific mental and behavioral health services to more accurately address the needs of women's experiences. There has been a commitment at DMHAS to have services that are gender-responsive and provide trauma informed care or trauma sensitive services. This commitment is supported by training, consultation, and agency-wide initiatives to change the way care is provided. The services funded through the WBHS include the seven women-only in-patient SUD treatment facilities where women can bring their children who are 5 years of age or younger. Approximately 200 women enter these intensive in-patient programs each year.

In addition to these specialized programs for mothers, there are another seven facilities that offer outpatient and intensive outpatient services specifically for women. These are distributed across the five DMHAS regions with the goal of having all services geographically proximal to all clients. There are also Recovery Specialists who assist women in identifying supports to sustain recovery and a Women's Recovery, Engagement, Access, Coaching & Healing (REACH) program that supports 15 Recovery Navigators across the five DMHAS regions. Recovery Navigators are women who have had their own recovery journey and use their personal experience in conjunction with the training they receive for recovery coaching and case management to help women engage with and access the appropriate level of SUD treatment services.

The DCF-funded Family Based Recovery program is available in two of the six DCF regions (different than the five DMHAS regions). This program provides intensive treatment services to parents of children up to 36 months of age through three home visits per week and a 24/hour call-line. Two of the visits focus on substance use disorder treatment and one visit focuses on the parent-child relationship. This intent of the program is to combine a mental and behavioral health focus with more traditional home visiting skills. In 2019 state fiscal year, 295 families received services through this program. This program has received national attention for its success in keeping families together and addressing parental SUD.

i. Gaps in current level of treatment and counseling services available to home visiting service populations.

While there are no obvious gaps in the types of services offered or availability of these services, by using the qualitative data to triangulate the issue some gaps emerge. In the provider focus groups, shortage of adult mental health services was identified as a problem and home visitors spoke about

client's mental health needs and crises taking precedence over the home visiting curriculum. Combined with the survey of home visiting programs where the most programs identified distance and transportation as barriers to SUD or MH services, this suggests that while services may be available they are inaccessible to this population. The home visiting population tends to be low-income families. This means that for employed parents their lower-wage jobs are less likely to be flexible to allow time off for travel to and participation in services. For families where the children are home with a parent and there is no other childcare, attending outpatient mental health or SUD services with children may not be allowed, feasible, or appealing. The burden of initiating services with the logistical challenges of small children may simply be overwhelming for families who are financially strained and already dealing with a mental health or SUD problem. Short of drastically improved public transportation and childcare, more services that can be delivered through tele-mental health, or that can provide childcare while parents attend outpatient treatment may be needed to address these gaps.

ii. Barriers to receipt of substance use disorder treatment and counseling services

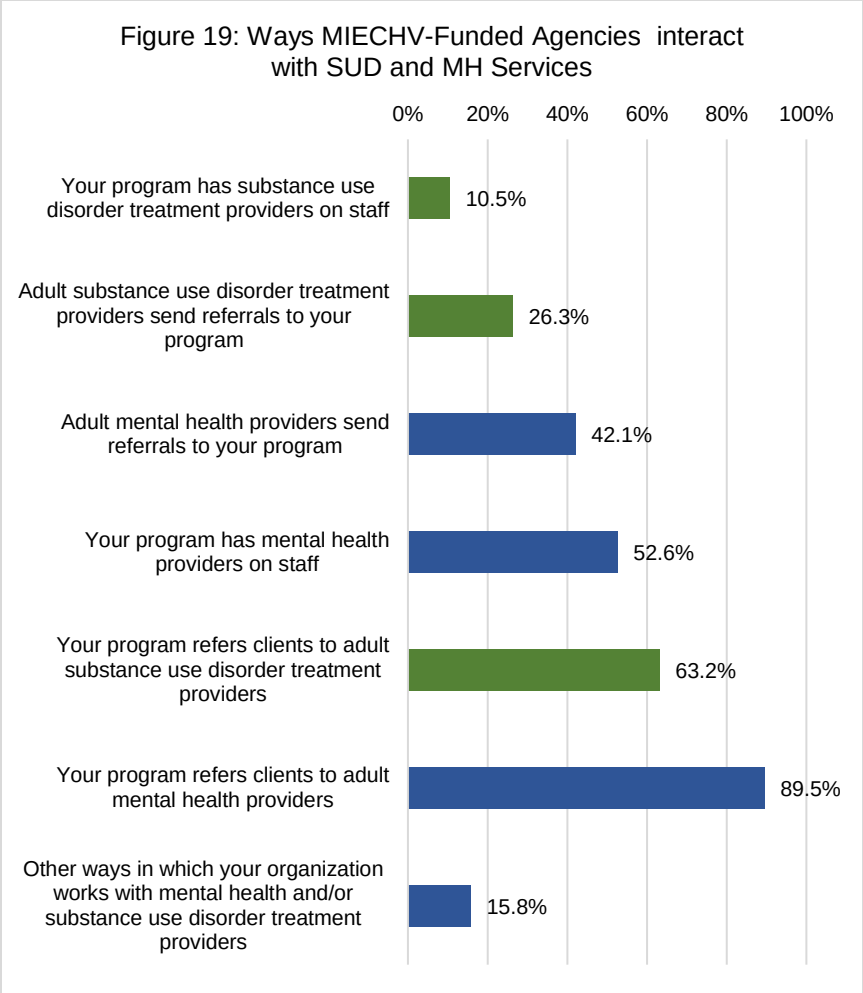
MIECHV programs identified transportation (58%) and distance to services (32%) as the most common barrier to MH/SUD services. Many families in Connecticut lack their own car and there is very little public transportation. So despite locations being available across the state and in all regions they are still not always accessible. Other barriers identified were insurance coverage (22%), age restrictions on children allowed in residential facilities (16%), no residential option available/accessible for reasons other than insurance (16%) and waiting lists (16%).

Mothers in the in-patient facility with their children reported that there is confusion between the DCF requirements and the DMHAS requirements for custody, treatment, and service compliance and the requirements can be contradictory. This creates some mistrust of the services and can be a barrier to seeking services. As discussed in the previous section, transportation or other access to services is a barrier. It is possible that the recent shift to tele-mental health necessitated by precautions for COVID-19 could help close this gap.

iii. Opportunities for collaboration with state and local partners.

There are existing collaborations and connections between home visiting agencies and MH or SUD treatment providers but there are also opportunities to expand this relationship. HV programs are currently working to connect families to SUD and MH programs. Some agencies have co-located services with 10% of agencies also providing SUD treatment and more than 40% providing adult MH services (Figure 19). These programs also refer clients to other providers. As illustrated in figure 19, 63% of HV programs refer client to SUD treatment providers and 89% refer to MH providers

In addition to referring clients to SUD and MH, these programs can be a referral source for HV. Of programs that responded to the survey, 35% used "outreach to SUD/MH treatment" as one of their referral strategies. Programs also report that 26% of programs receive referrals from SUD treatment providers and 42% of programs receive referrals from adult mental health services. These providers are possible referral sources for the majority of programs who do not report these type of connections.



As most programs are not currently receiving referrals from these sources, outreach and relationship building with these programs is an opportunity for collaboration at the local or regional level. These collaborations are more likely to be effective at the local level because of the different service regions that SUD/MH and HV agencies are divided into.

Of MIECHV-funded agencies programs that replied to the survey, all types of connections to mental health services are more common than to SUD services (Figure 19). Some of the conversations from the provider focus groups suggest that while there is general agreement that parents in MH or SUD treatment or services could benefit from HV, they can be a challenging population to serve. Substance use disorder treatment in particular can be very demanding for the clients in recovery and parents may need to reach a point of stability before they are ready for another type of service.

As an example of an existing local collaboration, the maternal/child inpatient SUD treatment facility where we conducted a family focus group automatically enrolls the women in a local Early Head Start Program and the women spoke positively about the EHS program. At a regional level, as explained in 4.i., the Family Based Recovery (FBR) program incorporates SUD treatment, with mental health treatment as needed, and with parent-child relationship building all delivered in-home. This is a combination program rather than an inter-agency collaboration but it delivers these key services to families.

iv. Current activities/(strategic plan if existent) to strengthen the system of care for addressing substance use disorder

A significant coordination of care effort for families in need of SUD or MH services is between DMHAS and DCF, particularly around compliance with CAPTA legislation. The DMHAS provider and recovery system has been preparing to support women through the birth process including helping women

develop Plans of Safe Care while they are pregnant. Coordinating policies and services across agencies is an important step to high-quality SUD and MH care for parents.

v. Optional Considerations Wrap around services (if existent)
vi. NA

5. Coordination with Title V MCH Block Grant, Head Start, and CAPTA Needs Assessments

a. Describe how you coordinated with and took into account other needs assessments, and at a minimum, the needs assessments required by Title V MCH Block Grant, Head Start, and CAPTA programs.

A goal of this NA was to address and understand the needs of families who were not the target population of other programs. These needs assessments and other documents were reviewed as they became available and any interim presentations were considered in this NA.

Title V Maternal Child Health Block Grant (MCHBG)

The MCHBG Needs Assessment was completed in August 2020. That needs assessment focused on the health status of pregnant women, mothers, infants, children, adolescents and children and youth with special health care needs. The final report grouped the focus populations into life-course stages and an additional category for children with special healthcare needs. For each stage, the assessment identifies three main themes as listed below:

Women's and Maternal Health
- Disparities in Maternal Morbidity and Mortality
- Disparities in Preconception and Interconception Health
- Mental Health and Help-seeking

Perinatal and Infant Health
- Persistent disparities in LBW and Infant Mortality
- Neonatal Abstinence Syndrome
- Disparities in sleeping and feeding

Child Health
- Medical Home
- Violence, Adversity, and Mental Health
- Disparities in Manageable/Preventable Childhood Conditions

Children with Special Healthcare Needs
- Medical Home
- Adequate/Continuous Insurance Coverage
- Mental Health Treatment/Counseling

Adolescent Health
- Substance use (vaping, prescription opioids)
- Risk-Taking and Self-Harm (unsafe driving, suicide)
- Bullying and Violence (LGBTQ, sexual violence)

Reducing health disparities is an area of synergy between the OEC and DPH as demonstrated in these needs assessments. A significant focus of the results of the MCHBG needs assessment was the persistent disparities in health outcomes across many indicators between White populations and Black, Latinx/Hispanic, and other groups including Asian, Pacific-Islanders, and Native peoples. The persistent

health disparities, particularly around pregnancy, childbirth, and the perinatal period are particularly concerning to the OEC.

According to the Title V MCHBG needs assessment, Black women (all races are non-Hispanic unless otherwise specified) have the highest rate of unintended pregnancy in the state (57%), the highest rate of pre-pregnancy blood pressure (7.1%), the highest rates of preeclampsia during pregnancy (16.3%), the highest rate of pre-term births (10.4%), and the highest percentage of low birthweight infants (9.8%). While infant mortality is on average very low, Black infant mortality is three times that of White infants, and Hispanic infants are 1.5 times as likely to die as White infants. Hispanic women's health tended to be slightly better than Black women's but not as good as White women's. The health of non-Hispanic women who identified as another race was difficult to characterize because of the variability but generally tended to be worse than White women's health.

The root cause of these health disparities are primarily structural determinants of health compounded by incidents of discrimination experienced during pregnancy. Black women experienced the most stressors during pregnancy with 6.8% experiencing 6 or more separate stressors (e.g. lost a job, someone they were close to died, etc…). Black women also report the highest rates of race-related discrimination or harassment in the 12-months prior to their pregnancy (30% compared to 25% for NH women of other races, 20% for Hispanic women and 7% for White women).

These health disparities were similar to many of the geographic findings in the MIECHV NA and were reflected in the non-health indicators used in this NA, such as poverty. Many of the MIECHV high-risk communities have a disproportionate share of Black and Latinx/Hispanic residents relative to the rest of Connecticut. Healthy births is an outcome where home visiting services could support improved outcomes. If home visiting programs focused on Black and Latinx/Hispanic communities then HV could help reach health equity by supporting marginalized women's healthcare engagement and help-seeking behaviors, support families in healthy sleeping and feeding arrangements, and improve child social-emotional development which is closely tied to children's mental health.

Home visiting could provide additional supports to vulnerable families to help reduce health disparities. A key difference between the needs assessments is that this MIECHV NA also identified some non-metro communities that are majority White but have poor outcomes across multiple indicators. These communities' birth-related indicators tended to be healthier than communities with higher percentages of Black and Hispanic/Latinx residents. Providing HV services in these communities would help to address some of service gaps in the non-metro areas that are unlikely to be a specific focus of Title V MCHBG funding. The agencies share a commitment to health equity.

Maltreatment Prevention

The Department of Children and Families (DCF) is the primary provider of services to address child maltreatment and has been in the process of developing a plan under the 2018 Family First Legislation. That development process was a multi-step, multi-stakeholder process. They divided into five different workgroups, including a group focused on defining which risk factors would define those groups who had candidacy for foster care, and a kinship and foster care workgroup. The Department was committed to a community involved process that incorporated the voices and perspectives of stakeholders and other community representatives.

This process was interrupted and delayed by COVID-19 because of the extensive community engagement that was involved. For example, the candidacy workgroup held nine interactive stakeholder meetings in the first two months of 2020. In many meetings, key data and results were presented to a diverse group of stakeholders and then the stakeholders would engage in structured conversations around the data and candidacy selection. This was a data-drive, community-engaged process with the aim to develop a comprehensive plan that would address real needs and have broad support in the community.

An early interest of DCF's in that process was how to use collective impact strategies to support families with services across agencies and how to align those systems and services to reduce duplication and working at cross-purposes. This NA has monitored the development of that process as much as possible given COVID-19 related changes. The focus of the Family First planning process was on families with an identified key risk factor for maltreatment. This is an expansion of DCF's already-strong secondary prevention programming.

Head Start Needs Assessments

Each HS program conducts a needs assessment for the community it serves resulting in many needs assessments of different towns or other geographic units. Because the needs assessments may be used for multiple purposes they can vary considerably in the topics that are included and covered in-depth. Two well-conducted and thorough needs assessment were reviewed, one for Bridgeport, which is a metro area, along with the surrounding towns, and the needs assessment for five towns in Litchfield County, an area that is mostly non-metro and has some of the lowest population density in the state. These needs assessments present strengths of their areas and of state services while noting gaps, such as the reduction in state support for childcare through cuts in the Care4Kids subsidy program.

Each needs assessment covered economic factors and extensive data on child-related services, health and education status, service access and other topics. Both needs assessments included some survey component of clients or customers of the agency and/or community partners. These needs assessments are more nuanced and specific for the geographic region they cover, but many of the topics are similar. Overall, there is a shared understanding of the role of economics and health in child and family outcomes across these needs assessments and in this NA. Head Start is a natural next step for many families who have engaged in home visiting in their early years and these needs assessment indicate that the perspective of needs and issues is similar to that of MIECHV.

b. Describe your efforts to convene stakeholders to review and contextualize results from various needs assessments in your state.

There were two primary avenues for receiving stakeholder feedback to contextualize the findings from this needs assessment along with other needs assessments and extant information. Initial results of this NA were presented in a series of detailed presentations to the OEC Home Visiting Team. The results and findings were critically examined and discussed in that process and the Home Visiting Team was able to ask questions about the results. As part of this process, context was provided by the program liaison staff who are in regular contact with the programs, the epidemiologist at OEC, the director of home visiting, and other home visiting staff members. Some of these team members were also apprised of the MCHBG needs assessment interim presentations and were part of or informed about the Family First planning process.

