CHR CNA

2024 Community Needs Assessment

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SUBMITTED BY HOLLERAN

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COMMUNITY ENGAGEMENT RESEARCH & CONSULTING

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COMMUNITY NEEDS ASSESSMENT OVERVIEW

Introduction

In 2024, CHR, an essential, comprehensive behavioral healthcare provider, undertook a Community Needs Assessment (CNA), a systematic approach to identifying community needs and determining program capacity to address the needs of the population being served. The population being served is children, adults and families, with emphasis on individuals with serious mental illness (SMI), substance use disorders (SUD), opioid use disorders (OUD) and children with serious emotional disorders (SED) in northcentral CT. The aim of the assessment was to reinforce CHR's commitment to the mental and behavioral health of residents and align its mental health prevention efforts with the community's greatest needs. The assessment examined a variety of mental health and substance use indicators including, but not limited to, mental health and substance use status, disparities among population groups, access to care, and awareness of services. The CNA identified current conditions and key mental health and substance use issues in the community, based on data and input from key community stakeholders. CHR contracted with Holleran Consulting, a research firm based in Wrightsville, Pennsylvania, to execute this project.

The completion of this CNA enables CHR to take an in-depth look at its community, allowing it to address the availability and accessibility of its services as well as the cultural and treatment needs for its population. The findings from the assessment will be utilized by CHR to prioritize issues related to mental health and substance use and develop a community health implementation plan focused on meeting community needs. CHR is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CNA Final Summary Report serves as a compilation of the overall findings of two research components.

CNA Components

- Secondary Data Profile
- Online Key Informant Survey

Organization Overview

CHR is the largest, most comprehensive behavioral health provider in the region, with strong collaborations with two co-located Federally Qualified Health Centers (FQHCs) and the only comprehensive Methadone program in the catchment area. Guided by compassion and respect, CHR transforms lives by offering hope. The organization received a Gold Seal of Approval from the Joint Commission demonstrating that CHR meets or exceeds quality and safety standards. It was recently accredited by the National Commission on Correctional Health Care for opioid treatment programs in six jails and prisons. Also, CHR is the first nonprofit behavioral healthcare agency in Connecticut to meet all of the strict federal criteria associated with certification as a Certified Community Behavioral Health Clinic (CCBHC).

CHR is focused on real solutions and effective care to meet the needs of children, families and adults

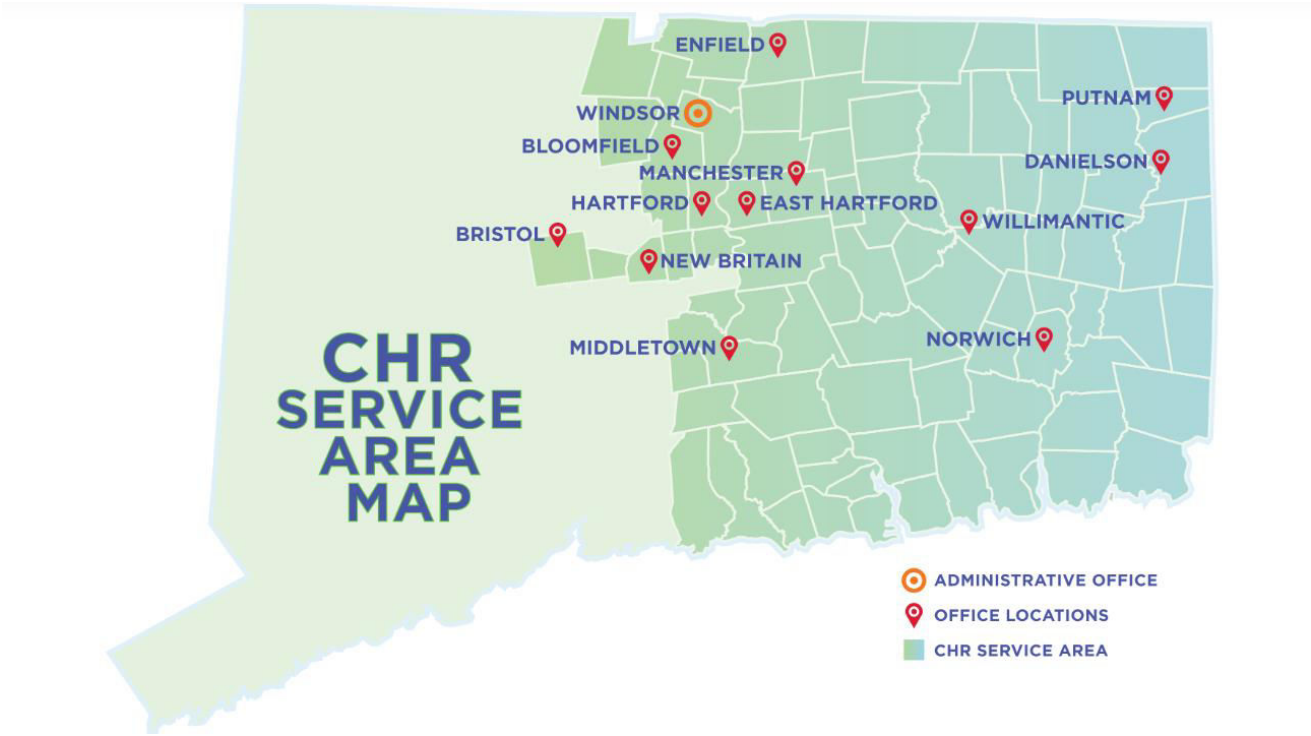
who are struggling with depression, anxiety, addiction, housing insecurity and much more. The organization responds to these needs through community partnerships, for example, its ongoing work with the Department of Correction and its collaboration with the Department of Children and Families to expand emergency mental health for youth. Its Diversity, Equity and Inclusion (DE&I) Roadmap established four priority areas for ongoing work including enhancing staff development, creating a just and inclusive culture, improving communication and becoming a more diverse community. Finally, CHR continues its tradition of advocating on the state and national stage for individuals and families with the most serious mental health, substance use and housing needs in 2024.

Service Area Overview

With its main locations in Enfield and Manchester, Connecticut, CHR provides services in the northcentral portion of the state. Locations include Bloomfield, Danielson, East Hartford, Putnam, Willimantic, Middletown, Norwich, and Windsor. The service areas consists of 5 counties as follows.

- Hartford
- Tolland
- Windham
- Middlesex
- New London

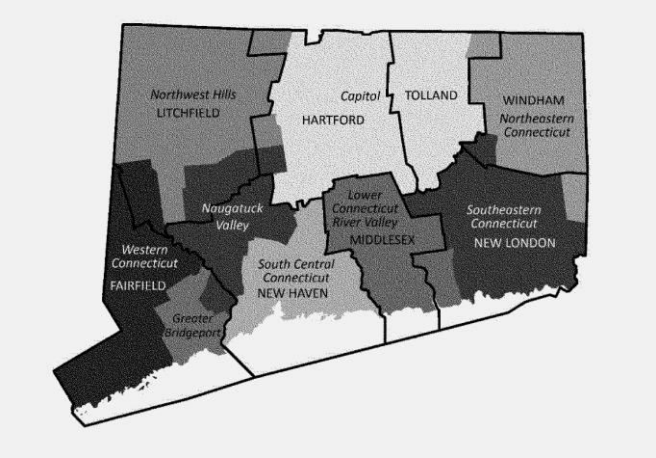
Service locations are identified on the map called CHR Service Area which encompasses these 5 counties.



CNA Methodology

The CNA is comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below:

A Statistical Secondary Data Profile compiles existing data from local and national sources depicting population and household statistics, health care access, mental health status, substance use status, and disparity statistics linked to social determinants of health for the service area. As of January 1, 2024, Connecticut is providing data via planning regions and not counties. Select demographic data supplied by the U.S. Census will be presented for 4 regions (Capitol, Northeastern CT, Southeastern CT and Lower CT River Valley) which are closely aligned geographically to the 5 counties. The regions are depicted below.



Also, data provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) is available for a separate set of regions (North Central, South Central and Eastern) and not counties.

County Health Rankings data is provided by county, 5 of which are in the CHR service area (Hartford, Tolland, Middlesex, Windham, New London). When available, county, state, regional and national comparisons were made. National comparisons include United States data, National Benchmark data from County Health Rankings and Healthy People 2030 (HP 2030) goals.

An Online Key Informant Survey was conducted with a total of 47 key informants between March 4 and 22, 2024. Key informants are defined as community stakeholders with expert knowledge, including public health and healthcare professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other community leaders. Key informants responding to this survey included participants from mental health and substance use treatment facilities, government/housing and transportation, social services, youth services, community members and hospitals. Questions focused on the most significant mental health and substance use issues in the service areas, awareness of the availability of services, access to services, underserved populations and top health issues.

Research Partner

CHR contracted with Holleran, an independent research and consulting firm located in Wrightsville, Pennsylvania, to conduct research in support of the CNA. Holleran has over 25 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted data from secondary data sources
- Collected, analyzed, and interpreted data from key informants through an online survey
- Prepared a final CNA report

Community Representation

Community engagement and feedback were an integral part of the CNA process. CHR sought community input through key informant surveys with community leaders and partners. Public health

and health care professionals as well as leaders and representatives of non-profit and community-based organizations shared knowledge about mental health and substance use and provided insight about the community, including underserved populations as well as gaps in services.

Research Limitations

As with all research efforts, there are some limitations related to this study's research methods that should be acknowledged. In some cases, local-level data may be limited or dated. This is an inherent limitation with secondary data. The most recent data are used whenever possible. In addition, timeline and other restrictions may have impacted the ability to survey all community stakeholders. CHR sought to mitigate limitations by including representatives who serve diverse and underserved populations throughout the research components.

Social Determinants of Health

An individual's health is influenced by numerous factors including a range of personal, social, economic, and environmental factors known as social determinants of health. These reach beyond the boundaries of traditional healthcare into public health sectors and can be important allies in improving population health. Addressing social determinants of health is important for improving health outcomes and reducing disparities. Research demonstrates that lower educational attainment, poverty, and race/ethnicity are risk factors for certain health conditions.

The U.S. Department of Health and Human Services Healthy People 2030, addresses conditions in the environment in which people are born, live, learn, work, play, worship, and age. The conditions affect a wide range of health, function, and quality-of-life outcomes and risks. Healthy People 2030 groups these determinants into 5 domains; economic stability, education access and quality and healthcare.

Throughout this report, data related to the social determinants of health and their impact on county, region, state and national health is provided.


Social Determinants of Health
Education Access and Quality
Health Care Access and Quality
Economic Stability
Neighborhood and Built Environment
Social and Community Context
Social Determinants of Health
Copyright-free
Healthy People 2030

KEY MENTAL HEALTH AND SUBSTANCE USE FINDINGS

The components of the CNA come together to reveal a unique perspective of the mental and behavioral health and substance use status of residents living in the service area. The key findings represent themes which have been pulled from the Secondary Data Profile and the Key Informant Survey and highlight the key takeaways that stand out across the research components, as found by the Holleran team. A number of health and social issues were found in both components and are worthy of attention by CHR.

The CHNA identified substantial issues related to the availability of and the ability to access health and support services, housing and income issues and significant mental health and substance abuse issues impacting the health of the service area population. These are detailed in this report and summarized in the Key Findings. In addition to the issues identified, many respondents to the Key Informant Survey made sure to mention that there are a number of issues that are being handled well in the community. These include

- Newly instituted same day appointments
- School awareness and empowerment programs
- Education about the MindMap initiative
- Public education about the dangers of opioids
- New programming in prisons
- The existence of many dedicated professionals
- Improved community collaboration
- Diversity and equity training and gender affirming care
- Funding for peer recovery resources

A summary of each of the Key Health Issues that were identified follows and each issue is supported by primary and secondary data as well as powerful comments by Key Informants. The key findings are presented alphabetically as follows.

- Accessing Mental Health/Substance Use Treatment
- Adolescent and Adult Mental Health
- Affordable Housing and Income and Other Social Supports
- Substance Use and Other Risk Behaviors

Accessing Mental Health/Substance Use Treatment

The ability to access health care services is key to community health. Identifying and decreasing barriers which impede access can markedly improve the mental health and well-being of individuals and families. Several measurable factors, including health insurance coverage, mental health provider density, and the awareness of services help describe the difficulty in accessing services for some populations and limited services in portions of the CHR service area.