The Advisory Board also reviewed interim results as different stages of data collection were completed. The Advisory Board represented stakeholders from across the state, many key state agencies and/or programs, and content experts. They provided a different perspective on the results and findings from their professional context. The Board was convened four times over the course of a year.

c. Explain how findings or data from Title V MCH Block Grant, Head Start, and CAPTA programs informed your MIECHV needs assessment update.

This NA considered the scope of services of the other needs assessments, their findings, and the way that issues were categorized and prioritized. The OEC wanted to identify a set of outcomes or issues where services were needed and HV could have a unique contribution to the issue. They also wanted to avoid having too many programs and state agencies prioritizing the same populations, leaving other populations without any service options. The most significant duplication of services across agencies is Child First services provided through MIECHV or other state funded home visiting through OEC and also being provided through DCF services.

The MCHBG needs assessment indicates a focus on health disparities around pregnancy and birth outcomes but provides different types of services than MIECHV HV. Aligning the home visiting vision with the focus on reducing health disparities represented a potential opportunity to amplify the impact of HV and of programming from the Department of Public Health. By focusing on equitable distribution of services to communities with higher numbers of families who identify as Black, Hispanic/Latinx or another non-White race or ethnicity the impact of both types of programming would be larger. Additionally, HV and MCHBG programming could both take a primary, if targeted or indicated, prevention approach.

In considering how this NA identified community needs in relation to the Family First processes and eventual services possibilities, it was apparent that the primary overlap in target population is families with young children who are identified as at-risk for becoming a candidate for foster care. The definition of “at-risk for foster care” is determined at the state level thus allowing Connecticut, where there are already secondary prevention programs being implemented, to have a more expansive definition of “at-risk” than other states where there were few existing secondary programs.

A more expansive definition of at risk of foster care placement will allow a wider array of upstream services to be provided through DCF funding. Families receiving those services would still need to have some clearly identifiable risk factors for foster care, which represents a more severe situation than the typical maltreatment report or general maltreatment prevention from HV. These factors suggest that there will be an expansion of secondary prevention of maltreatment and treatment programs to address this population.

The distinction between the risk and safety factors on most reports of child maltreatment compared to the risk and safety factors that result in a removal to foster care is an important distinction between the anticipated Family First programming and HV services that include *preventing child maltreatment* as an outcome. A family could have a report of maltreatment but the family assessment identifies no immediate safety factors and a low-risk of a future incident. This family could benefit from services but the chances of their child being removed to foster care are relatively low. There are many more reports of child maltreatment, primarily child neglect, than children removed from their homes to foster care.

These considerations position the eventual Family First and other DCF-provided maltreatment prevention programming and interventions to provide services to families downstream, i.e. after some incident or risk factor has brought them to the attention of the system. One aspect to note is that given the significant stigma families have around DCF services that was expressed in our family and provider focus groups, having a clear distinction between prevention services and those provided by DCF was anticipated to reduce barriers to engagement.

In totality, the service area that fell between MCHBG programming and DCF programming was the prevention-focused early childhood services that were likely to be relatively consistent with the focal populations of Head Start. This prevention-focused service is consistent with the goals of MIECHV and with a strengths-based approach to family engagement. Families that have characteristics that can make it difficult to care for children, such as experiencing maternal depression, or being a young, first-time mother are unlikely to receive services from other sources, but are excellent candidates to benefit from home visiting services.

6. Conclusion

a. Summarize major findings of the statewide needs assessment update

One goal for this needs assessment was to answer some critical question the following crucial questions. What is the most important contribution home visiting can make to the families of Connecticut? Where is home visiting needed most? How should families and home visiting programs connect?

What is the most important contribution home visiting can make to the families of Connecticut?

Home visiting programs have the potential to achieve a variety of key outcomes for families across child and maternal health, child development, education preparedness, and maltreatment prevention outcomes. Additionally, home visiting programs can address families across the range from prevention to treatment services. However, this range also means that the benefits can be diffused across multiple outcomes, in vastly different populations, and in different locations. Without a cohesive and strategic deployment of HV, programs can make a significant impact for the families involved but have little impact on the overall community or state. Identifying the best role for home visiting involved understanding what families wanted and needed, what HV providers thought but also how other professionals perceived home visiting, and positioning home visiting within the state's network of other family-serving services.

Primary prevention around healthy births, positive child development, and upstream maltreatment prevention were areas that were generally not filled by other state agencies' services, that families wanted, and providers identified as important, but currently limited, components of a service array. The Department of Public Health provides some specific prenatal programming, but also focuses on improving access and systems of care rather than providing services to individuals. The Department of Children and Families provides many treatment-type programs and are expected to expand their secondary prevention services under Family First. However, currently to access their services families have to have an accepted (but not substantiated) report of maltreatment. Federally funded IDEA services work with children with an identified delay at a certain level of severity, but also do not provide general child development promotion services. Collectively, the systems of care are being improved and different types of treatment services are offered but there is very little primary prevention available to families.

Families wanted non-stigmatizing services that were available before their family reached a crisis point. They liked their home visiting programs and enjoyed the health and child development curricula, and many had an important relationship with their home visitor. They did not want to have to wait until their family reached a crisis point and there was an acute incident that resulted in their being referred to DCF.

In the focus groups of providers and other professionals the need for services that were lighter touches to prevent downstream problems was raised. Professionals were also aware of the stigma that many parents associated with home visiting and the confusion from families and other professionals about which families were appropriate for which available programs.

This NA process identified a key niche for home visiting to fill in the state to help provide a strong continuum of services for families.

Where is home visiting needed most?

Connecticut is a very small state geographically, but because of the town-based governmental system there are vast disparities in areas in close geographic proximity. There are also areas that are more difficult to serve because of the distances between families can make it difficult to reach service quotas. MIECHV

home visiting is also allocated by community-level need – making it distinct from many other programs which focus on individual's risks and needs rather than the overall community need. All communities have families who need support, but communities where there are concentrations of many types of need and where the needs are more severe can be less healthy places to raise children. All counties, save one, have at least one high-risk town.

In addition to the three counties with higher-than-average levels of risk, there were 22 individual towns in the other counties that are pockets of high-risk factors. Some of these high-risk towns in low-risk counties, such as Bridgeport, are metro areas with a significant number of services, but others are small, often isolated, and have few if any services like home visiting. The combination of the county-level and town-level analysis revealed some important service needs across the state. One important finding was the high-risk towns in more isolated areas that are underserved relative to the rest of the state. The mapping process visually displayed the need by domain across the towns. A complete set of maps has been included in the Map Appendix.

Allocating funding to balance the needs of communities in more and less healthy counties across the state is a challenge, but the needs assessment has revealed the need for a broad reach for home visiting including in the more remote non-metro communities.

How should families and home visiting programs connect?

The needs assessment found a balkanized referral system characterized by some strong relationships in some communities but many other problems. These existing relationships may unintentionally have excluded newer organizations, providers reported a lack of communication across town or regional boundaries that may or may not have demarcated an actual service boundary, and the survey revealed a heavy dependence on other professionals for referrals to HV. This system required a significant amount of outreach by individual programs to develop relationships with other professionals along with some direct outreach to families. The survey showed that a majority of programs received referrals from other professionals and then directly contacted the family – without knowing what information the family had been given or if they had even been consulted.

This was not what families wanted. Families wanted to self-refer or opt into programs without having to be referred by another professional. They suggested non-stigmatizing locations and professionals (like pediatricians) as ways they would want to learn about a program like home visiting. They talked about feeling judged and their parenting found wanting when many types of professionals referred them to home visiting. Initially, they thought others would see them as bad parents because they "needed" home visiting. Once they engaged in the program, they had a very different perspective on the services and described home visiting as a program that good parents participated in because it was positive for their children and family.

Families and programs need new avenues of connection that are less dependent on specialized provider referral networks and more accessible to individual parents.

b. Describe dissemination of the statewide needs assessment update to stakeholders

Different components of the information in this NA has been presented to a variety of stakeholders through presentations. A thorough and detailed readout of the data occurred over a series of eight weekly meetings with the OEC Home Visiting Team. Presentations have been given to the state home

visiting providers at a quarterly meeting and the home visiting research consortium. A more accessible report was prepared and disseminated to agencies interested in applying for the next round of home visiting funding. That report is also available on the OEC website. The complete NA will be disseminated to partner agencies and programs such as the Title V MCHBG and the Head Start Coordinator at OEC. Additionally, the report will be available to agencies and some future presentations have already been scheduled.

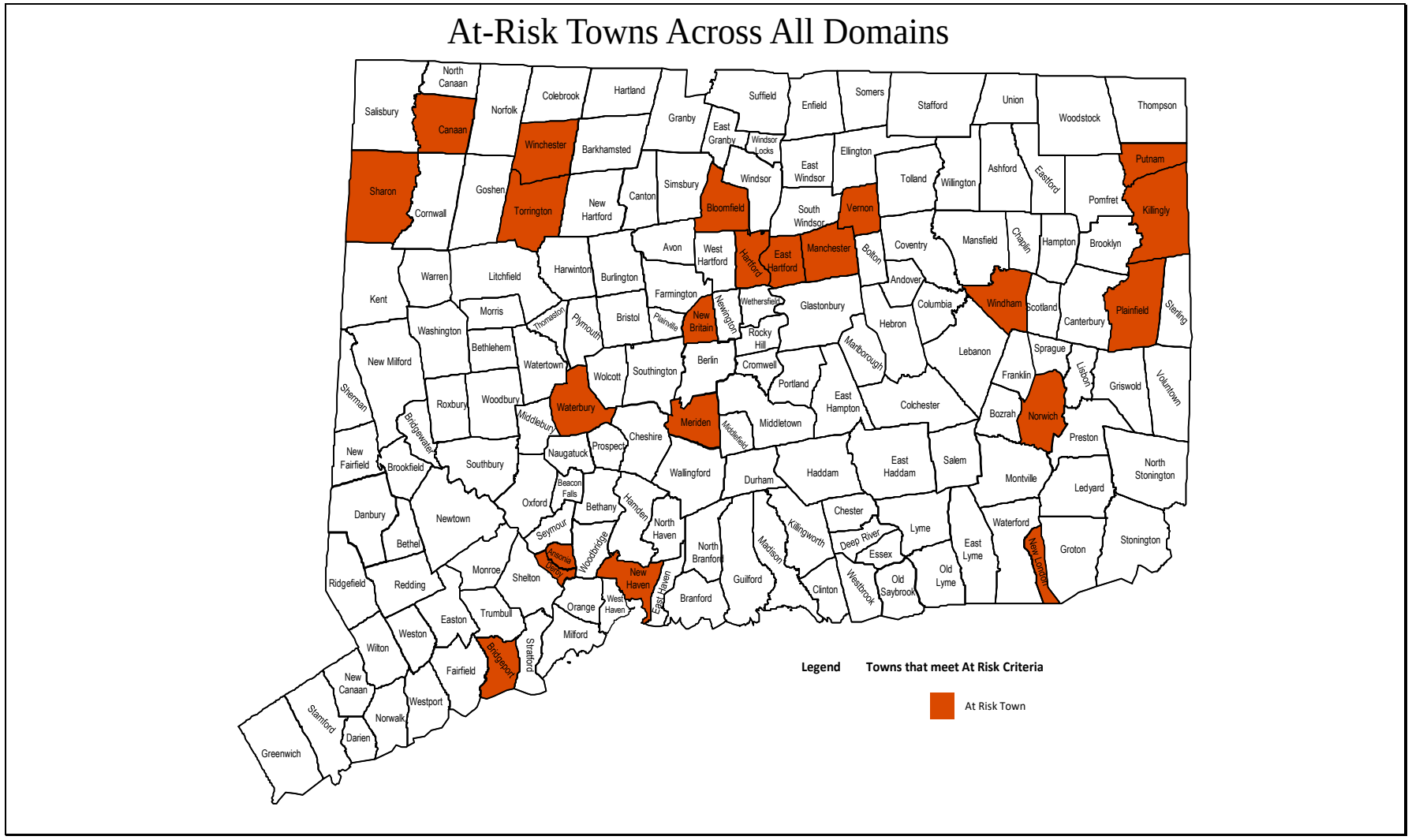
Map Appendix

The map appendix includes a map of the at-risk towns across all domains, detailed maps of each indicator, and the at-risk downs for each domains. The final page is a table of the specific indicators for each domain and the sources.

Table of Maps

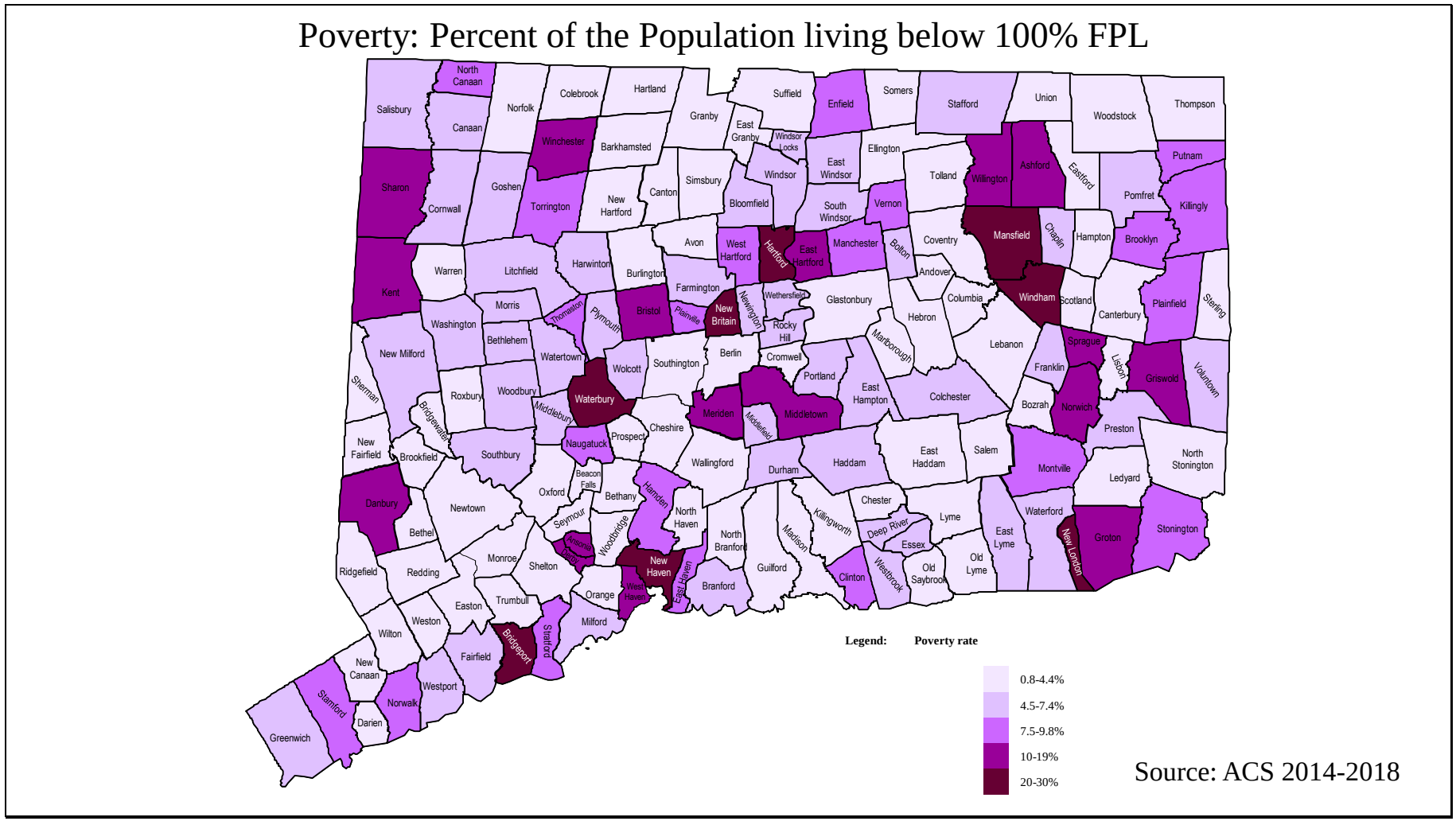
MIECHV Needs Assessment Maps

Map 1

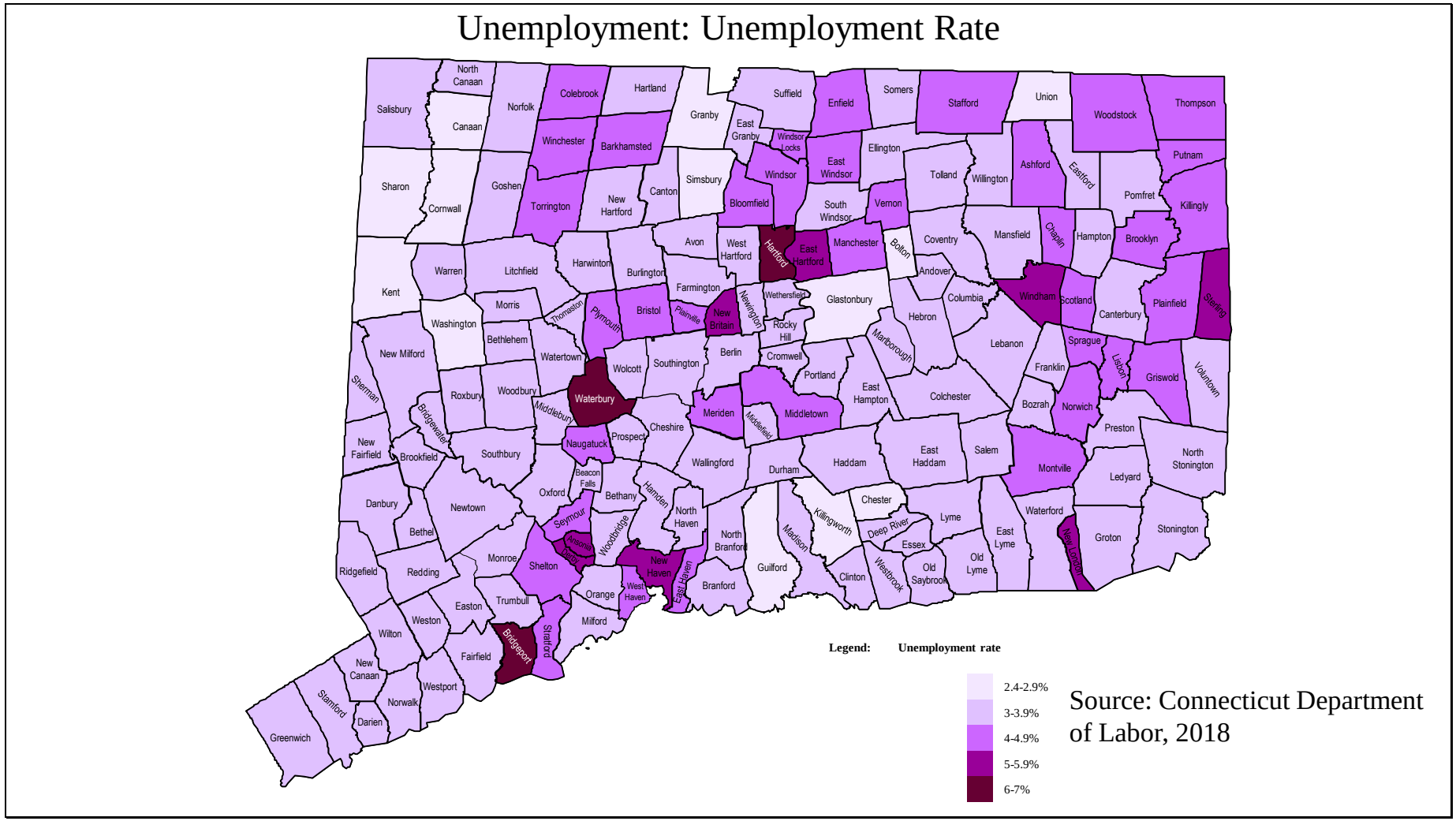

At-Risk Towns Across All Domains
Salisbury
North Canaan
Canaan
Norfolk
Colebrook
Hartland
Granby
Suffield
Enfield
Somers
Stafford
Union
Woodstock
Thompson
Sharon
Cornwall
Goshen
Torrington
Winchester
Barkhamsted
New Hartford
Canton
Simsbury
Bloomfield
Windsor
East Granby
Windsor Locks
East Windsor
Ellington
Tolland
Willington
Ashford
Eastford
Pomfret
Putnam
Killingly
Vernon
South Windsor
Manchester
East Hartford
Hartford
West Hartford
Avon
Harwinton
Burlington
Bristol
Plainville
New Britain
Newington
Wethersfield
Glastonbury
Rocky Hill
Berlin
Cromwell
Portland
East Hampton
Middletown
Middlefield
Meriden
Waterbury
Wolcott
Southington
Prospect
Cheshire
Naugatuck
Beacon Falls
Oxford
Seymour
Ansonia
Derby
Woodbridge
Bethany
Hamden
North Haven
New Haven
West Haven
East Haven
Orange
Milford
Stratford
Bridgeport
Fairfield
Trumbull
Monroe
Shelton
Easton
Weston
Redding
Ridgefield
Wilton
New Canaan
Westport
Norwalk
Darien
Stamford
Greenwich
Danbury
Newtown
Bethel
Brookfield
New Fairfield
Southbury
Roxbury
Woodbury
Middlebury
Watertown
Washington
Bethlehem
New Milford
Sherman
Bridgewater
Litchfield
Warren
Kent
Morris
Thomaston
Plymouth
Farmington
Hebron
Columbia
Andover
Bolton
Coverntry
Mansfield
Chaplin
Hampton
Brooklyn
Windham
Scotland
Canterbury
Plainfield
Sterling
Lebanon
Sprague
Franklin
Lisbon
Griswold
Voluntown
Bozrah
Norwich
Colchester
Marlborough
Preston
North Stonington
Montville
Ledyard
Salem
East Haddam
Haddam
Durham
Wallingford
Chester
Deep River
Essex
Lyme
Old Lyme
Old Saybrook
Westbrook
Clinton
Killingworth
Madison
Guilford
Branford
North Branford
Waterford
New London
East Lyme
Groton
Stonington
Legend
Towns that meet At Risk Criteria
At Risk Town

Socioeconomic Status

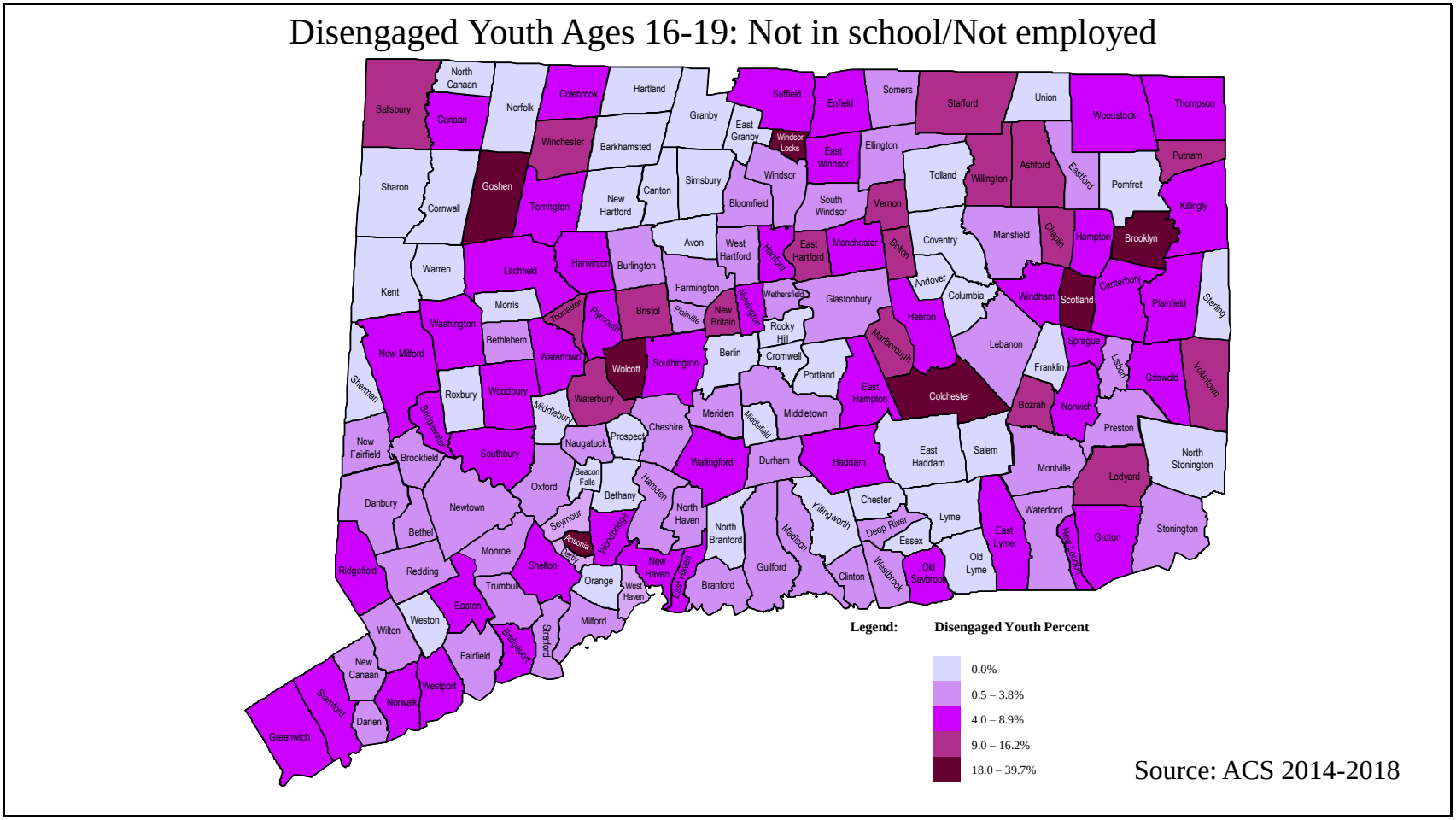
Map 2


Poverty: Percent of the Population living below 100% FPL
Salisbury
North Canaan
Canaan
Norfolk
Colebrook
Hartland
Granby
Suffield
Enfield
Somers
Stafford
Union
Woodstock
Thompson
Winchester
Barkhamsted
East Granby
Windsor Locks
Ellington
Putnam
Sharon
Cornwall
Goshen
Torrington
New Hartford
Canton
Simsbury
Windsor
East Windsor
Tolland
Willington
Ashford
Eastford
Pomfret
Killingly
Bloomfield
South Windsor
Vernon
Mansfield
Chaplin
Hampton
Brooklyn
Avon
West Hartford
Hartford
East Hartford
Manchester
Bolton
Coventry
Kent
Warren
Litchfield
Harwinton
Burlington
Farmington
Andover
Windham
Scotland
Canterbury
Plainfield
Sterling
Morris
Thomaston
Plymouth
Bristol
Plainville
New Britain
Newington
Wethersfield
Glastonbury
Columbia
Hebron
Rocky Hill
Washington
Bethlehem
Watertown
Wolcott
Southington
Berlin
Cromwell
Marlborough
Lebanon
Sprague
Franklin
Lisbon
Griswold
Voluntown
New Milford
Sherman
Roxbury
Woodbury
Waterbury
Middlebury
Meriden
Middletown
Portland
East Hampton
Colchester
Bozrah
Norwich
Bridgewater
Prospect
Cheshire
Middlefield
Preston
New Fairfield
Brookfield
Southbury
Naugatuck
Wallingford
Durham
Haddam
East Haddam
Salem
Montville
Ledyard
North Stonington
Danbury
Newtown
Oxford
Beacon Falls
Bethany
Hamden
North Haven
Chester
Lyme
Waterford
Groton
Stonington
Bethel
Seymour
Woodbridge
North Branford
Killingworth
Deep River
Essex
East Lyme
New London
Ridgefield
Redding
Monroe
Shelton
Ansonia
New Haven
West Haven
East Haven
Guilford
Madison
Clinton
Westbrook
Old Saybrook
Old Lyme
Branford
Orange
Trumbull
Easton
Weston
Wilton
Milford
Stratford
Bridgeport
Fairfield
New Canaan
Westport
Norwalk
Darien
Stamford
Greenwich
Legend: Poverty rate
0.8-4.4%
4.5-7.4%
7.5-9.8%
10-19%
20-30%
Source: ACS 2014-2018

Map 3

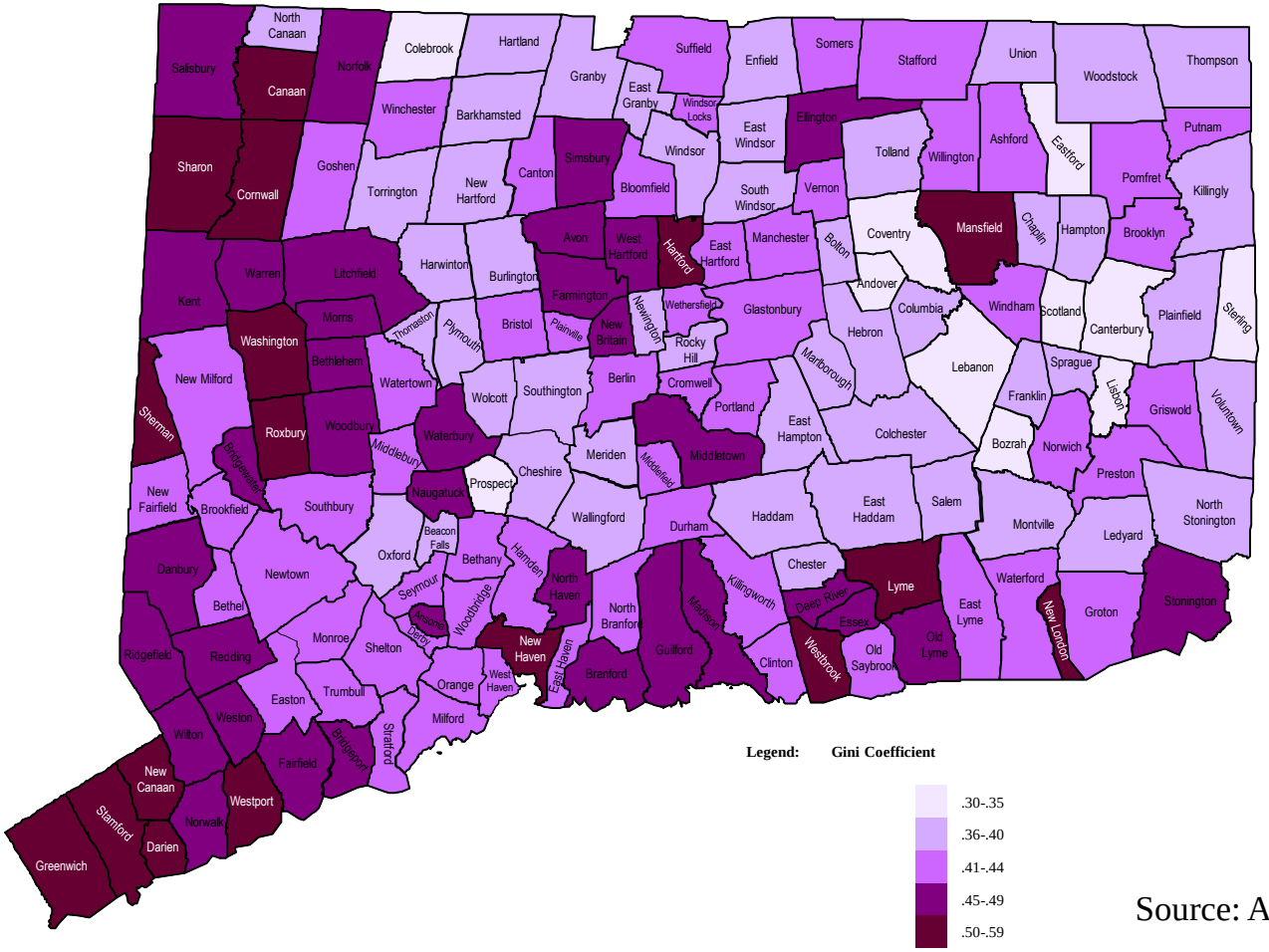

Unemployment: Unemployment Rate
Legend: Unemployment rate
2.4-2.9%
3-3.9%
4-4.9%
5-5.9%
6-7%
Source: Connecticut Department of Labor, 2018