The percentage of the population with health insurance is higher in all 4 regions that make up the CHR service area than in the state and in the United States. About 95% of individuals in all regions are

covered by health insurance. The Healthy People 2030 goal related to health care access is "Increase the proportion of people with health insurance" under the age of 65. The target is 92.4% of all people will have health insurance. The percentage of individuals in Hartford City with health insurance coverage is lower (90.5%). A high percentage of Hartford City residents who do have insurance have public coverage (53.0%), including Medicaid. Positively, the percentage of the population with health insurance is higher than this target in the service area. However, the Lack of or Insufficient Health Insurance Coverage (66.0%) were identified by Key Informants as barriers to receiving treatment.

Key informants were asked to address the issue of provider and program accessibility. As part of the Key Informant Survey, 57.4% of respondents ranked Access to Care among the Top 5 Health Issues for the community. They were also asked to agree or disagree with statements that address the sufficiency of mental health/substance use services, Medicaid or financial assistance, bilingual services and prevention education and outreach. For both mental health and substance use, an overwhelming majority disagree that Treatment Providers, Medicaid or Financial Assistance Providers, Bilingual Providers and Prevention, Education and Outreach are available. The results indicate that the lack of bilingual providers (selected by 82.6% of Key Informants) is particularly strong. "Significant staffing issues causes waitlists where individuals become more severe while waiting on services" and "There are not enough prevention or support programs available. The system is set up to be more reactive vs. proactive."

Often, the emergency room is used as a replacement when healthcare providers are not present or accessible in a community. 41.3% of Key Informants selected the Hospital Emergency Department as the first place a majority of individuals go when they are in need of mental health and substance use treatment. "It is often the Emergency Rooms that get inundated with the underserved populations, making themselves more vulnerable and invisible to the EDs because they are now 'frequent flyers' that aren't taken seriously anymore." Far fewer respondents (15.0%) selected their Primary Care Provider or Family Doctor (19.6%) as the first line of treatment. Social Service Agency/Non-Profit Community Provider follow closely behind.

Social and financial support issues also reflect the ease of access to mental health and substance use services in a community. The most commonly identified reason that individuals do not seek treatment is that they are Not Ready for Treatment (selected by 72.3%). However, financial issues such as the Inability to Pay out of Pocket Expenses (68.1%) are also identified as barriers. 18.6% of Key Informants perceived Primary Care Services to be unaffordable, commenting "Reimbursement rates have barely changed in over a decade yet cost of living has skyrocketed."

Key to the utilization of treatment services is whether or not community members are aware of available services or understand mental health and substance use issues. Key Informants were asked about the community's awareness of mental health and substance use issues. The vast majority of respondents perceive that the public does not understand mental health (80.8%) or substance use (82.9%) issues. "There are gross misunderstandings about mental health and addiction. What folks think

they know is fueled by fear. " Responses were mixed as they relate to community residents knowing where to get treatment for mental health and substance use issues. About one-third believe that individuals know where to access treatment while about the same think that they do not. One Key Informant remarked "I believe most people know where to start to get services for MH/SA issues." On the other hand, "Mental health and substances abuse is talked about more frequently than it has been in the past, which is wonderful. However, due to limited resources or bad experiences or fear of services and what they mean, people struggle to engage."

Adequacy of Mental Health and Substance Use Services

The adequacy and availability of treatment and prevention services impacts the mental health of the community and may disproportionately affect select populations. The availability of trained professionals, gaps in programming and the ease (or difficulty) in navigating the mental health system were measured in this CNA.

Provider density is the ratio of population to healthcare provider. In Connecticut, there is one mental health provider for every 218 individuals (population). The ratio is better in Hartford County (168 individuals per provider) but far worse in Tolland County (347 individuals per mental health practitioner). In terms of comparison, the National Benchmark is 240:1. One Key Informant provided reasons for the lack of trained professionals. "Providers in this field are overworked, underpaid and overregulated, which is why more and more providers are leaving the field." Diversity of providers, including a lack of providers of color was mentioned as well.

However, Eastern and South Central Connecticut (which are two of 5 regions defined by SAMHSA and within CHR's service area) have the highest percentage of population receiving mental health services in the past year (17.6%). All 3 regions in the service area exceed the state (17.1%) and the nation (14.7%) which is very favorable. Although this points to higher utilization, it may also be interpreted as an indication that there is a greater need.

Limited availability of mental health and substance use services may be challenging in specific areas. The Health Resources and Services Administration (HRSA) designates mental health areas as Health Professional Shortage Areas (HPSAs) which are geographic areas of populations that lack enough health care providers to meet the health care needs of that population. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. Hartford County appears to have more areas designated as HPSAs than other counties in the CHR service area, indicating an area of need and one with limited resources for county residents. All 5 counties have some areas of shortage for mental health professional shortages. Key informants (61.7%) confirmed this by finding mental health and substance use services lacking in the community. "The lack of capacity in 28 and 30-day substance treatment programs means that clients are often discharged from detox to the streets, or often can't access rehabilitation programs if they're not abusing a substance that requires a medically monitored detox."

Respondents were asked to rank the adequacy of mental health and substance use services by age cohorts. Half or more of Key Informants disagree that mental health services are adequate for teens (ages 13 to 17), young adults (ages 18 to 25), adults (ages 26 to 64), and seniors (ages 65 and over). Almost half of respondents (46.6%) disagree that there are adequate mental health services for children (birth to age 12). As it pertains to substance use, a majority of respondents (more than 50%) disagree or strongly disagree that services are adequate for teens, young adults and seniors. Responses were mixed as to whether or not substance use services are adequate for adults. One respondent expressed concern for all age groups, "I believe the mental health/substance use and child welfare systems of care are all currently inadequate to meet the needs/demands of the child/adult populations served. I believe a good portion of that is due to lack of staffing and workforce issues that escalated during COVID and have not resolved."

The inadequacy of services can lead to a rise in underserved populations. Although 63.8% of Key Informants perceive that those without insurance are the most underserved group, there are still more than half (51.1%) who feel that those with private health insurance but who are unable to afford their out-of-pocket expenses are also underserved. Over one-third (38.3%) also selected those with public health insurance (Medicaid) as underserved. This demonstrates that both groups, the underinsured and the uninsured, are perceived to be underserved populations.

Key Informants were asked if there are specific Racial/Ethnic Populations, as well as any other population groups, such as Homeless, Disabled, etc., who are underserved in terms of receiving mental health and substance use services. Black/African American (70.2%) is perceived by most to be underserved. This is followed by Latino/Hispanic (57.4%). "(We) need more clinical staff who are of color who are serving the community they represent." The Homeless, those who are Uninsured or Underinsured and those with Low Incomes are also perceived by most to be underserved. "We are struggling every day to try to figure something out for a handful of clients in my programs that are homeless and on the street."

Finally, respondents were asked their opinions about system gaps that exist in the community. According to respondents, Long Waiting Lists (85.1%) and Insurance Barriers (70.2%) create a gap in services. A Lack of Providers and Support to Navigate the Mental Health System are also at the top of the list. "Often times when individuals seek help, they get placed in boxes and are unable to seek all the resources that are needed to help support them. The systems are hard to navigate, the forms are confusing to complete and collaboration struggles occur." The Lack of Programming and Providers was also selected by 46.8% of Key Informants as a barrier to seeking treatment. Key Informants mentioned the lack of evening and weekend treatment appointments as well.

Adolescent and Adult Mental Health

The mental health and risk behaviors of adolescents and adults were examined. Although several groups report being in fairly good mental health, data for depression, anxiety and suicide in several counties and regions indicate that severe mental health issues are prevalent. This is particularly true in

Hartford, Tolland and Windham counties and Eastern Connecticut.

In Connecticut during 2012 to 2016[1], 83.7% of adult residents reported being in good mental health. During 2016, this was greatest among younger adults, men, Hispanic adults, adults with higher incomes and educational levels and adults without disabilities. However, adults in Hartford (city) have a lower good mental health percentage (77.3%) than the state. Nationally, the average number of mentally unhealthy days in the past month reported is 4.0 days and in Connecticut it is 4.3 days. The number of mentally unhealthy days is higher than this in all counties and is highest in Windham County (4.8 days). There is also some concern in Windham County for disconnected youth who are defined as being ages 16 to 19 and neither in school nor working. The percentage of disconnected youth in Windham County (6.9%) is much higher than in Connecticut (4.8%). However, the county is similar to the National Benchmark for disconnected youth which is 7.0%.

Key Informant survey respondents were asked to identify the Top 5 Health Issues affecting their service area. The most important health issue, ranked by 87.2% of respondents as number one, is Mental Health/Suicide. When asked to rank the Top 3 most pressing mental health issues in the community, an overwhelming majority selected Trauma (68.1%), followed by Anxiety (57.4%) and Depression (51.1%). When asked to select the most significant mental health issues, respondents also selected Trauma (26.2%) and Anxiety (23.8%). "The individuals I work with have experienced trauma from a young age; affecting their basic development which has an impact of their thinking, emotional regulation and abilities to interact with others in a healthy way." As it pertains to children and teenagers Key Informants commented, "Youth in the program use drinking, marijuana and vaping to cope with their trauma and depression" and "There are increasing behavioral health concerns among teenagers and young adults. There is lack of insight about the danger of racism, sexism, antisemitism and hate towards LGBTQ+ individuals."

Key Informants were also asked to estimate the percentage of cases where a mental health diagnosis is also accompanied by a substance use or addition problem, known as co-occurring disorders. Almost 45% estimate that this happens 51% to 75% of the time. "The population served now has more co-occurring issues than ever. Psychiatric issues and substance use issues feed off each other making the challenges extreme."

The perceptions of Key Informants are substantiated with data from SAMHSA which tracks several indicators related to mental illness, suicide and depression. According to SAMHAS, Eastern Connecticut (which includes Windham and New London counties) has the highest percentage in the past year of mental illness (20.2%) and serious thoughts of suicide (4.6%) among the regions in the CHR service area. North Central Connecticut (parts of Tolland and Hartford counties) and Eastern Connecticut have the highest percentage of a major depressive episode (7.3%). In the state, one in 6 adults in 2020 was diagnosed with depression (17.7%). The risk of depression in Connecticut is highest

[1] More recent data were not found.

among adults aged 18 to 34 (22.5%), females (22.8%), non-Hispanic White (19.0%), adults from households earning less than $35,000 (26.0%) and $335,000 to $74,999 (18.4%), adults with health insurance (18.5%) and adults with a disability (35.9%). Overall, the prevalence of depression in Connecticut has climbed since 2016 when it was 15.9%.

These higher-than-average statistics point to poor outcomes for residents. The age-adjusted suicide rate per 100,000 is highest in Tolland County (16.0). In all counties in the service area, the suicide rate is higher than it is in Connecticut (11.1) with the exception of Hartford County (10.3). The Healthy People 2030 target related to suicide is defined as 12.8 per 100,000 age adjusted population. Hartford and Middlesex counties and Connecticut meet this target but the rate in Tolland and New London counties is concerning.

Affordable Housing and Income and Other Social Supports

Financial challenges including finding affordable housing, paying medical bills, buying nutritious food, and dealing with transportation costs can create distress for some populations in the service area. This affects their ability to support their families, seek healthcare and feel healthy. One Key Informant summed up the impact from these challenges. "I would imagine that this added stress and trauma of not being able to afford basic needs is impacting people's mental and physical well-being, and people may be deciding to not access healthcare in order to pay for other essentials."

Finding affordable housing, particularly for those who rent rather than own their own homes is difficult. To assess this, the severe housing cost burden in an area is measured. Thirty percent (30%) of a household's total income is considered the cut off for housing-cost burden and avoiding financial hardship. Renters in all 4 regions in the service area spend from 41.1% (Northeastern CT) to 47.0% (Capitol Region) on housing costs which include rent, utilities and other expenses. This is much higher than the benchmark 30%, creating hardship. In Hartford City, 55.1% of renters are housing-cost burdened. According to County Health Rankings, which measures "severe" housing cost burden, 16.3% of the population in Connecticut is severely burdened with the cost of housing. Fewer households in Windham County (12.2%) experience this issue however, Hartford County is 15.6%. Compounding this, the availability of housing assistance is perceived by Key Informants to be the top missing and lacking social support in the service area.

A lack of social support due to living alone or being a single head of household may lead to social isolation and additional financial stress, eventually affecting mental health. In all 4 regions, the state and the nation, over half of households live alone and approximately 16% to 17% of these are comprised of an individual who is 65 years and older. About 18% of households are headed by a male alone while about 28% are headed by a female alone. Among the regions, about 18% of the female headed households have children under the age of 18 present. In East Hartford and Hartford City, female headed households (22.3% and 25.8% respectively) have children under 18.

The impact of financial challenges on individuals and families is great. The percentage of the

population living below 100% of the poverty level varies across the regions from 6.3% in the Lower CT River Valley to 10.4% in the Capitol Region and is 10.1% in Connecticut. In Hartford City, 26.9% of the population live below the poverty level. In the 4 regions, almost 63,000 households live below the poverty level. About 50,000 of them are reported to receive supplemental security and/or cash public assistance. In East Hartford and Hartford City alone, 12,377 households receive supplemental security income and/or cash public assistance. A higher percentage of households in the Capitol Region have no vehicle available to them than in the other regions, the state and nation. For renter-owned households, the percentage of those without vehicle access ranges from 12.8 percent in the Lower CT River Valley Region to 22.3% in the Capitol Region. 36.2% of renters in Hartford City have no access to a vehicle. The lack of transportation makes it difficult to access other social supports, healthcare and mental health treatment. This is confirmed by Key Informants. 63.8% perceived a lack of transportation to contribute to why individuals do not seek treatment. Also, transportation was identified as a missing and/or lacking service by the greatest percentage of respondents (17.4%).

Other social issues including language barriers (selected by 34.0%), Social Stigma (61.7%) and Immigration Status (25.5%) were noted as reasons individuals do not seek treatment. A large majority of Key Informants indicated that the lack of providers that accept Medicaid or provide financial assistance is an important issue in determining whether someone will seek and receive treatment. Additionally, only 28.3% of Key Informants perceive that support group services are meeting the needs in the community and only about one-quarter believe that primary care providers are meeting the needs of individuals. One respondent remarked, "There is still a very strong stigma about those who use. Often, we see individuals who are self-medicating with substances because they don't have insurance or can't afford proper treatment."

Finally, access to nutritious food is key to adequate growth and development and living a healthy life. The Food Environment Index measures limited access to healthy foods and grocery stores as well as food insecurity (access to a reliable food source during the past year). The measurement is based on a score of 0 (worst) to 10 (best). For all counties, the Food Environment Index is worse than the National Benchmark of 8.7. In addition, in Windham County 12.8% of people did not have a reliable source of food (food insecurity) which is worse than other counties in the service area as well as the state (10.2%) and the National Benchmark (12.0%). In comparison, the Healthy People 2030 target for Food Insecurity is 6.0%. The counties, state and National Benchmark are much higher than the goal. Body Mass Index (BMI) is a factor of diet and physical activity and is correlated with chronic health conditions. A BMI equal to or greater than 30 is defined as obese. Obesity is highest in Windham County (33.6% of the population). This is consistent with the high percentage of adults in the county who do not have access to a reliable food source and also report having no leisure time physical activity (22.6%).

Substance Use and Other Risk Behaviors in Adults and Youth

Adult drinking, smoking and illicit drug use are risk behaviors that have unintended consequences leading to poor health outcomes for the individual, family and public health. The CHR service area was

assessed in terms of substance use and risk behaviors. It appears that substance use is typically higher in the service area than in the state and the nation, particularly in Windham, New London and for some indicators Hartford and Tolland counties. This is concerning for providers and also an indication that this area may need to be a focus of attention in terms of service provision.

SAMHSA tracks several indicators related to alcohol, marijuana, cocaine and heroin use in the past year by individuals 12 years of older. In the case of marijuana use, the time period is within the past month. North Central Connecticut, (parts of Tolland and Hartford counties) has the highest percentage of alcohol use disorder (6.25%), marijuana use (11.83%) and heroin use (0.67%). Substance use in Connecticut is generally less than in the 3 regions in the CHR service area. Across the board, the percentage of use of various substances is higher in Connecticut and the 3 regions than in the United States.

Excessive drinking includes binge drinking (defined as adult males having 5 or more alcoholic drinks and adult females having 4 or more drinks on 1 occasion) and/or heavy drinking (adult males having more than 2 alcoholic drinks and adult females having more than 1 drink per day). Windham County has the highest percentage of excessive drinking among adults (21.7%). In the United States this is much lower (15.0%). A respondent commented about the consequence of excessive drinking. "Alcohol use continues to be an issue which we are seeing more and more with drunk driving." Also, Windham County has the highest percentage of adult smokers (17.7%), far exceeding Connecticut (12.6%). Smoking can cause long-term negative effects on the body, including heart disease, cancer, and diabetes.

Drug overdose resulting in death is assessed as a mortality rate per 100,000 population. The rate of drug overdose mortalities is highest in Windham County (42.0), followed by New London County (41.0). Tolland County, where the rate is much lower (28.1) compares most closely to the National Benchmark (23.0). Healthy People 2030 has established a goal for Drug Overdose Deaths to "Reduce Drug Overdose Deaths" and a target has been set of 20.7 per 100,000 population. The rate in Windham County is significantly higher than this goal.

In terms of the Top 5 Health Issues, Key Informants (80.9%) ranked Substance Use/Alcohol Use as very high on the list. Opioid use was selected by 42.6% of respondents as a key substance use issue as well as a significant issue impacting residents in the service area. One respondent addressed this. "Many people I work with come in abusing heroin, cocaine, PCP, Fentanyl. I still see the issue of prescription drug abuse and a significant problem with individuals abusing Alcohol." As with adolescent and adult mental health, trauma is perceived to be a potential cause of substance use. "Trauma at the individual and community level is endemic and often the root of other MH and SA issues. I think prescription drug use is a big issue for our youth who are experimenting. This is concerning because pills may look like the prescription medication and they may not be and may contain life threatening fentanyl and xylazine."

When asked to rank specific Substance Use issues and those most significant, 70.2% of Key Informants selected Alcohol use as the top issue, followed by Opioid use (51.1%) and then the use of illicit drugs (38.3%). E-cigarettes/vaping was also selected as significant. A Key Informant has seen a "significant increase in juvenile use of vaping products: both THC and nicotine." "Youth in the program use drinking, marijuana and vaping to cope with their trauma and depression." Finally, another respondent commented that vaping and marijuana use in adolescents is concerning, particularly as parents provide it to their children.

Finally, harm reduction services as a means to addressing the issue of substance use in the service area was mentioned by several respondents. "The drug supply is becoming increasingly dangerous and toxic; harm reduction interventions should be incorporated into treatment settings so that a continuum of services is available".

COMMUNITY NEEDS ASSESSMENT REPORT CARD

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DOMAIN	INDICATOR	MEASURE	U.S.	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley Region
SOCIO-ECONOMIC FACTORS	LANGUAGE	Population 5 Years and Older who speak English less than "very well"	8.2%	8.4%	8.0%	3.4%	5.3%	3.4%
	INCOME	Population below 100% of the poverty level	12.5%	10.1%	10.4%	8.7%	9.5%	6.3%
		Households with Food Stamp/SNAP benefits	14,486,880	161,051	50,140	4,410	12,988	5,289
	HEALTH INSURANCE	% of population without health insurance coverage	8.7%	5.2%	4.0%	4.3%	4.4%	3.2%
	EDUCATION	% of bachelor's degree or higher in adults 25 years and over	34.3%	41.4%	41.4%	25.0%	33.8%	45.3%
	AFFORDABLE HOUSING AND TRANSPORTATION	Renter households spending more than 30% of their income on housing	46.4%	48.2%	47.0%	41.1%	45.7%	46.5%
		Owner households spending more than 30% of their income on housing	21.9%	26.8%	23.8%	24.2%	24.6%	19.3%
		Female householder, no husband present	27.4%	28.4%	29.8%	28.6%	28.4%	28.7%
		Householders living alone	56.2%	54.0%	52.5%	54.0%	54.5%	53.9%
		Households with no vehicle available	3.1%	2.6%	2.7%	1.6%	2.0%	2.2%

			National Benchmark	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
SOCIO-ECONOMIC FACTORS	BUILT ENVIRONMENT AND SOCIAL/ ECONOMIC FACTORS	Food environment index = food access and insecurity (ranking from 1 = worst to 10 = best)	8.7**	8.1	8.1	8.2	7.6	8.2	7.9
		Severe housing problems: Overcrowding	--	1.9%	1.8%	0.9%	1.2%	1.2%	1.4%
		Severe housing problems: Inadequate facilities	--	0.7%	0.7%	0.3%	0.5%	0.1%	0.2%
ACCESS	PROVIDER DENSITY	Mental health providers to population ratio	240:1*	218:1	168:1	206:1	230:1	347:1	246:1
	KEY INFORMANT PERCEPTIONS	Percent of key informants who strongly agree or agree that the public understands mental and behavioral health issues.		19.2%					
		Percent of key informants who agree or strongly agree that there are a sufficient number of organizations that provide treatment for mental health issues.		15.2%					
		Percent of key informants who agree or strongly agree that there are a sufficient number of organizations that provide treatment for substance abuse issues.		13.3%					
		Percent of key informants who chose "long waiting list" as system gaps/barriers to receiving treatment.		85.1%					
		Percent of key informants who chose "homeless" as the most underserved population.		83.0%					

= Areas of Geatest Strength = Areas of Moderate Need = Areas of Greatest Need

*National benchmark represents the 10th percentile | **National benchmark is reverse coded, representing the 90th percentile | --Data not available

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DOMAIN	INDICATOR	MEASURE	National Benchmark	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
HEALTH BEHAVIORS	PHYSICAL AND MENTAL HEALTH	% of population with adult obesity (BMI ≥ 30)	30.0%*	29.5%	31.8%	28.4%	31.3%	28.2%	33.6%
		Physical inactivity (Adults Aged 20 years and Over)	19.0%*	20.2%	21.3%	15.7%	17.4%	17.9%	22.6%
		Population reporting "fair" or "poor" overall health	11.0%*	11.0%	11.9%	8.9%	10.3%	9.4%	12.3%
		Poor mental health days (average within past 30 days)	4.0*	4.3	4.7	4.7	4.7	4.5	4.8
		% Frequent Mental Distress	14.0%*	13.5%	14.5%	14.0%	14.3%	14.2%	15.3%
		Intentional self-harm (suicide)	14.5 (U.S)	11.1	10.3	12.1	13.0	16.0	Unreliable
		Percent of Key Informants who chose "Opioid Overdose" as most significant mental health issue	26.2%						

DOMAIN	INDICATOR	MEASURE	U.S.	Connecticut	North Central CT	South Central CT	Eastern CT
HEALTH BEHAVIORS	MENTAL HEALTH	Any mental illness in the past year – Adult Aged 18 or Older	18.8%	18.6%	19.1%	17.4%	20.2%
		Serious mental illness - Adult Aged 18 or Older	4.5%	4.2%	4.3%	4.4%	4.4%
		Major depressive episode - Adult Aged 18 or Older	7.0%	6.8%	7.3%	6.9%	7.3%
		Individuals who had serious thoughts of suicide in the past year - Adult Aged 18 or Older	4.2%	4.2%	3.9%	4.2%	4.6%
		Received mental health services in the past year – Adult Aged 18 or Older	14.7%	17.1%	17.1%	17.6%	17.6%
	SUBSTANCE USE	Alcohol Use Disorder in the past year among individuals - Aged 12 and Older	5.44%	6.06%	6.25%	5.93%	6.11%
		Average Annual Rate of First Use of Marijuana among individuals -12 Years and Older	2.10%	2.92%	3.00%	2.96%	3.11%
		Marijuana Use in the Past Month among individuals - Aged 12 Years and Older	9.52%	10.88%	11.83%	10.96%	11.36%
		Cocaine Use in the Past Year Among Individuals - Aged 12 Years and Older	2.03%	2.29%	2.27%	2.50%	2.47%
		Heroin Use in the Past Year among individuals - Aged 12 Years and Older	0.32%	0.60%	0.67%	0.59%	0.64%

DOMAIN	INDICATOR	MEASURE	National Benchmark	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
HEALTH BEHAVIORS	SUBSTANCE USE	Adults who are current smokers	15.0%*	12.6%	15.0%	14.2%	15.5%	13.5%	17.7%
		Excessive drinking in adults	15.0%*	17.4%	18.2%	21.3%	20.8%	17.4%	21.7%
		Drug Overdose Mortality Rate per 100,000	23.0*	34.2	38.1	36.6	41.0	28.1	42.0
		Percentage of disconnected youth	7.0%*	4.8%	5.2%	4.4%	4.8%	3.1%	6.9%
		Percent of key informants who chose "Opioid Use" as most significant substance abuse issue	25.0%						

= Areas of Geatest Strength = Areas of Moderate Need = Areas of Greatest Need

*National benchmark represents the 10th percentile | **National benchmark is reverse coded, representing the 90th percentile | --Data not available

COMMUNITY NEEDS ASSESSMENT DETAILED FINDINGS

Secondary Data Profile

Population Statistics

The estimated population is highest in the Capitol Region (977,165 individuals). The next largest Region is Southeastern CT with 280,293. Connecticut has a population of over 3.6 million. Unlike the state and the nation, the percent of males is slightly larger than females in the Northeastern and Southeastern Regions.