Map 4


Disengaged Youth Ages 16-19: Not in school/Not employed
Legend:
Disengaged Youth Percent
0.0%
0.5 – 3.8%
4.0 – 8.9%
9.0 – 16.2%
18.0 – 39.7%
Source: ACS 2014-2018

Map 5

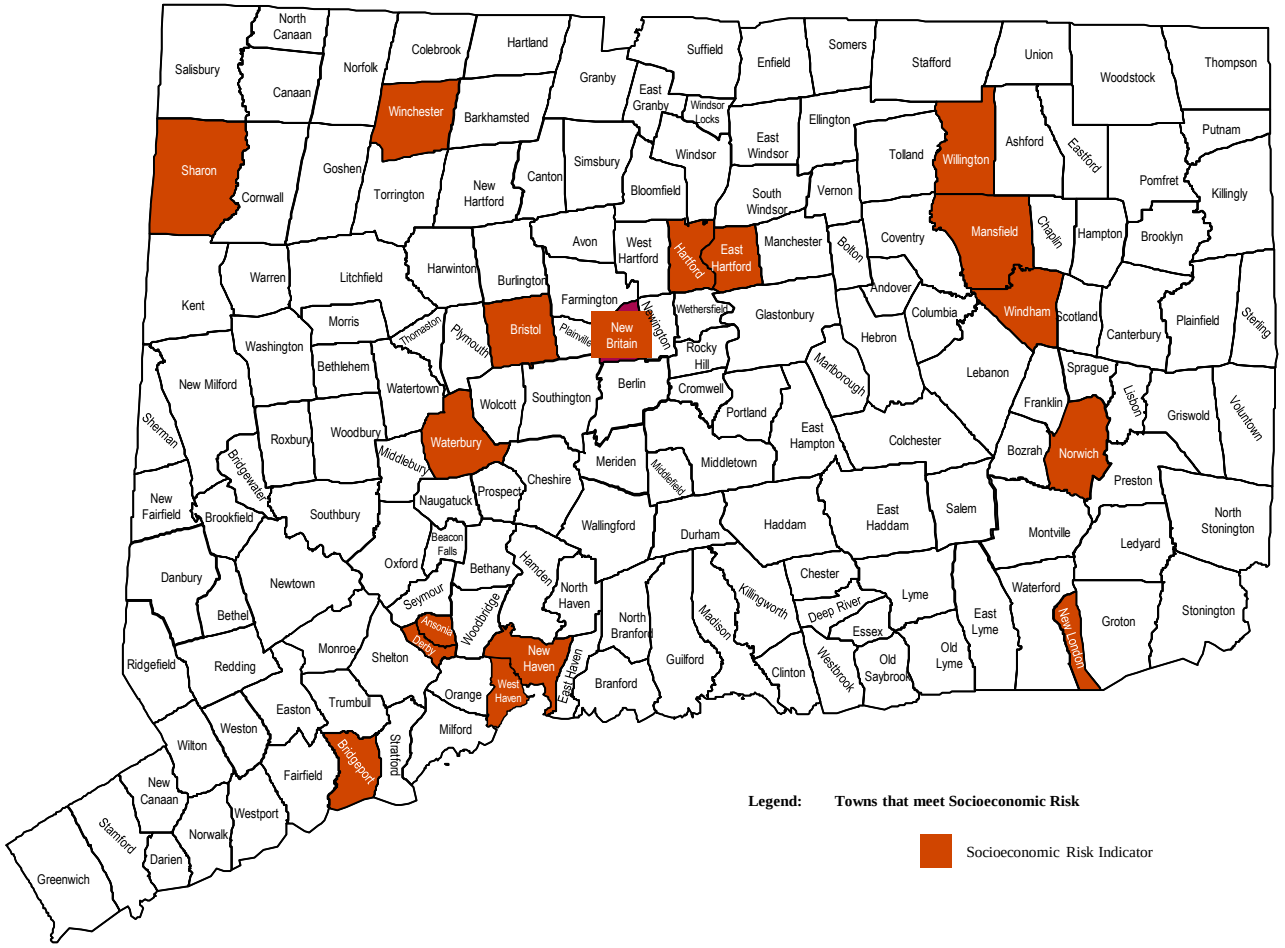
Income Inequality: Gini Coefficient



Source: ACS 2014-2018

Map 6

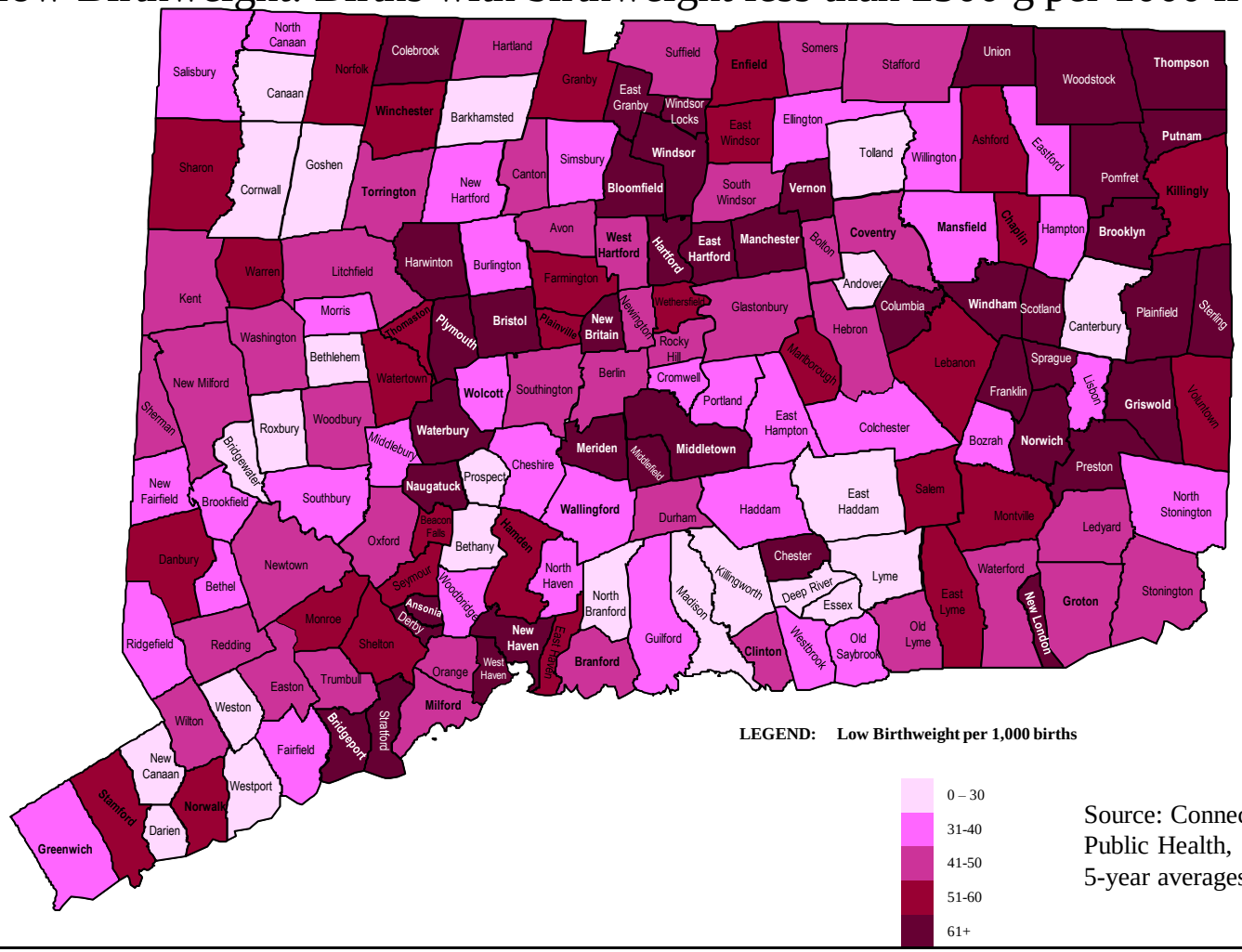
At-Risk Communities: Socioeconomic Status Domain



Adverse Perinatal Outcomes

Map 7

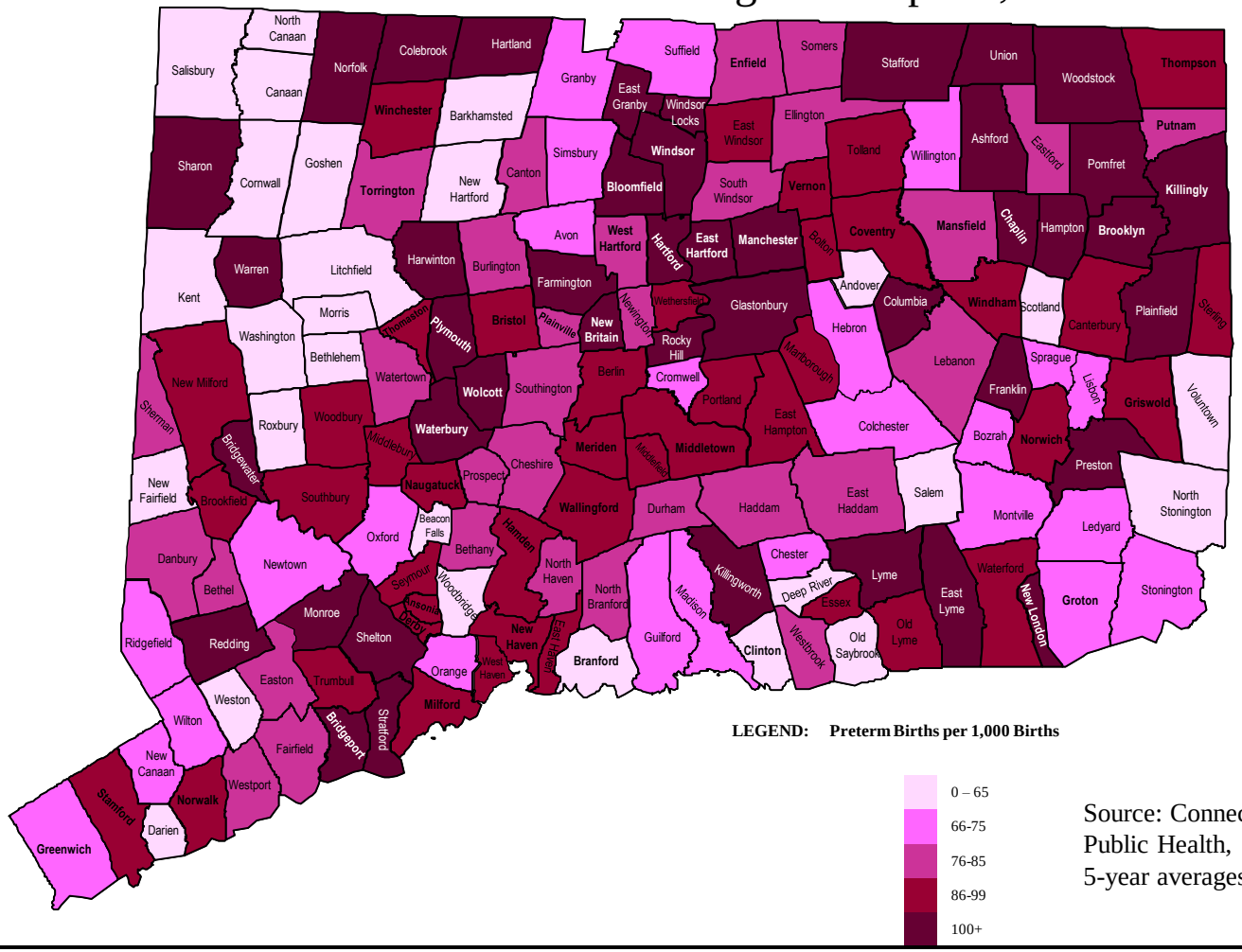
Rates of Low Birthweight: Births with birthweight less than 2500 g per 1000 live births



Source: Connecticut Department of Public Health,
5-year averages 2014-2018

Map 8

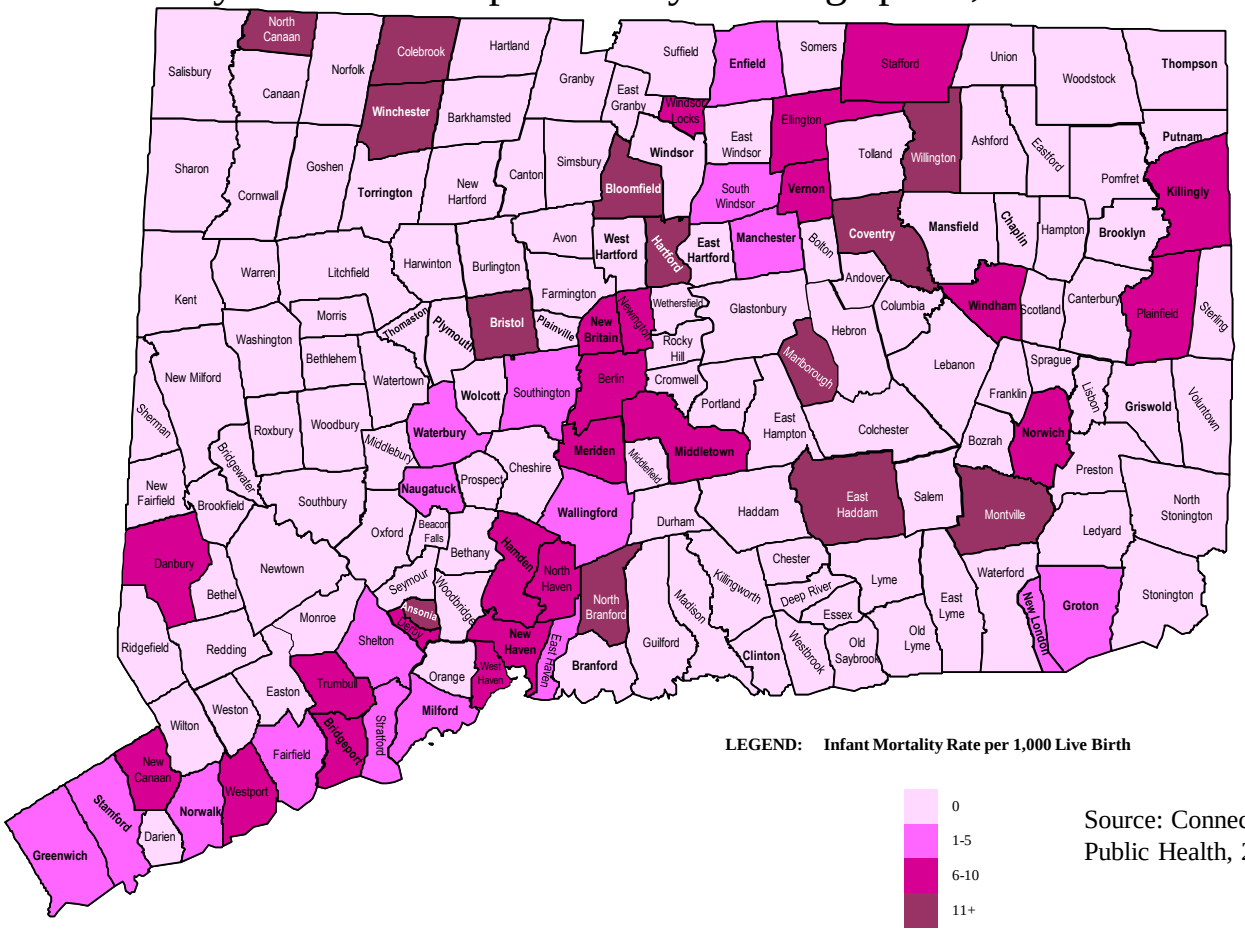
Preterm birth rates: Births less than 37 weeks gestation per 1,000 live births