Table 1A. Overall Population (2018 - 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley Region
Population (2018-2022)	331,097,593	3,611,317	977,165	95,687	280,293	175,244
Male population	49.6%	49.0%	48.9%	50.1%	50.1%	49.2%
Female population	50.4%	51.0%	51.1%	49.9%	49.9%	50.8%

Source: U.S. Census Bureau

Hartford City has a higher population than East Hartford. Connecticut has a population of about 3.6 million people. Hartford City has a slightly lower percentage of male population compared to East Hartford, Connecticut, and The United States.

Table 1B. Overall Population (2018 - 2022) (East Hartford, Hartford City)

	United States	Connecticut	East Hartford, CDP	Hartford City
Population (2018-2022)	331,097,593	3,611,317	50,942	121,057
Male population	49.6%	49.0%	49.0%	47.9%
Female population	50.4%	51.0%	51.0%	52.1%

Source: U.S. Census Bureau

Racial and Ethnicity Composition

The population in the four regions is predominantly White and this is similar in the state and the nation. However, the presence of other races is higher in the Capitol Region than in the other regions. The percentage of Hispanics in the Capitol Region is similar to Connecticut and the U.S. In the other regions, it is much lower.

Table 2A. One Race/Ethnicity (2018 - 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley
White	72.2%	75.9%	72.6%	92.3%	85.2%	89.5%
Black/African American	13.7%	11.6%	13.7%	1.8%	6.2%	5.3%
American Indian/Alaska Native	0.9%	0.3%	0.3%	0.5%	0.5%	0.2%
Asian or Pacific Islander	6.3%	5.1%	6.3%	1.6%	4.2%	3.7%
Native Hawaiian and Pacific	0.2%	0.0%	0.0%	0.1%	0.0%	0.0%
Some Other Race	6.6%	7.0%	7.0%	3.8%	3.9%	1.3%
Hispanic or Latino *(of any race)*[a]	18.7%	17.4%	17.9%	11.8%	11.4%	7.0%

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic

Somewhat over half of the population is White in East Hartford and is even lower in Hartford City. This differs from the national and state percentages, which are considerably higher. East Hartford and Hartford have notably higher percentages of Black/African American and Hispanic or Latino populations compared to the national and state averages.

Table 2B. One Race/Ethnicity (2018 - 2022) (East Hartford, Hartford City)

	United States	Connecticut	East Hartford, CDP	Hartford City
White	72.2%	75.9%	54.3%	31.5%
Black/African American	13.7%	11.6%	30.4%	41.7%
American Indian/Alaska Native	0.9%	0.3%	3.5%	0.7%
Asian or Pacific Islander	6.3%	5.1%	3.7%	2.5%
Native Hawaiian and Pacific	0.2%	0.0%	0.1%	0.1%
Some Other Race	6.6%	7.0%	10.9%	23.5%
Hispanic or Latino *(of any race)*[a]	18.7%	17.4%	37.3%	46.1%

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic

Figure 1. Racial breakdown of three major races and one ethnic group, 2018 - 2022

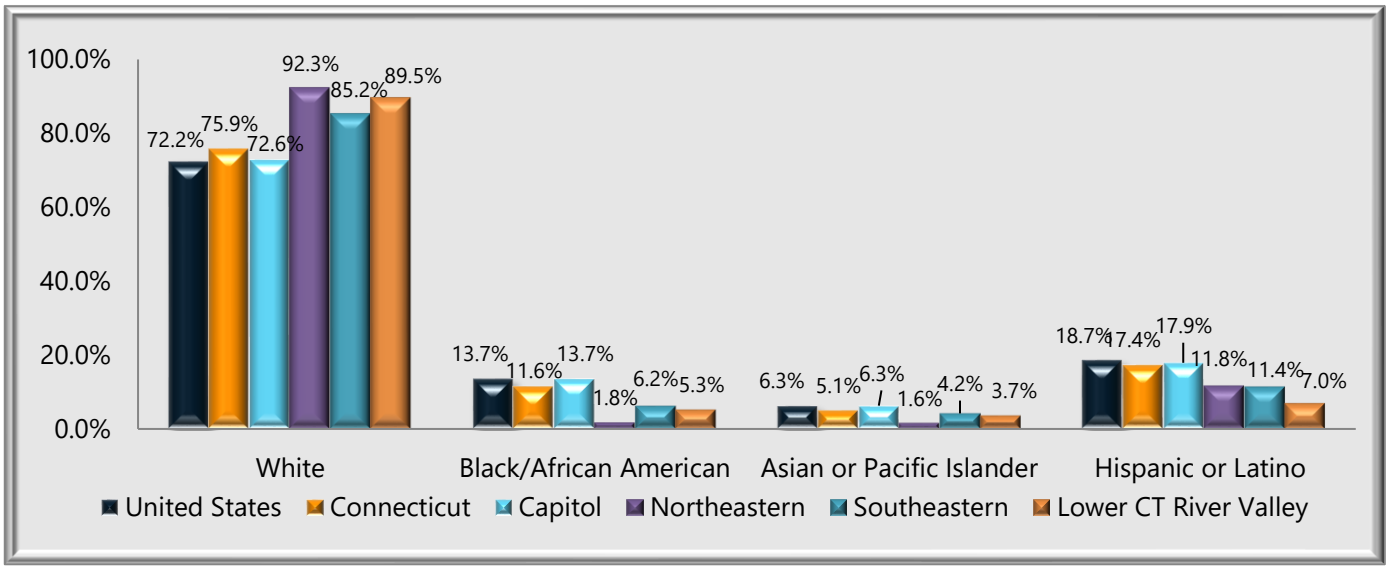
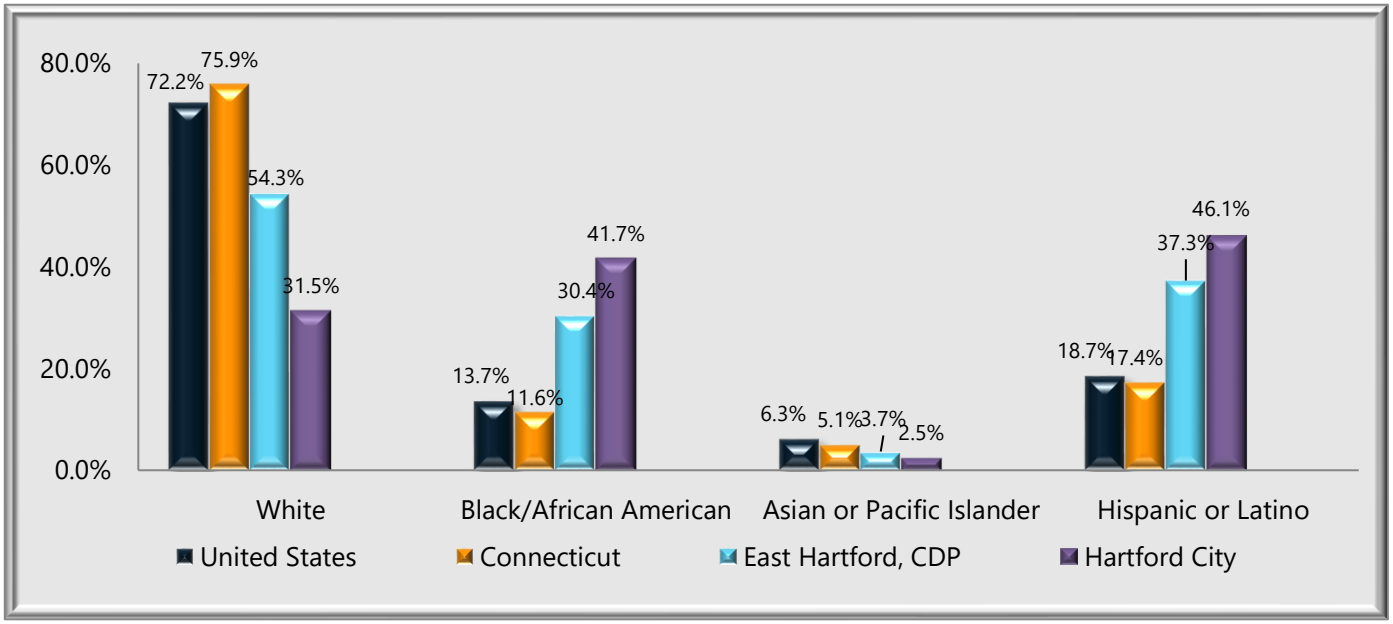


Figure 1B. Racial breakdown of three major races and one ethnic group, 2018 – 2022 (East Hartford, Hartford City)



Additionally, in the Capitol Region, there is a higher percentage of the population that speaks a language other than English when compared to other regions. However, the percentage of those speaking another language other than English in the Capitol Region is similar to Connecticut and the U.S. The percentage of people speaking English only is highest in the Northeastern Region at 91.2%.

Table 3A. Language Spoken at Home, 5 Years Old and Older (2018 - 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley Region
English only	78.3%	77.4%	76.4%	91.2%	86.6%	89.6%
Language other than English	21.7%	22.6%	23.6%	8.8%	13.4%	10.4%
Speak English less than "very well"	8.2%	8.4%	8.0%	3.4%	5.3%	3.4%
Spanish	13.3%	12.2%	12.2%	5.3%	7.2%	3.7%
Speak English less than "very well"	5.2%	4.9%	4.3%	1.9%	2.9%	1.4%
Other Indo-European languages	3.7%	6.9%	7.4%	2.4%	3.5%	4.4%
Speak English less than "very well"	1.1%	2.3%	2.4%	0.9%	1.1%	1.2%
Asian and Pacific Islander languages	3.5%	2.5%	2.9%	1.0%	2.3%	1.7%
Speak English less than "very well"	1.6%	1.0%	1.0%	0.6%	1.3%	0.7%
Other languages	1.2%	1.0%	1.2%	0.2%	0.3%	0.6%
Speak English less than "very well"	0.4%	0.3%	0.3%	0.0%	0.1%	0.1%

Source: U.S. Census Bureau

The population of people who speak a language other than English is higher in East Hartford and Hartford City compared to national and state percentages. The percentage of people who speak English only is lowest in Hartford City.

Table 3B. Language Spoken at Home, 5 Years Old and Older (2018 - 2022) (East Hartford, Hartford City)

	United States	Connecticut	East Hartford, CDP	Hartford City
English only	78.3%	77.4%	60.9%	56.8%
Language other than English	21.7%	22.6%	39.1%	43.2%
Speak English less than "very well"	8.2%	8.4%	11.7%	19.1%
Spanish	13.3%	12.2%	28.3%	36.2%
Speak English less than "very well"	5.2%	4.9%	7.7%	16.1%
Other Indo-European languages	3.7%	6.9%	5.9%	4.2%
Speak English less than "very well"	1.1%	2.3%	2.3%	2.0%
Asian and Pacific Islander languages	3.5%	2.5%	2.1%	1.2%
Speak English less than "very well"	1.6%	1.0%	1.1%	0.5%
Other languages	1.2%	1.0%	2.7%	1.5%
Speak English less than "very well"	0.4%	0.3%	0.6%	0.5%

Source: U.S. Census Bureau

Figure 2A. Percentage of population speaking a language other than English at home, 2018 – 2022

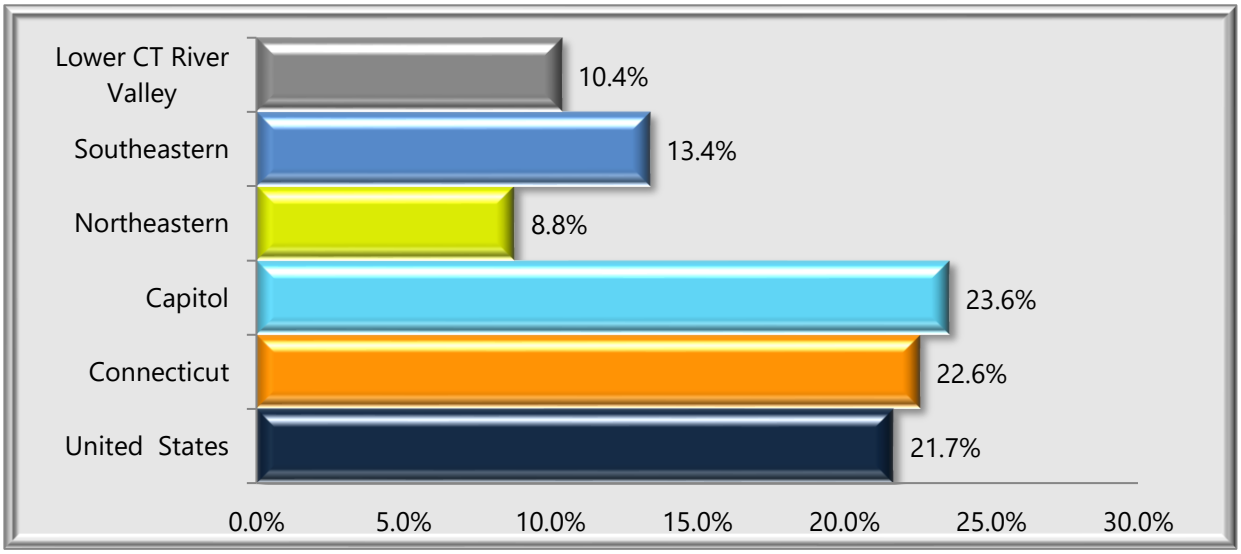
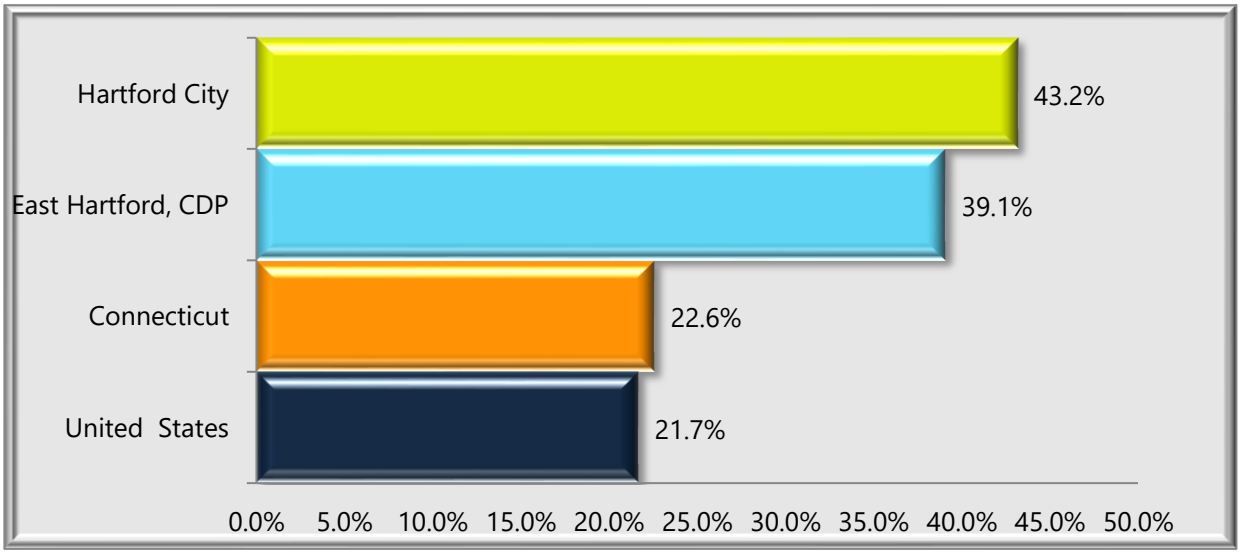


Figure 2B. Percentage of population speaking a language other than English at home, 2018 – 2022 (East Hartford, Hartford City)



Household Statistics

The majority of residences in the service area are occupied by the owner. The percentage of those who own their residence and have a mortgage in the 4 regions is somewhat higher than in Connecticut and the U.S. The median housing value is highest in the Lower CT River Valley Region at $345,383.

Thirty percent (30%) of a household's total income is considered the cut off for housing-cost burden and avoiding financial hardship. The percentage of homeowners spending more than 30% of their income on their mortgage/owner costs is slightly lower in the 4 regions than in the state. However, the percentages are several points higher than in the U.S. which is 17.6%. The percentage of renters spending more than 30% of their income on rent is similar to the state and nation for 3 of the 4

regions. Favorably, renters in the Northeastern Region make up a smaller percentage (41.1%) of those with housing cost burden.

This may be related to the median rent Northeastern CT which is lower than all other regions, the state and nation at $1,182. The median rent in Connecticut is $1,374.

Table 4A. Housing Characteristics (2018 - 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley
Owner-Occupied Housing						
Owner-occupied units	81,497,760	932,588	252,141	28,696	75,262	54,922
Housing units with a mortgage	61.5%	62.3%	66.2%	69.0%	62.7%	65.0%
Housing units without a mortgage	38.5%	37.7%	33.8%	31.0%	37.3%	35.0%
Median value	$281,900	$323,700	$296,624	$272,738	$285,623	$345,383
Households spending 30% or more of income on mortgage/Owner	21.9%	26.8%	23.8%	24.2%	24.6%	19.3%
Renter-Occupied Housing						
Occupied units paying rent	42,085,857	458,864	129,744	9,199	37,002	17,443
Median dollars	$1,268	$1,374	$1,358	$1,182	$1,317	$1,397
Households spending 30% or more of income on rent	46.4%	48.2%	47.0%	41.1%	45.7%	46.5%

Source: U.S. Census Bureau

In Hartford City, most residents rent their housing which differs from East Hartford, the state, and the nation where a majority of residences are owner-occupied. The percentage of those who own their residence and have a mortgage is similar throughout East Hartford, the state, and the nation but is slightly higher in Hartford City. The median housing value is highest in Connecticut at $323,700.

The percentage of those who own their residence and are housing cost burdened is highest in Hartford city (39.4%) which is almost double the nation percentage (21.9%). The percentage of renters spending more than 30% of their income on rent is somewhat higher in East Hartford and Hartford City.

The median rent is the lowest in Hartford compared to East Hartford, the state, and the nation at $1,154.

Table 4B. Housing Characteristics (2018 - 2022) (East Hartford, Hartford City)

	United States	Connecticut	East Hartford, CDP	Harford City
Owner-Occupied Housing				
Owner-occupied units	81,497,760	932,588	11,948	12,378
Housing units with a mortgage	61.5%	66.3%	69.9%	74.5%
Housing units without a mortgage	38.5%	33.7%	30.1%	25.5%
Median value	$281,900	$323,700	$201,500	$198,900
Households spending 30% or more of income on mortgage/Owner	21.9%	26.8%	31.5%	39.4%
Renter-Occupied Housing				
Occupied units paying rent	42,085,857	458,864	8,031	35,093
Median dollars	$1,268	$1,374	$1,163	$1,154
Households spending 30% or more of income on rent	46.4%	48.2%	51.9%	55.1%

Source: U.S. Census Bureau

Figure 3A. Households spending more than 30% of income on mortgage, 2018 – 2022

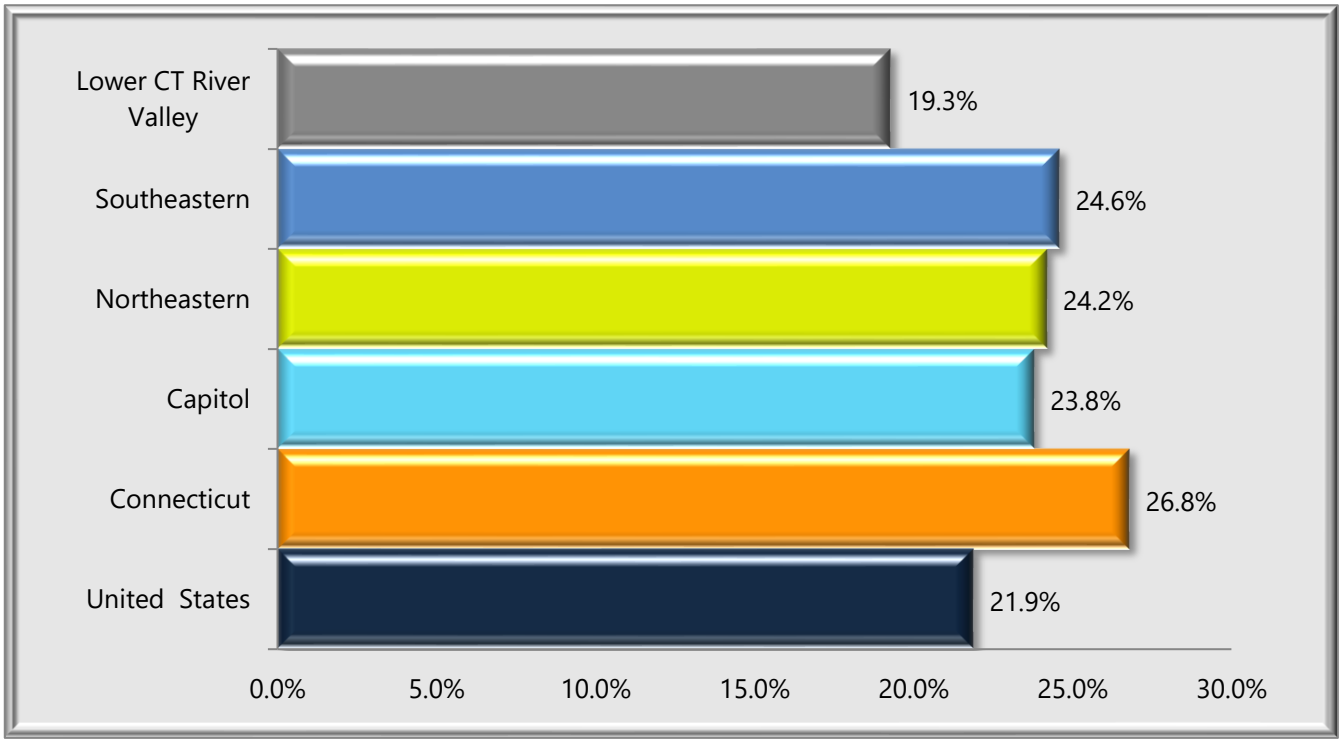


Figure 3B. Households spending more than 30% of income on mortgage, 2018 – 2022 (East Hartford, Hartford City)