Source: Connecticut Department of Public Health,
5-year averages 2014-2018

Map 9

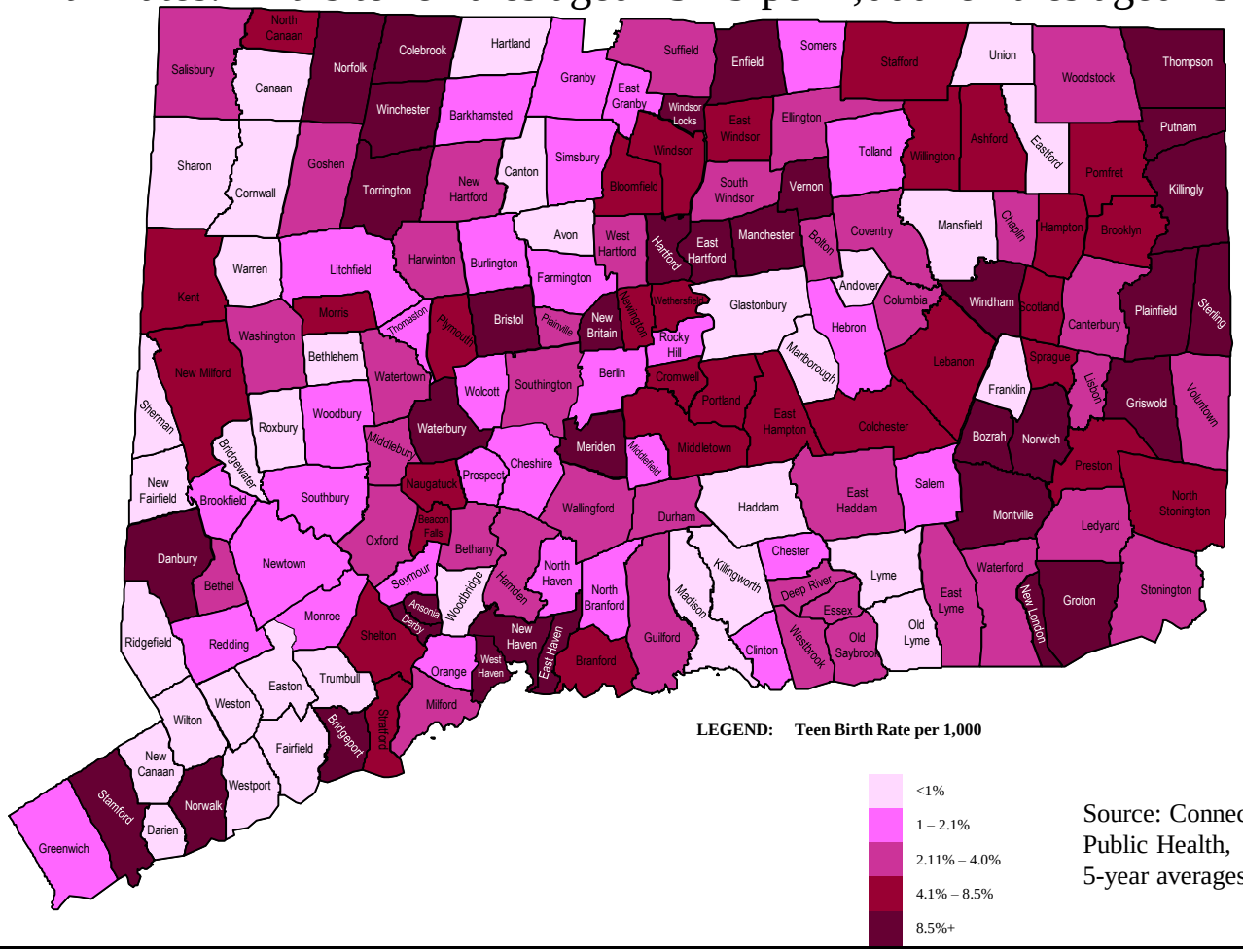
Infant Mortality Rate: Deaths prior to 1 year of age per 1,000 live births



Source: Connecticut Department of Public Health, 2018

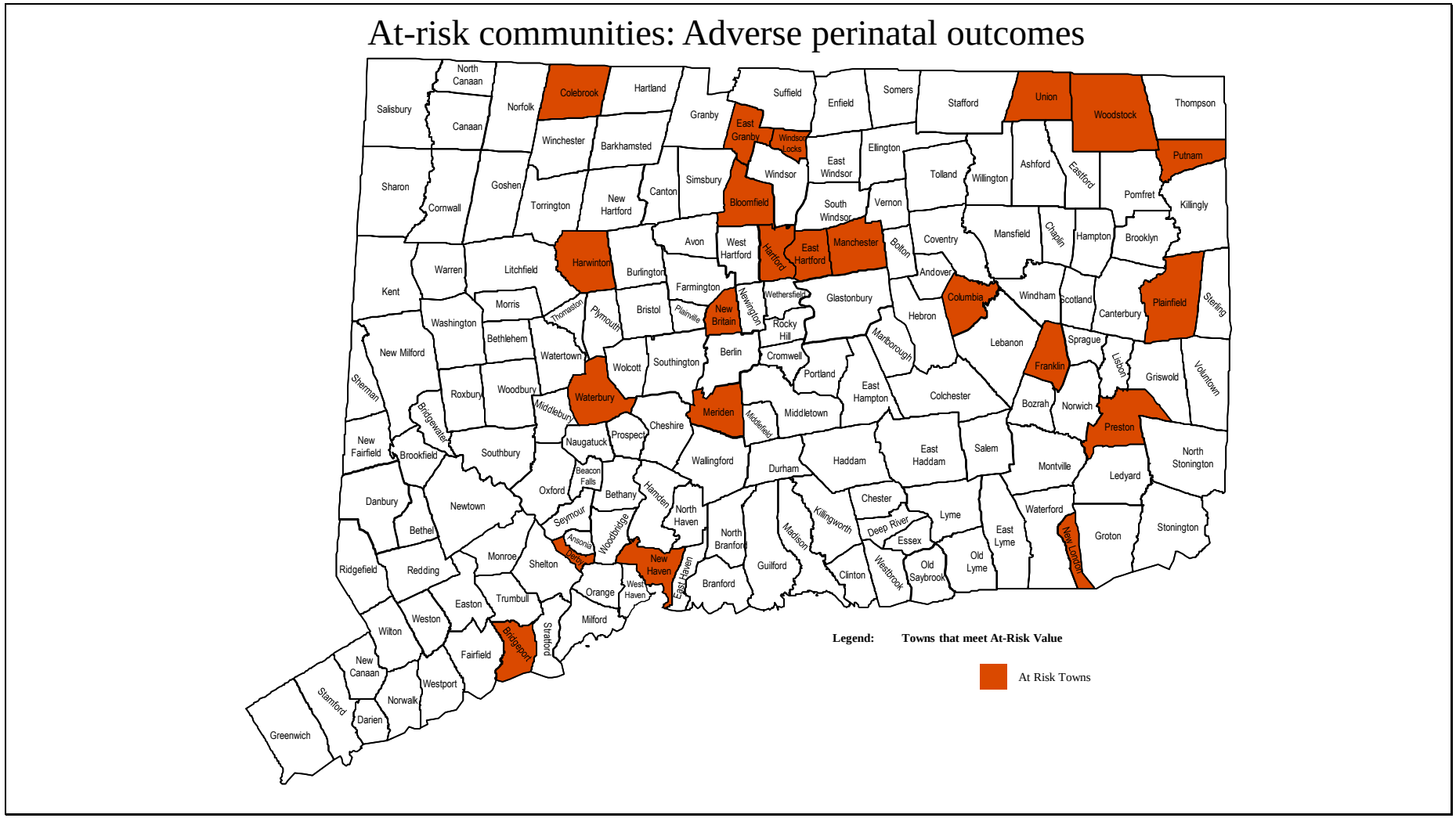
Map 10

Teen Birth Rates: Births to females aged 15-19 per 1,000 females aged 15-19



Source: Connecticut Department of Public Health,
5-year averages 2014-2018

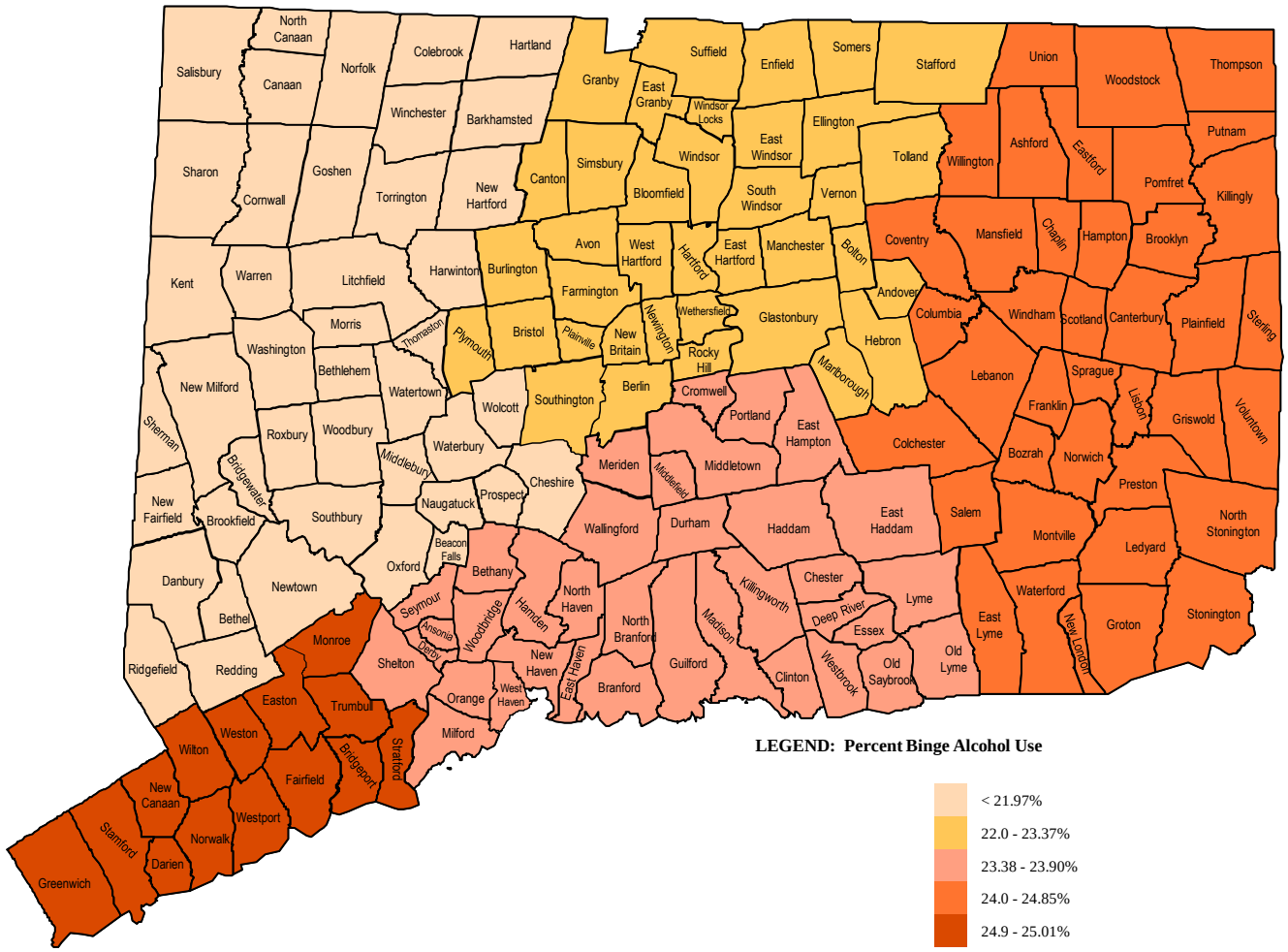
Map 11


At-risk communities: Adverse perinatal outcomes
Salisbury
North Canaan
Canaan
Norfolk
Colebrook
Hartland
Granby
Suffield
Enfield
Somers
Stafford
Union
Woodstock
Thompson
Putnam
Sharon
Cornwall
Goshen
Winchester
Torrington
Barkhamsted
New Hartford
Canton
Simsbury
East Granby
Windsor Locks
Bloomfield
Windsor
East Windsor
South Windsor
Ellington
Vernon
Tolland
Willington
Ashford
Eastford
Pomfret
Killingly
Kent
Warren
Litchfield
Harwinton
Burlington
Avon
West Hartford
Hartford
East Hartford
Manchester
Bolton
Coventry
Mansfield
Chaplin
Hampton
Brooklyn
Andover
Columbia
Windham
Scotland
Canterbury
Plainfield
Sterling
Morris
Thomaston
Plymouth
Bristol
Plainville
New Britain
Newington
Wethersfield
Glastonbury
Rocky Hill
Hebron
Lebanon
Sprague
Franklin
Lisbon
Griswold
Voluntown
Washington
Bethlehem
Watertown
Wolcott
Southington
Berlin
Cromwell
Portland
Marlborough
East Hampton
Colchester
Bozrah
Norwich
Preston
North Stonington
New Milford
Sherman
Roxbury
Woodbury
Bridgewater
Middlebury
Waterbury
Meriden
Middlefield
Middletown
Cheshire
Prospect
Naugatuck
New Fairfield
Brookfield
Southbury
Beacon Falls
Oxford
Bethany
Hamden
Wallingford
Durham
Haddam
East Haddam
Salem
Montville
Ledyard
Danbury
Newtown
Seymour
North Haven
Chester
Lyme
Waterford
Groton
Stonington
Bethel
Ansonia
Derby
Woodbridge
New Haven
North Branford
Killingworth
Deep River
Essex
East Lyme
New London
Ridgefield
Redding
Monroe
Shelton
Madison
Guilford
Clinton
Westbrook
Old Saybrook
Old Lyme
Easton
Trumbull
Orange
West Haven
East Haven
Branford
Wilton
Weston
Milford
Stratford
Bridgeport
New Canaan
Fairfield
Westport
Stamford
Norwalk
Darien
Greenwich
Legend:
Towns that meet At-Risk Value
At Risk Towns