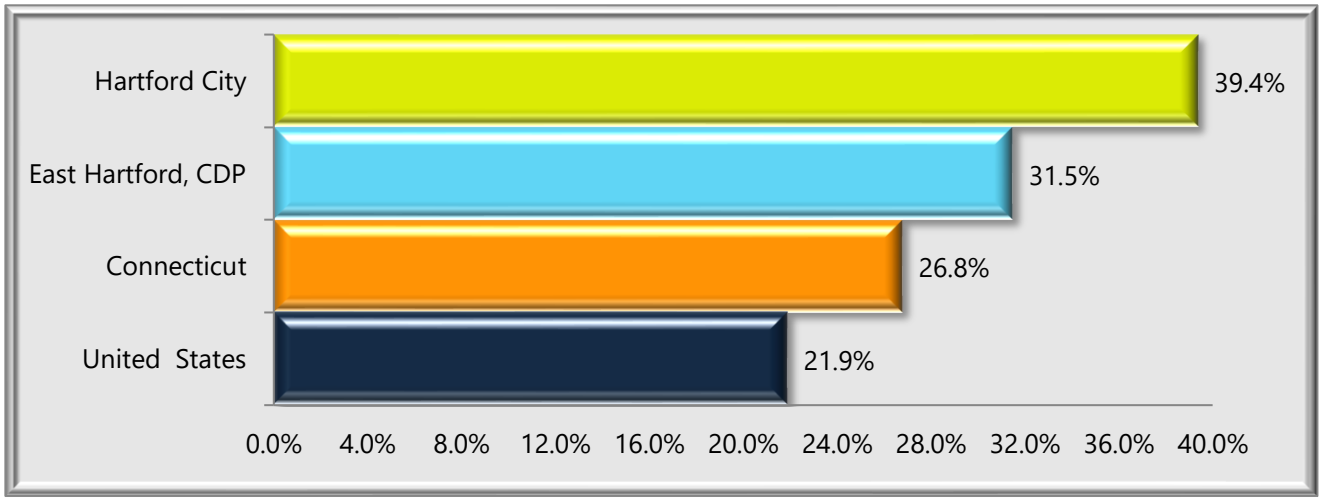


Figure 4A. Households spending more than 30% of income on rent, 2018-2022

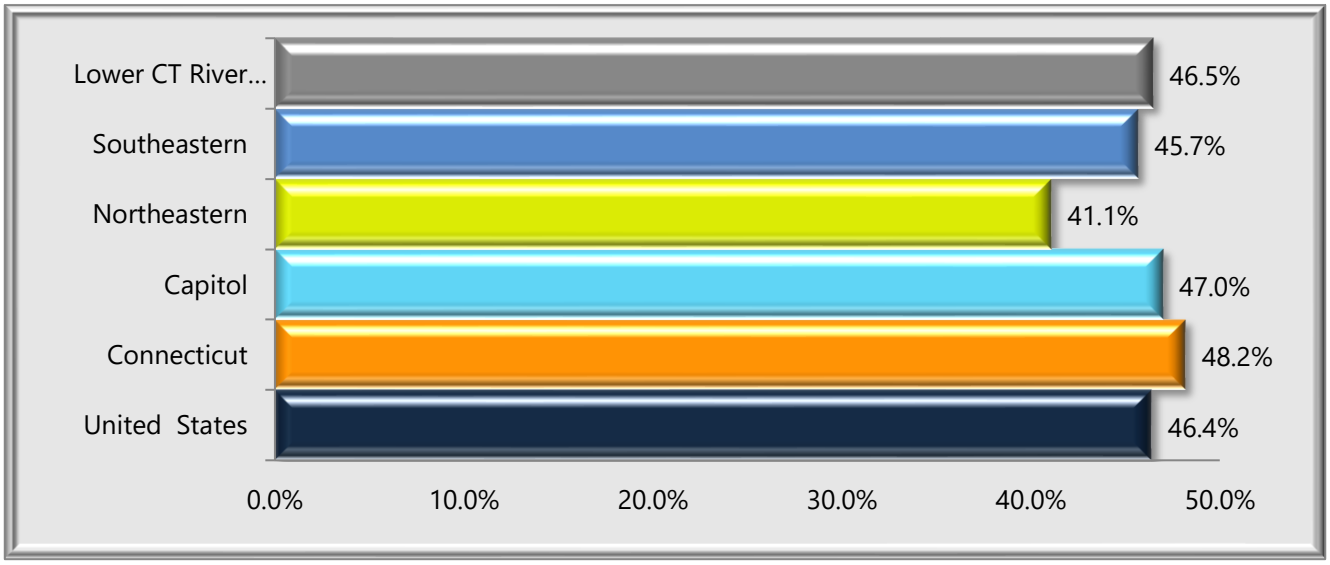
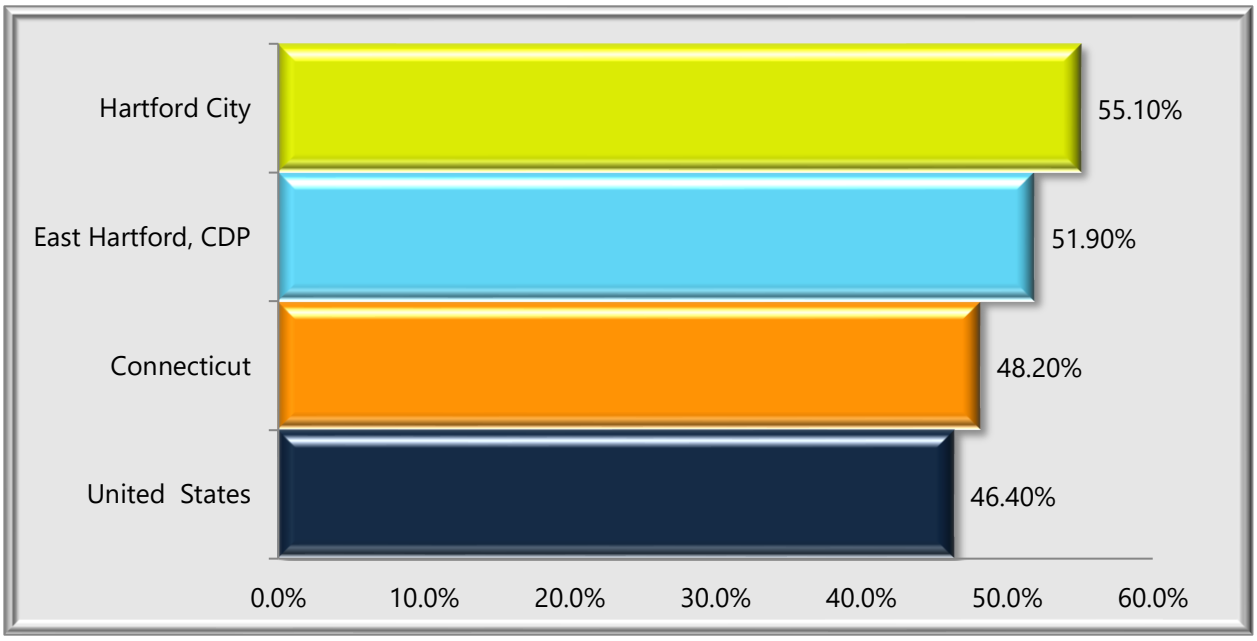


Figure 4B. Households spending more than 30% of income on rent, 2018-2022 (East Hartford, Hartford City)



In general, the 4 regions are similar to Connecticut and the U.S. in type of households. In all 4 regions, the state and the nation, over half of households live alone as single households. This is slightly lower in the Capitol Region (52.5%). Among households living alone, approximately 16% to 17% of households in the region are comprised of an individual who is 65 years and older. About 18% of married couple households have children under the age of 18. A lower percentage of households are headed by males than females. About 18% of households are headed by a male alone while about 28% are headed by a female with no spouse present. About 18.0% of the female headed households have children under the age of 18 present.

Table 5A. Households by Type (2018 - 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley
Households						
With own children under 18 years	30.2%	29.1%	29.2%	28.7%	28.6%	28.8%
Householder Living Alone*	56.2%	54.0%	52.5%	54.0%	54.5%	53.9%
65 years and older	16.7%	17.4%	16.2%	17.1%	17.2%	17.2%
Married-couple household	47.5%	47.4%	45.3%	46.5%	46.4%	46.5%
With own children under 18 years	18.4%	18.2%	17.9%	17.9%	17.8%	18.1%
Male householder, no wife present	18.1%	17.4%	17.9%	17.8%	17.9%	17.9%
With own children under 18 years	6.8%	6.0%	6.3%	6.1%	6.2%	5.9%
Female householder, no husband present	27.4%	28.4%	29.8%	28.6%	28.4%	28.7%
With own children under 18 years	18.2%	18.2%	18.9%	18.6%	18.6%	18.6%

Source: U.S. Census Bureau

*Householder living alone applies to male and female householders no spouse/partner present

The percentage of households with children under 18 is fairly consistent across both cities, the state, and the nation. Similarly, around half of all households consist of individuals living alone, reflecting a consistent trend across these regions. The percentage of people 65 years and older living alone is slightly higher in East Hartford (19.4%) compared to Hartford City, Connecticut, and the U.S.. East Hartford and Hartford City have fewer married couple households and fewer of these households have children under 18.. Female-headed households are more prevalent than male-headed households throughout the four locations. Female-headed households have a higher percentage of children under 18 years in East Hartford and Hartford City.

Table 5B. Households by Type (2018 - 2022) (East Hartford, Hartford City)

	United States	Connecticut	East Hartford, CDP	Hartford City
Households				
With own children under 18 years	30.2%	29.1%	31.4%	32.0%
Householder Living Alone*	56.2%	54.0%	51.9%	55.4%
65 years and older	16.7%	17.4%	19.4%	16.4%
Married-couple household	47.5%	47.4%	35.4%	20.4%
With own children under 18 years	18.4%	18.2%	14.5%	9.6%
Male householder, no wife present	18.1%	17.4%	21.9%	25.1%
With own children under 18 years	6.8%	6.0%	8.2%	12.0%
Female householder, no husband present	27.4%	28.4%	35.7%	46.6%
With own children under 18 years	18.2%	18.2%	22.3%	25.8%

Source: U.S. Census Bureau

*Householder living alone applies to male and female householders no spouse/partner present

Income and Poverty Status

The following table (Table 19) depicts the households earning an income for each region. On average, households in the regions are earning more than the state and national averages. The highest percentage of households in the regions have annual incomes from $100,000 to $149,000. This is similar to Connecticut. The highest percentage of households in this income bracket is in the Northeastern Region (20.4%). The median household and family incomes are higher in the regions than in the U.S. and similar or lower than the state. The Lower CT River Valley Region has the highest household and family incomes among the regions at $99,385 and $128,409. Mean household and family incomes are as high as the state in this region.

Table 6A. Household and Family Income (2018 – 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley Region
Household Income						
Less than $10,000	4.9%	4.3%	4.9%	3.4%	3.5%	3.3%
$10,000 TO $14,999	3.8%	3.4%	3.6%	2.9%	3.9%	2.4%
$15,000 to $24,999	7.0%	6.0%	5.8%	5.5%	6.6%	4.8%
$25,000 to $34,999	7.4%	6.0%	6.4%	5.8%	6.8%	5.7%
$35,000 to $49,999	10.7%	8.9%	8.8%	8.9%	10.3%	7.7%
$50,000 to $74,999	16.1%	13.9%	13.6%	18.0%	15.7%	13.8%
$75,000 to $99,999	12.8%	12.0%	12.2%	15.8%	12.8%	12.5%
$100,000 to $149,999	17.1%	17.8%	18.5%	20.4%	18.8%	19.7%
$150,000 to $199,999	8.8%	10.8%	11.1%	10.2%	10.2%	13.5%
$200,000 or more	11.4%	17.0%	15.0%	9.0%	11.5%	16.7%
Median household income	**$75,149**	**$90,213**	**$93,702**	**$83,130**	**$82,906**	**$99,385**
Mean household income	**$105,833**	**$130,601**	**$118,916**	**$100,409**	**$103,770**	**$130,062**
Family Income						
Median family income	**$92,646**	**$115,539**	**$117,818**	**$96,264**	**$103,477**	**$128,409**
Mean family income	**$124,530**	**$158,585**	**$143,728**	**$114,330**	**$123,852**	**$161,259**

` Source: U.S. Census Bureau

On average, households in East Hartford and Hartford City are earning less than the state and national averages. The highest percentage of households between East Hartford and Hartford City have annual incomes from $50,000 to $74,999. The highest percentage of households in this income bracket is East Hartford (17.4%). The median household and family incomes are higher in the U.S. and highest in the state of Connecticut. Connecticut also has the highest mean household and family income at $130,601 and $158,585. This is more than double the mean household and family income in Hartford City at $61,201 and $71,994.