Substance Use Disorder & Mental Health

Map 12

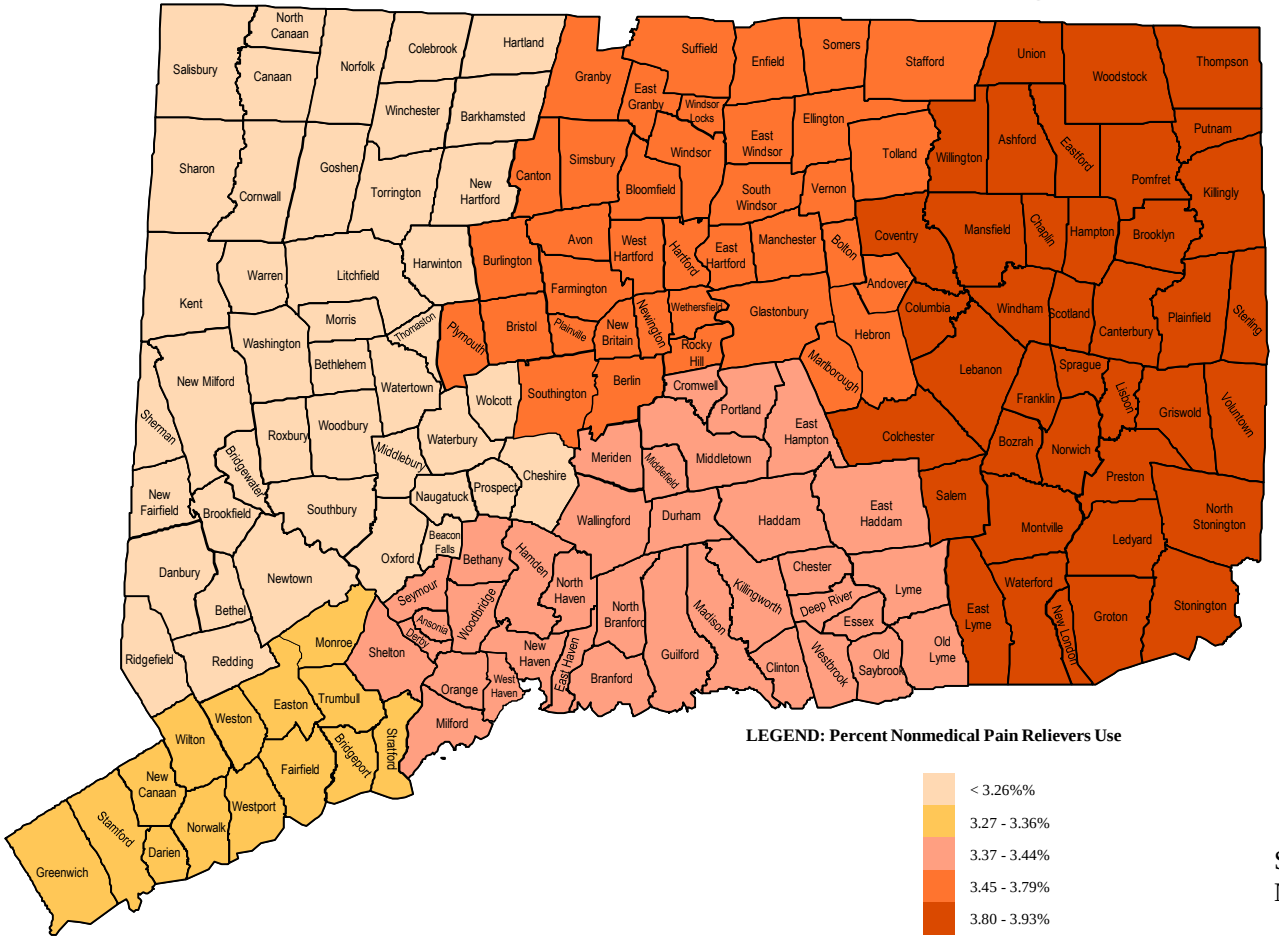
Binge Alcohol Use in Past Month Ages 12+



Source: SAMSHA
NSDUH 2012-14

Map 13

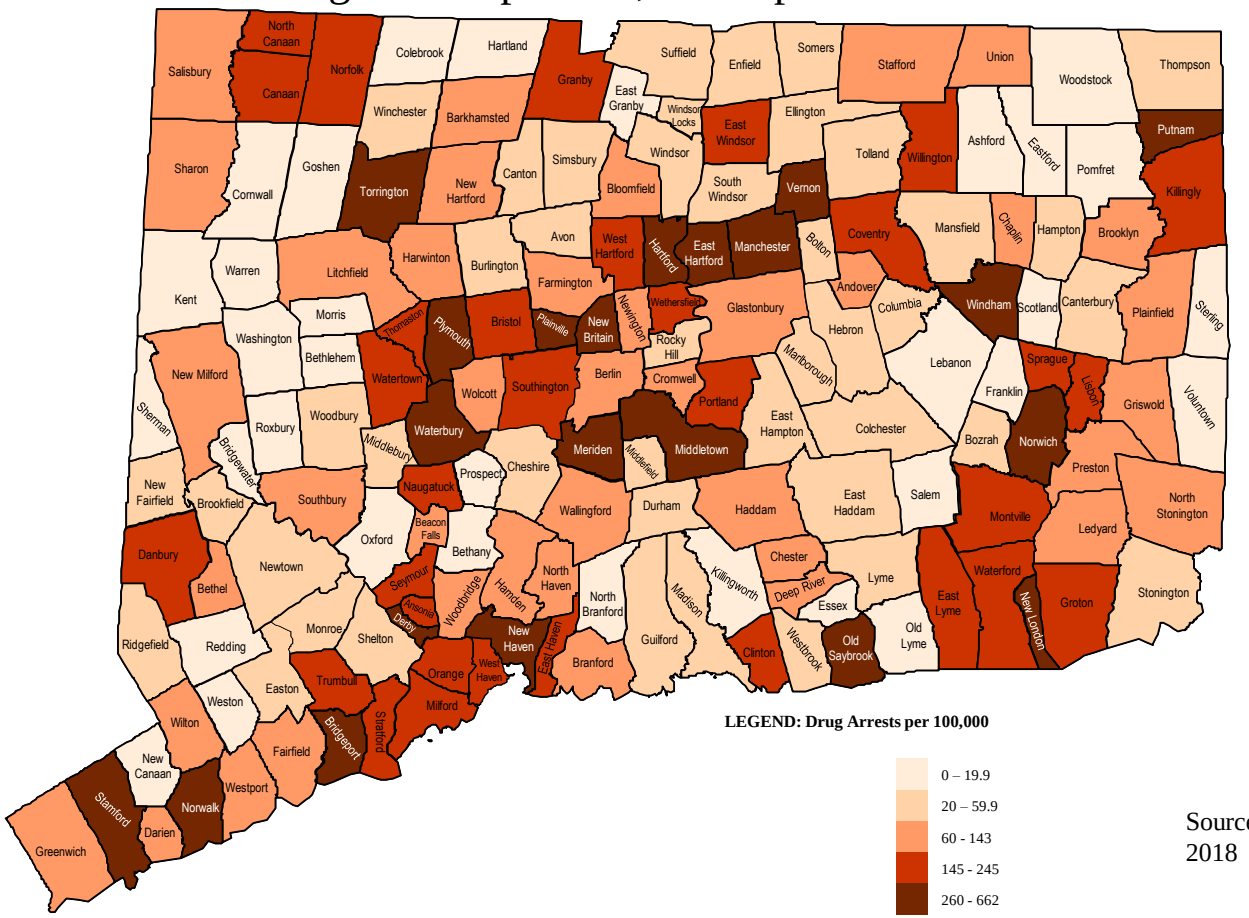
Nonmedical Use of Pain Relievers in Past Month, Ages 12+



Source: SAMSHA
NSDUH 2012-14

Map 14

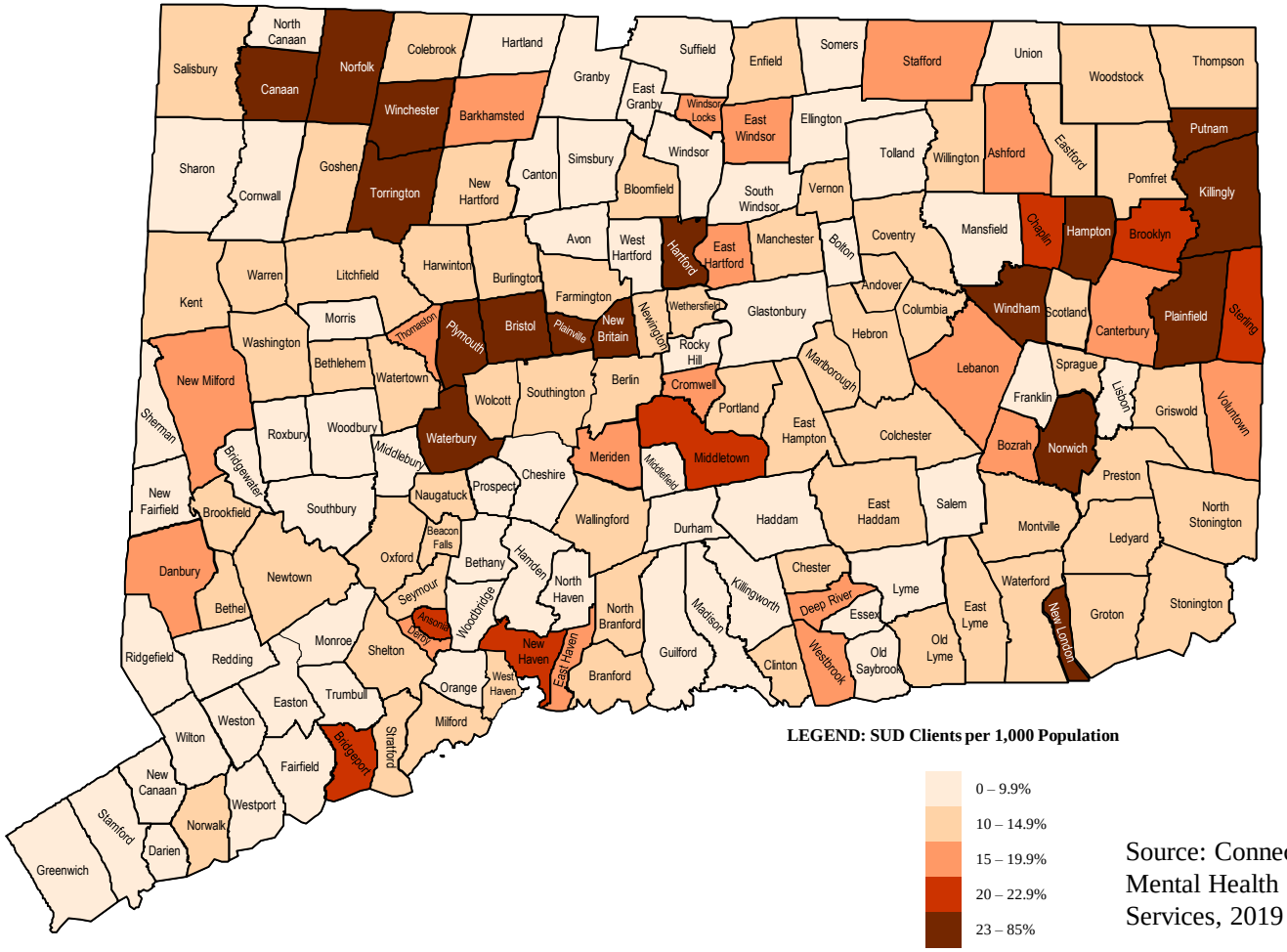
Drug Arrests per 100,000 Population



Source: CT DESPP, 2018

Map 15

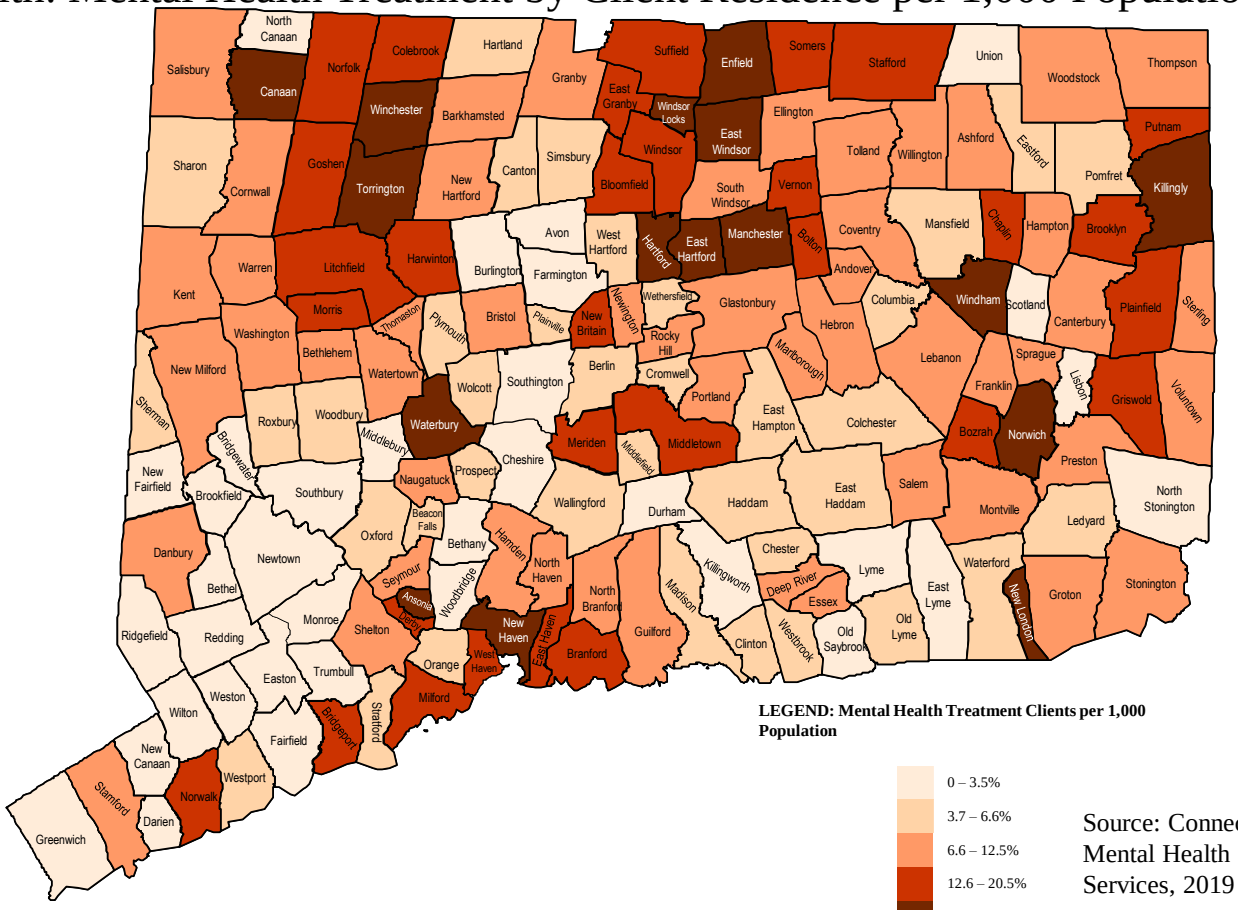
Substance Use Disorder: SUD Treatment by Residence per 1,000



Source: Connecticut Department of Mental Health and Addiction Services, 2019

Map 16

Mental Health: Mental Health Treatment by Client Residence per 1,000 Population



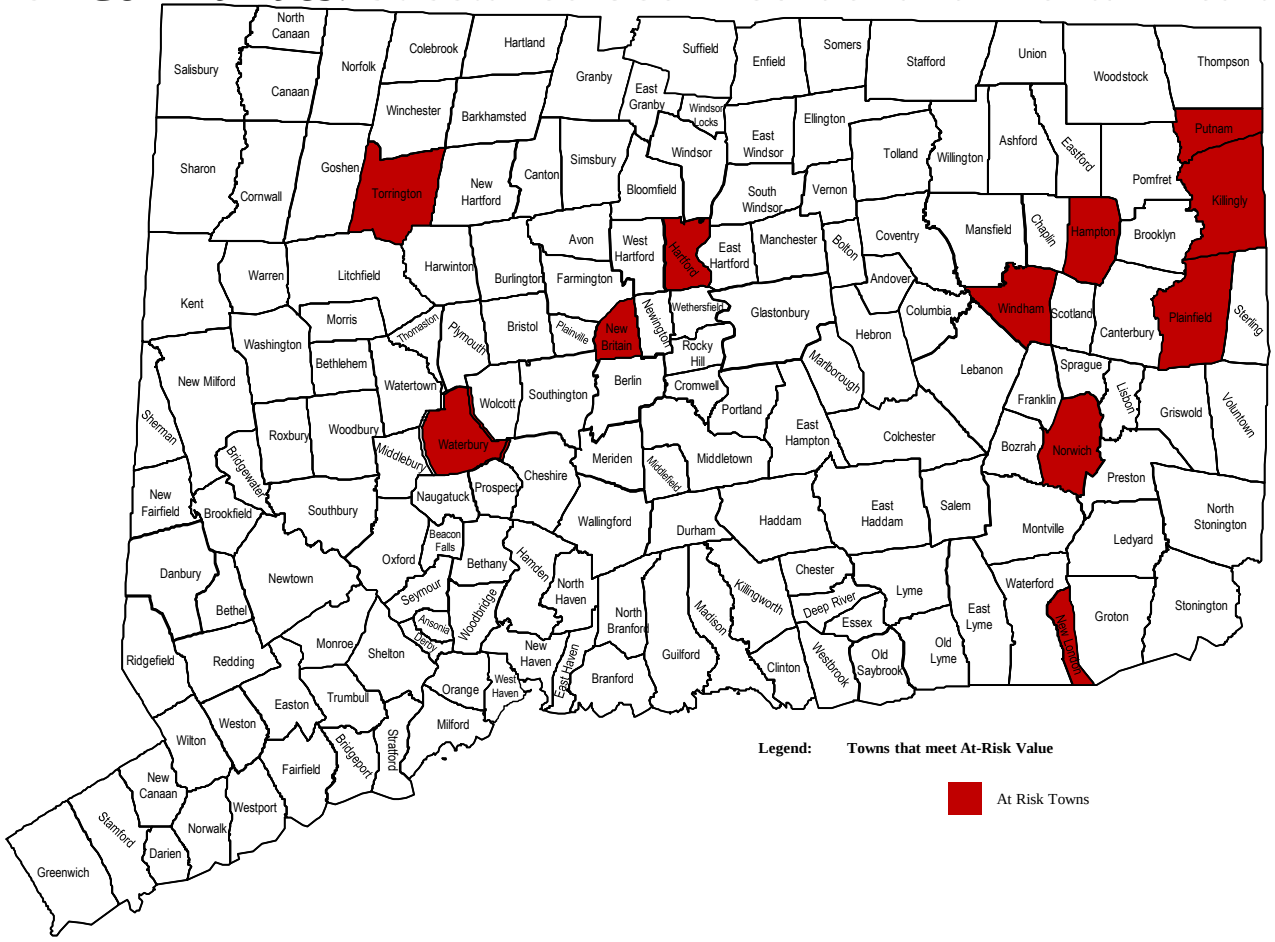
LEGEND: Mental Health Treatment Clients per 1,000 Population

- 0 – 3.5%
- 3.7 – 6.6%
- 6.6 – 12.5%
- 12.6 – 20.5%
- 23 – 45%

Source: Connecticut Department of Mental Health and Addiction Services, 2019

Map 17

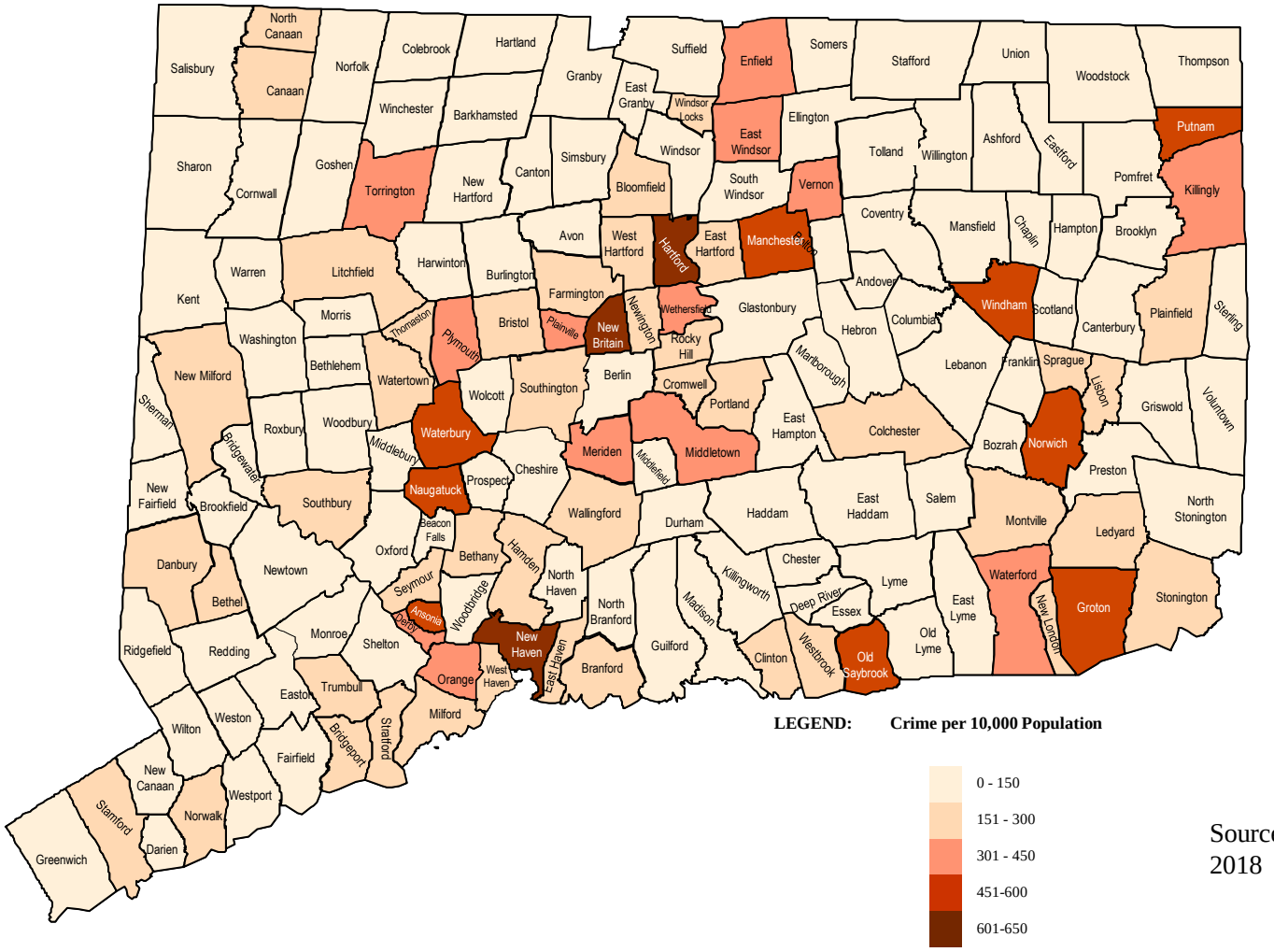
At-Risk Communities: Substance Use Disorder and Mental Health



Crime

Map 18

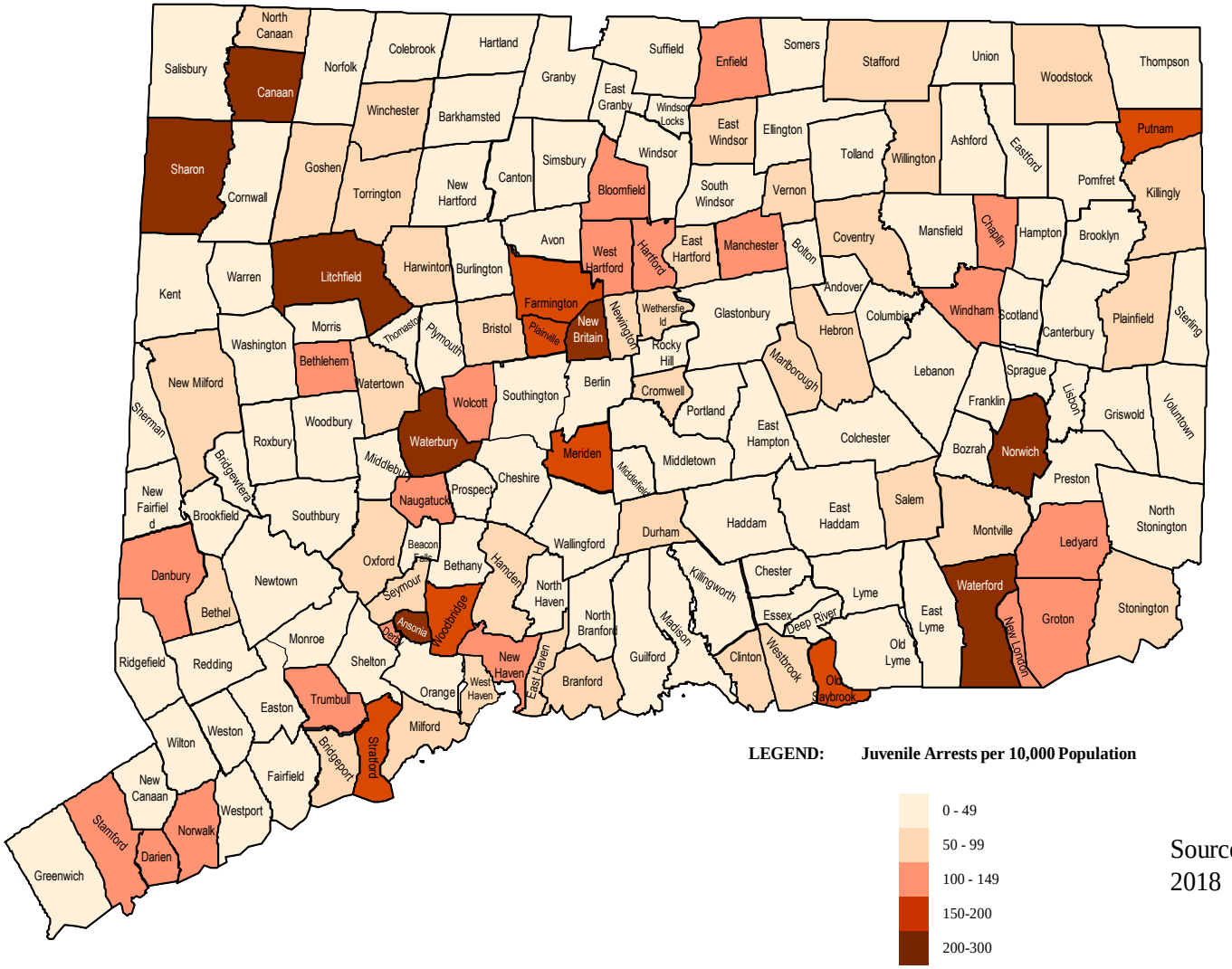
Crime rates per 10,000 persons



Source: CT DESPP, 2018

Map 19

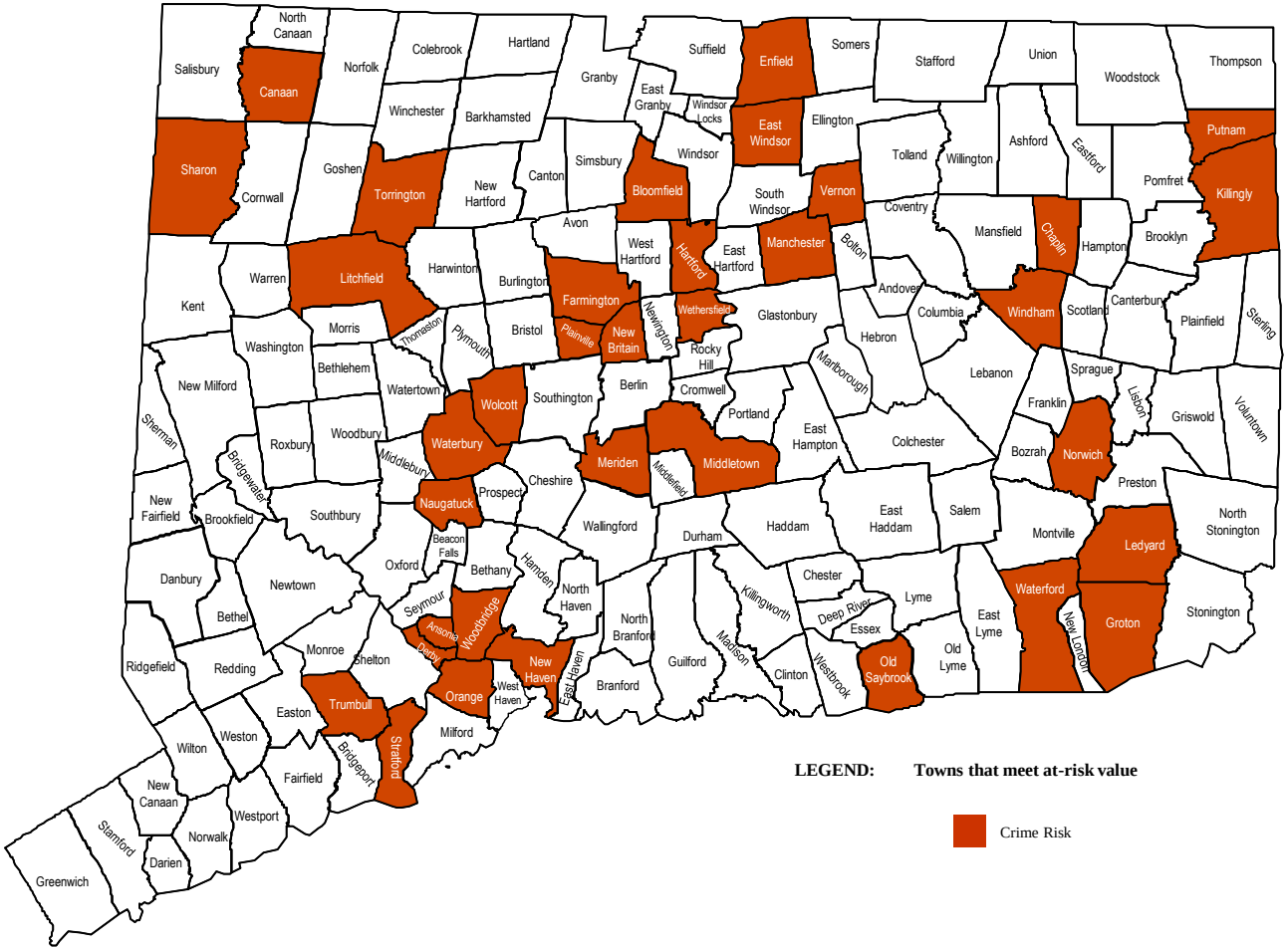
Juvenile Arrest Rates per 10,000 persons