Table 6B. Household and Family Income (2018 – 2022) (East Hartford, Hartford City)

	United States	Connecticut	East Harford, CDP	Hartford City
Household Income				
Less than $10,000	4.9%	4.3%	7.1%	11.0%
$10,000 TO $14,999	3.8%	3.4%	4.2%	10.5%
$15,000 to $24,999	7.0%	6.0%	7.8%	10.6%
$25,000 to $34,999	7.4%	6.0%	8.1%	11.8%
$35,000 to $49,999	10.7%	8.9%	12.6%	13.0%
$50,000 to $74,999	16.1%	13.9%	17.4%	15.8%
$75,000 to $99,999	12.8%	12.0%	15.2%	10.5%
$100,000 to $149,999	17.1%	17.8%	15.4%	8.6%
$150,000 to $199,999	8.8%	10.8%	6.7%	4.6%
$200,000 or more	11.4%	17.0%	5.4%	3.6%
Median household income	**$75,149**	**$90,213**	**$64,244**	**$41,841**
Mean household income	**$105,833**	**$130,601**	**$80,586**	**$61,201**
Family Income				
Median family income	**$92,646**	**$115,539**	**$77,413**	**$49,771**
Mean family income	**$124,530**	**$158,585**	**$90,266**	**$71,994**

` Source: U.S. Census Bureau

In general, those in the 4 regions and Connecticut are less likely to live in poverty when compared with the nation where 12.5% live in poverty. The federal poverty level represents the dollar amount below which a household has insufficient income to meet minimal basic needs. The federal poverty level may also be reported as a percentage. Households that are below 100% of the poverty level have an income less than the amount deemed necessary to sustain basic needs ($15,060/year per person). Households at 100% to 149% of the poverty level have an income 1.0 to 1.49 times the necessary amount. The percentage of the population living below 100% of the poverty level varies across the regions from 6.3% in the Lower CT River Valley to 10.4% in the Capitol Region. In Connecticut 10.1% live below the poverty level.

Table 7. Health and Human Services Poverty Guidelines (2024)

Size of Family/ Household	48 Contiguous States and the District of Columbia 100% of Poverty Level
1	$15,060
2	$20,440
3	$25,820
4	$31,200
5	$36,580
6	$41,960
7	$47,340
8	$52,720
For each additional person after 8, add: $5,380	

Source: U.S. Department of Health and Human Services

Table 8A. Percent of Population Below Poverty Level (2018 - 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley Region
All people below poverty level	40,521,584	355,692	101,370	8,356	26,614	10,964
Percent all people below poverty level	12.5%	10.1%	10.4%	8.7%	9.5%	6.3%
Under 18 years	29.6%	27.6%	27.4%	26.7%	27.1%	17.8%
Related children under 18	28.9%	26.8%	26.9%	25.5%	26.0%	16.9%
18 to 64 years	57.3%	58.8%	58.6%	59.7%	61.4%	61.9%
65 years and over	13.1%	13.6%	13.9%	13.6%	11.6%	20.3%

Sources: Bureau of Labor Statistics & U.S. Census Bureau

Hartford City has a considerably higher percentage of people below the poverty level compared to nation, state, and East Hartford. East Hartford, Connecticut, and the U.S. have at least 13% of the 65 years and over population living below poverty which is slightly higher than the percentage seen in Hartford City (11.6%).

Table 8B. Percent of Population Below Poverty Level (2018 - 2022)

	United States	Connecticut	East Hartford, CDP	Hartford City
All people below poverty level	40,521,584	355,692	6,910	30,538
Percent all people below poverty level	12.5%	10.1%	13.7%	26.9%
Under 18 years	29.6%	27.6%	26.7%	32.7%
Related children under 18	28.9%	26.8%	26.7%	32.4%
18 to 64 years	57.3%	58.8%	59.5%	55.7%
65 years and over	13.1%	13.6%	13.7%	11.6%

Sources: U.S. Census Bureau

Figure 5A. Percentage of people below the poverty level, 2018 – 2022

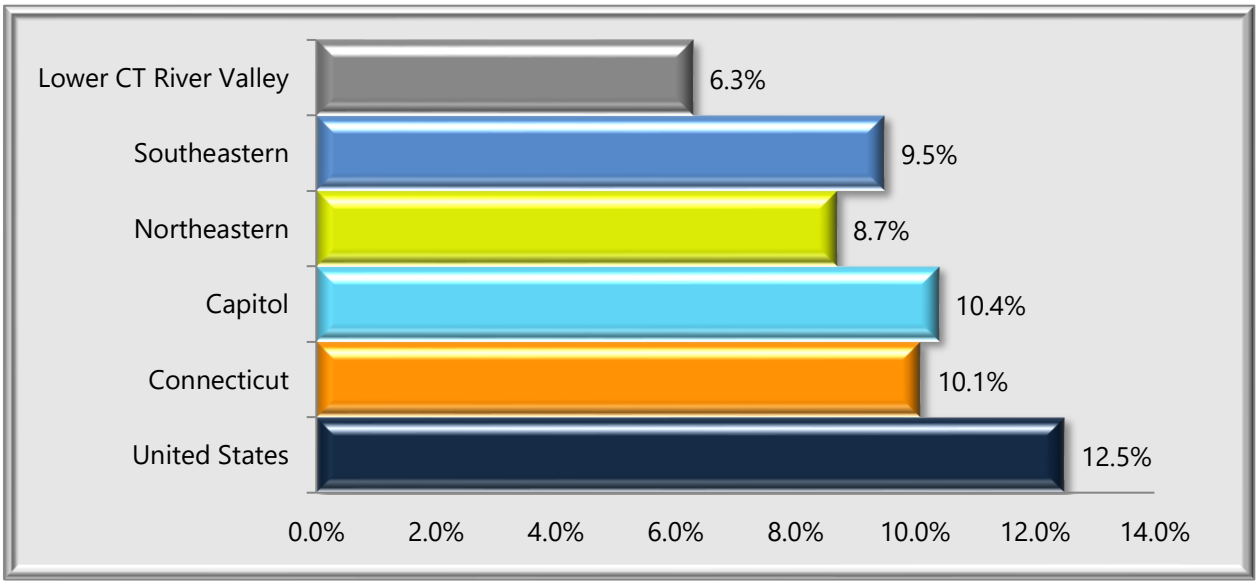
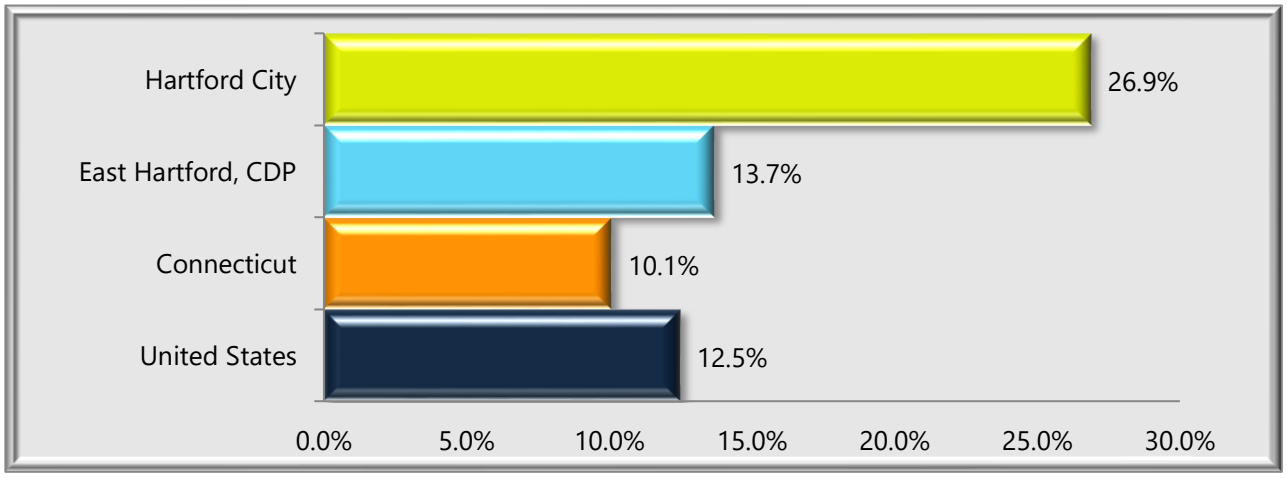


Figure 5B. Percentage of people below the poverty level, 2018 – 2022 (East Hartford, Hartford City)



In total, almost 63,000 households live below the poverty level in the four regions. About 50,000 of them are reported to receive supplemental security and/or cash public assistance. The figures are higher in relation to households that received a food subsidy such as food stamps and SNAP benefits in the past 12 months.

Table 9A. Households with Supplemental Benefits in the Past 12 Months (2018 – 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley
Households below poverty level	15,616,265	147,678	42,593	3,416	11,434	5,401
Households with supplemental security income	6,457,476	65,735	18,695	1,911	5,350	2,398
Average Mean supplemental security income	$11,137	$11,357	$11,544	$12,469	$11,474	$12,649
Households with cash public assistance income	3,339,152	42,149	14,507	1,675	3,789	1,533
Average Mean cash public assistance income	$4,243	$4,755	$5,866	$5,040	$4,221	$6,424
Households with food stamps/SNAP benefits in the past 12 months	14,486,880	161,051	50,140	4,410	12,988	5,289

Source: U.S. Census Bureau

In total, about 16,740 households are living below poverty in both East Hartford and Hartford City. Approximately, 6,723 households are receiving supplemental security income and 21,694 of them are receiving food stamps/SNAP benefits in the last 12 months. The average mean supplemental security income is similar throughout East Hartford, Connecticut, and the U.S., but lower in East Hartford. Likewise, the average mean cash public assistance income is similar amongst Hartford City, Connecticut, and the U.S., but less in East Hartford.

Table 9B. Households with Supplemental Benefits in the Past 12 Months (2018 – 2022) (East Hartford City, Hartford City)

	United States	Connecticut	East Hartford, CDP	Hartford City
Households below poverty level	15,616,265	147,678	3,172	13,568
Households with supplemental security income	6,457,476	65,735	1,184	5,539
Average Mean supplemental security income	$11,137	$11,357	$11,811	$10,268
Households with cash public assistance income	3,339,152	42,149	654	5,000
Average Mean cash public assistance income	$4,243	$4,755	$2,912	$4,524
Households with food stamps/SNAP benefits in the past 12 months	14,486,880	161,051	4,018	17,676

Source: U.S. Census Bureau

Education Statistics

91.0% or better have a high school degree or higher throughout all regions. This is similar to the state (91.3%) and slightly higher than the nation (89.1%). Individuals living in the Lower CT River Valley region are more likely to have a high school diploma or bachelor's degree than the other regions and the state and nation. One-quarter (25.0%) of people in Northeastern CT have a bachelor's degree or higher whereas 45.3% have attained this level in Lower CT. In the state 41.4% have bachelor's degrees or higher.

Table 10A. Educational Attainment, Population 25 Years and Over (2018 - 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley
Less than 9th grade	10,742,781	101,820	675,246	68,920	197,755	128,960
9th to 12th grade, no diploma	13,856,917	118,256	25,897	1,922	5,537	2,319
High school graduate (includes equivalency)	59,741,825	650,788	34,778	4,085	9,511	3,775
Some college, no degree	44,692,390	414,533	169,941	24,018	58,571	30,676
Associate's degree	19,815,732	192,167	111,307	14,498	40,400	22,256
Bachelor's degree	47,391,673	573,917	55,774	7,145	16,870	11,558
Graduate or professional degree	30,359,674	469,309	154,850	9,844	38,034	32,151
Percent high school graduate or higher	89.1%	91.3%	91.0%	91.3%	92.4%	95.3%
Percent bachelor's degree or higher	34.3%	41.4%	41.4%	25.0%	33.8%	45.3%

Source: U.S. Census Bureau

The percentage of people who have graduated high school or higher is lower in Hartford City (74.7%) compared to East Hartford, the state, and the nation. Similarly, Hartford City had the lowest percentage of bachelor's degree or higher. People in the state of Connecticut have a higher percentage of graduating high school and with a bachelor's degree or higher than those in East Hartford, Hartford City, and the nation.