Source: CT DESPP, 2018

Map 20

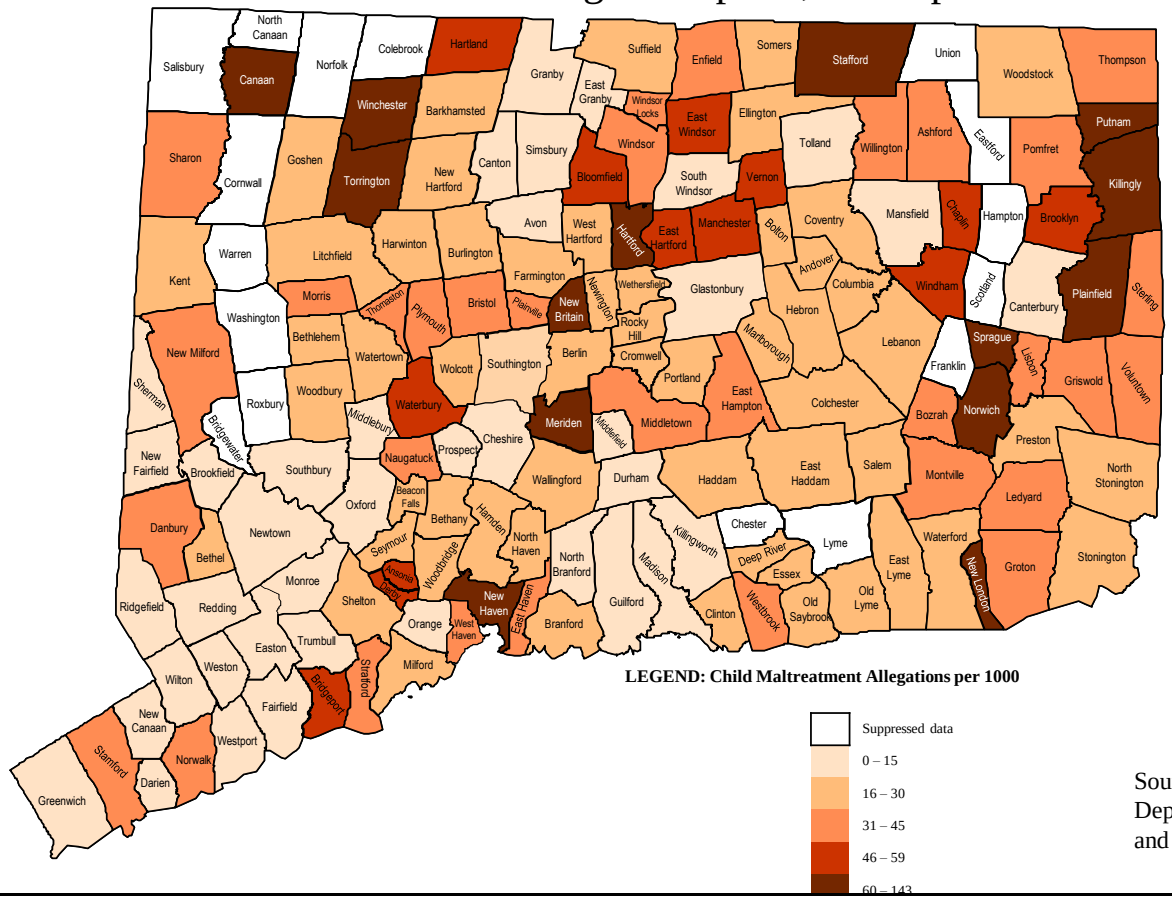
At-Risk Communities: Crime



Child Maltreatment

Map 21

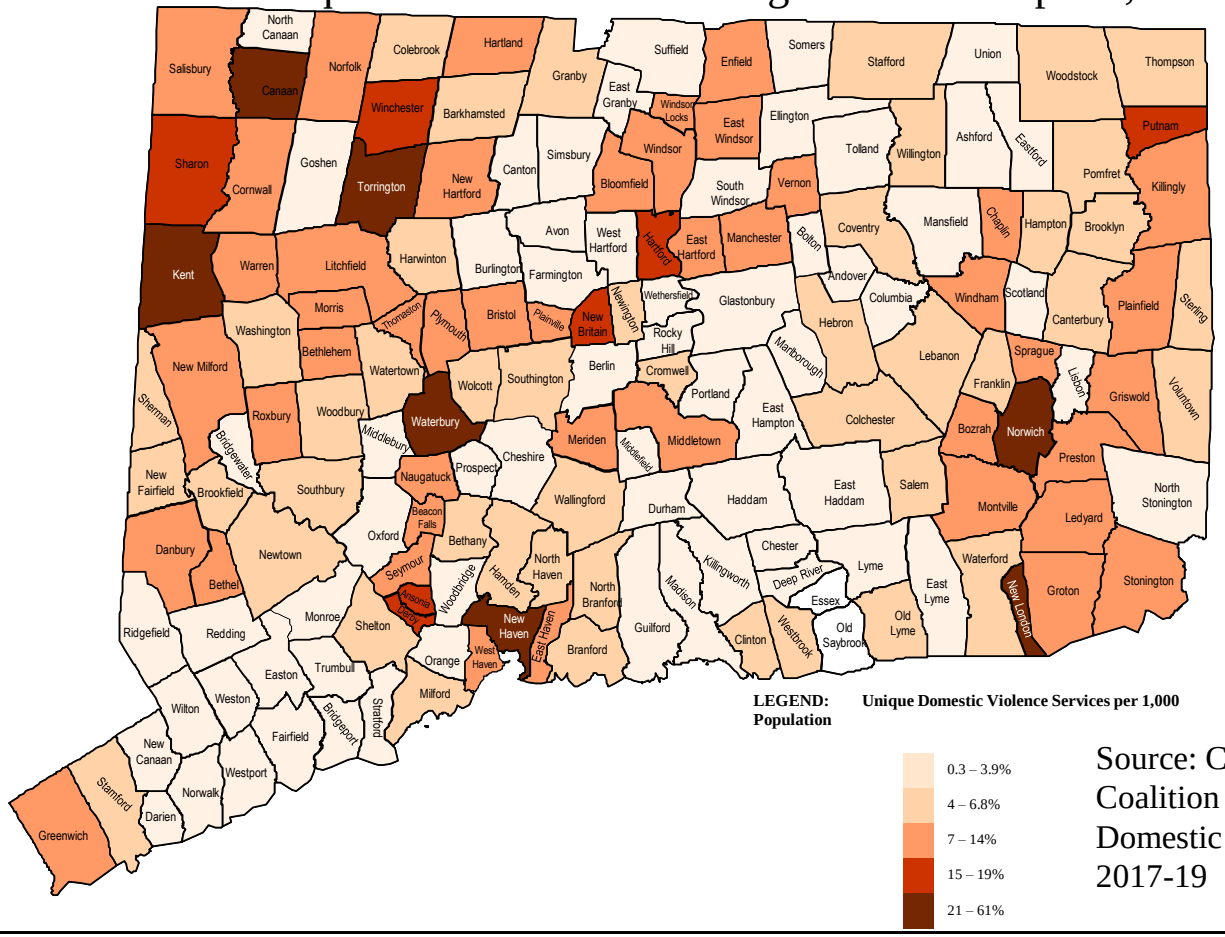
Child Maltreatment Rate: Allegations per 1,000 Population



Source: Connecticut Department of Children and Families, 2018

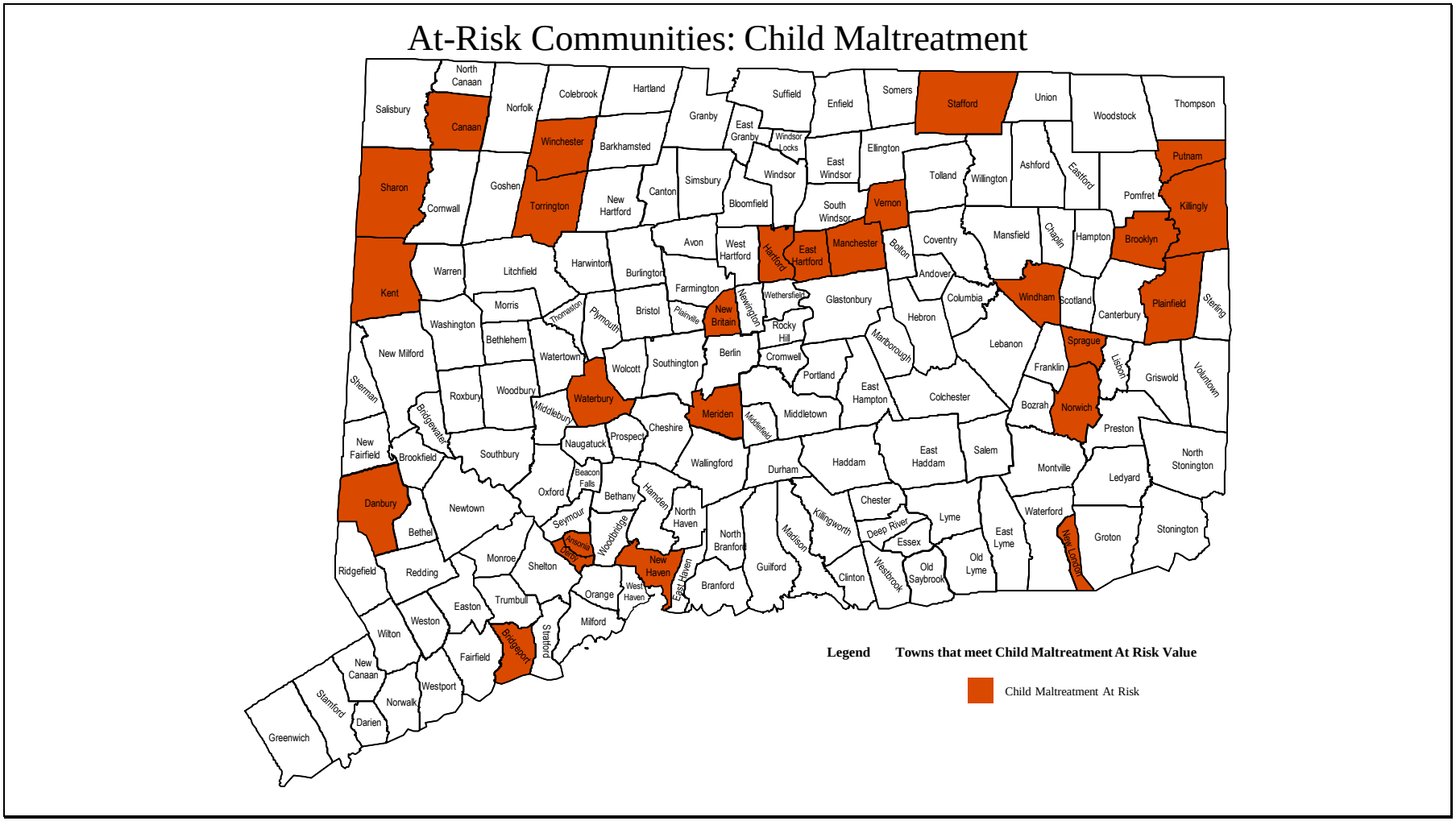
Map 22

Domestic Violence Rate: Unique Individuals Contacting DV Services per 1,000 Population



Source: Connecticut Coalition Against Domestic Violence, 2017-19

Map 23


At-Risk Communities: Child Maltreatment
Salisbury
North Canaan
Canaan
Norfolk
Colebrook
Hartland
Granby
Suffield
Enfield
Somers
Stafford
Union
Woodstock
Thompson
Winchester
Barkhamsted
East Granby
Windsor Locks
Ellington
Putnam
Sharon
Goshen
Torrington
New Hartford
Canton
Simsbury
Windsor
East Windsor
Tolland
Willington
Ashford
Eastford
Pomfret
Killingly
Cornwall
Bloomfield
South Windsor
Vernon
Kent
Warren
Litchfield
Harwinton
Burlington
Avon
West Hartford
Hartford
East Hartford
Manchester
Bolton
Coverntry
Mansfield
Chaplin
Hampton
Brooklyn
Morris
Farmington
Wethersfield
Glastonbury
Andover
Windham
Scotland
Plainfield
Sterling
Washington
Thomaston
Plymouth
Bristol
Plainville
New Britain
Newington
Rocky Hill
Hebron
Columbia
Canterbury
Bethlehem
Marlborough
Lebanon
Sprague
New Milford
Watertown
Wolcott
Southington
Berlin
Cromwell
Portland
Franklin
Lisbon
Griswold
Voluntown
Sherman
Roxbury
Woodbury
Waterbury
Middlebury
Meriden
Middlefield
Middletown
East Hampton
Colchester
Bozrah
Norwich
Bridgewater
Cheshire
Preston
New Fairfield
Brookfield
Southbury
Naugatuck
Prospect
Wallingford
Durham
Haddam
East Haddam
Salem
Montville
Ledyard
North Stonington
Beacon Falls
Danbury
Oxford
Bethany
Hamden
Chester
Lyme
Waterford
Newtown
Seymour
North Haven
Killingworth
Deep River
Essex
East Lyme
Groton
Stonington
Bethel
Ansonia
Derby
Woodbridge
New Haven
North Branford
Madison
Old Lyme
New London
Ridgefield
Redding
Monroe
Shelton
East Haven
Guilford
Clinton
Westbrook
Old Saybrook
Easton
Trumbull
Orange
West Haven
Branford
Weston
Milford
Wilton
Bridgeport
Stratford
Fairfield
New Canaan
Westport
Norwalk
Stamford
Darien
Greenwich
Legend
Towns that meet Child Maltreatment At Risk Value
Child Maltreatment At Risk

Data Dictionary

Map 31

Domain	Indicator	Year	Source	Source Link
Socioeconomic Status (SES)	Population in Poverty	2014-2018	ACS	http://data.ctdata.org/dataset/poverty-status-by-town
	Unemployment	2018	CT DOL	https://www1.ctdol.state.ct.us/lmi/digest/pdfs/cedjun19.pdf
	Disengaged Youth	2014-2018	ACS	http://data.ctdata.org/dataset/disengaged-youth
	Income Inequality	2014-2018	ACS	http://data.ctdata.org/dataset/gini-ratio
Adverse Perinatal Outcomes	Preterm Birth	2014-2018	CT DPH	File received by OEC
	Low Birth Weight	2014-2018	CT DPH	File received by OEC
	Teen Pregnancy	2014-2018	CT DPH	https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports
	Infant Mortality	2018	CT DPH	https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports
Substance Use Disorder	Binge Alcohol Use	2012-2014	SAMSHA	https://www.samhsa.gov/data/sites/default/files/NSDUHsubstateExcelTabs2014/NSDUHsubstateExcelTabs-2014.xlsx
	Non-medical Use Pain Relievers	2012-2014	SAMSHA	https://www.samhsa.gov/data/sites/default/files/NSDUHsubstateExcelTabs2014/NSDUHsubstateExcelTabs-2014.xlsx
	Drug Arrests	2018	CT DESPP	https://portal.ct.gov/-/media/DESPP/Division-of-Crimes-Analysis/2018_Crime_in_CT_Final.pdf?la=en
	SUD Treatment	2019	CT DMHAS	https://portal.ct.gov/-/media/DMHAS/EQMI/Annual-Report-SFY2019.pdf
	Mental Health Treatment	2019	CT DMHAS	https://portal.ct.gov/-/media/DMHAS/EQMI/Annual-Report-SFY2019.pdf
Crime	Crime Reports	2018	CT DESPP	https://portal.ct.gov/-/media/DESPP/Division-of-Crimes-Analysis/2018_Crime_in_CT_Final.pdf?la=en
	Juvenile Arrests	2018	CT DESPP	https://portal.ct.gov/-/media/DESPP/Division-of-Crimes-Analysis/2018_Crime_in_CT_Final.pdf?la=en
Child Maltreatment	Child Maltreatment	2018	CT DCF	https://catalog.data.gov/dataset/ct-dcf-abuse-neglect-reports-and-allegations-by-town-and-state-fiscal-year-56a71
	Domestic Violence	2017-2019	CTCADV	File received by OEC

This page intentionally left blank.