Table 10B. Educational Attainment, Population 25 Years and Over (2018 - 2022) (East Hartford, Hartford City)

	United States	Connecticut	East Hartford, CDP	Hartford City
Less than 9th grade	10,742,781	101,820	2,061	9,054
9th to 12th grade, no diploma	13,856,917	118,256	2,068	10,201
High school graduate (includes equivalency)	59,741,825	650,788	13,764	25,106
Some college, no degree	44,692,390	414,533	7,554	13,514
Associate's degree	19,815,732	192,167	3,016	4,959
Bachelor's degree	47,391,673	573,917	3,906	7,877
Graduate or professional degree	30,359,674	469,309	2,392	5,439
Percent high school graduate or higher	89.1%	91.3%	88.1%	74.7%
Percent bachelor's degree or higher	34.3%	41.4%	18.1%	17.5%

Source: U.S. Census Bureau

Figure 6A. Population with a high school diploma, 2018 – 2022

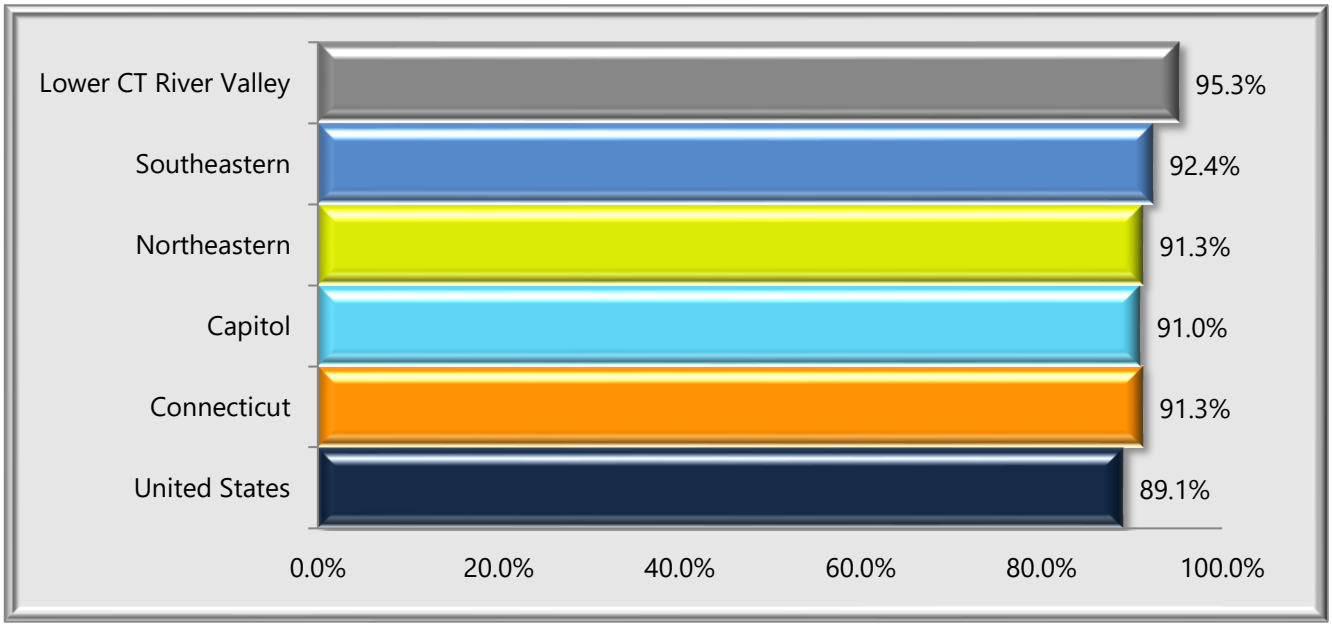


Figure 6B. Population with a high school diploma, 2018 – 2022 (East Hartford, Hartford City)

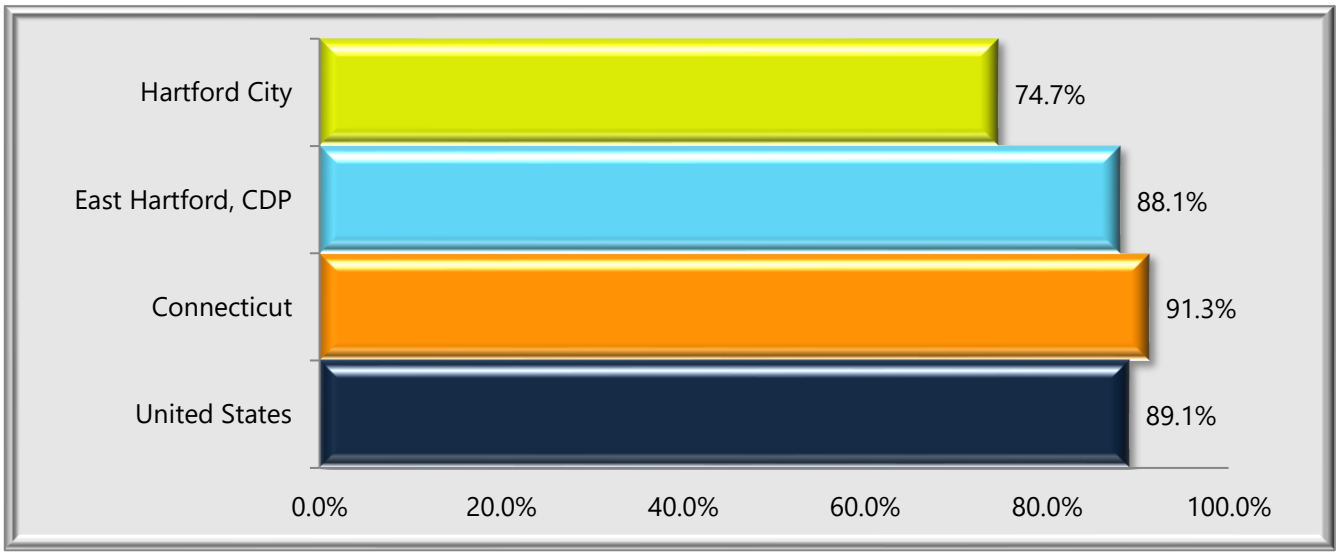


Figure 7A. Population with a bachelor's degree or higher, 2018 – 2022

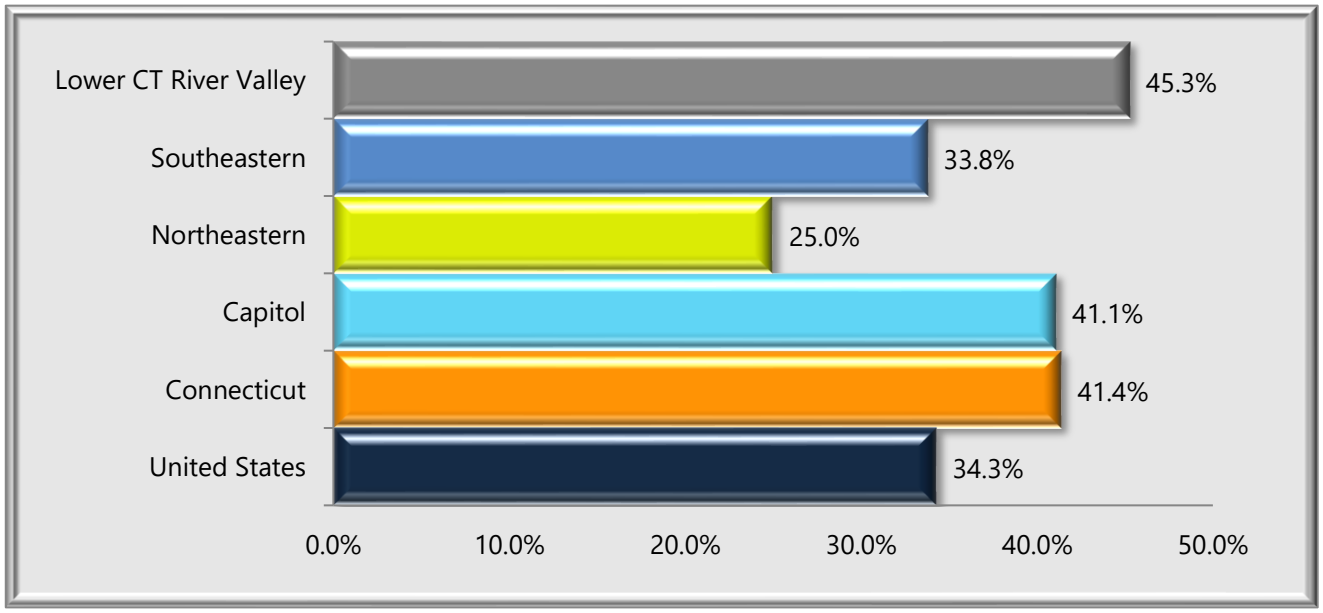
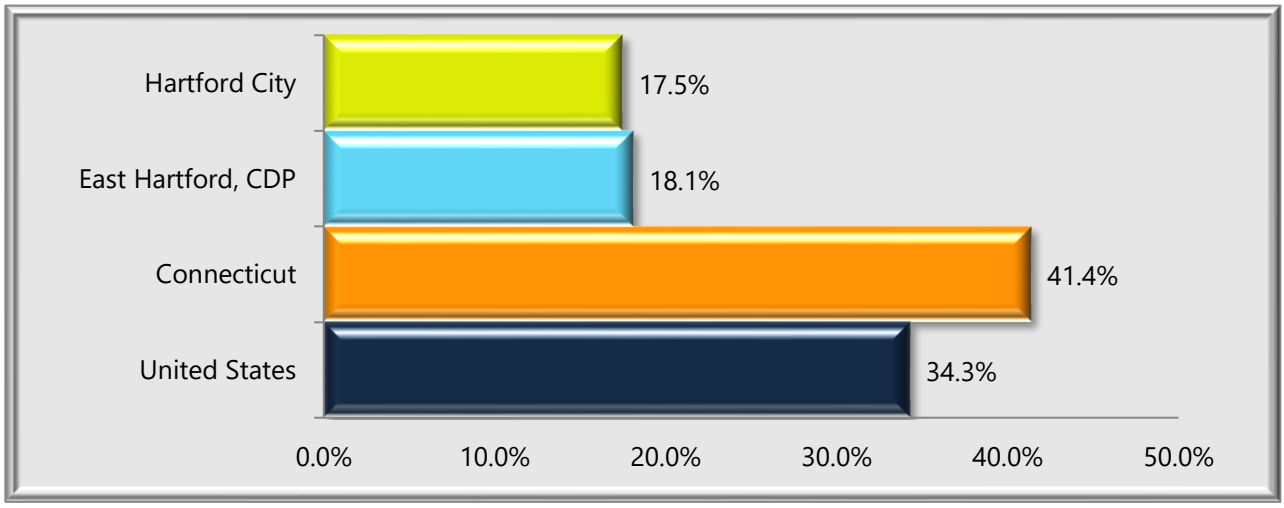


Figure 7B. Population with a bachelor's degree or higher, 2018 – 2022 (East Hartford, Hartford City)



Access to Transportation/Household Vehicles

The percentage of those with no vehicle in the regions is generally similar to Connecticut (2.6%) for owner-occupied homes. This varies greatly in comparison to the state for renter-occupied homes. Among the regions, a higher percentage of owner-occupied and renter-occupied households in the Capitol Region have no vehicle available to them than in the other regions, the state and nation. However the percentage for owner-occupied households is low (2.7%) and these households may have access to public transportation in a partially urban area. For renter-owned households, the percentage of those without vehicle access is much higher, ranging from 12.8 percent in the Lower CT River Valley Region to 22.3% in the Capitol Region and lower than the nation.

Table 11A. Number of Vehicles Available per Household (2018 – 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley
Owner-occupied households	81,497,760	932,588	252,141	28,696	75262	54,922
No vehicle available	3.1%	2.6%	2.7%	1.6%	2.0%	2.2%
1 or more vehicles available	96.9%	97.4%	97.3%	98.4%	98.0%	97.8%
Renter-occupied households	44,238,593	477,219	134,408	9,878	38,548	18,162
No vehicle available	17.9%	20.2%	22.3%	15.0%	17.5%	12.8%
1 or more vehicles available	82.1%	79.8%	77.7%	85.0%	82.5%	87.2%

Source: U.S. Census

Both East Hartford and Hartford City have higher percentages of owner-occupied and renter-occupied households that do not have vehicles available. Hartford City has more than double the percentage of households with no vehicle available compared to the state and the nation.

Table 11B. Number of Vehicles Available per Household (2018 – 2022)

	United States	Connecticut	East Hartford, CDP	Hartford City
Owner-occupied households	81,497,760	932,588	11,948	12,378
No vehicle available	3.1%	2.6%	4.1%	7.9%
1 or more vehicles available	96.9%	97.4%	95.9%	92.1%
Renter-occupied households	44,238,593	477,219	8,138	35,899
No vehicle available	17.9%	20.2%	24.5%	36.2%
1 or more vehicles available	82.1%	79.8%	75.5%	63.8%

Source: U.S. Census

Mental Health and Substance Use Statistics

Health Care Access Statistics

The Healthy People target related to health care access is "Increase the proportion of people with health insurance "(AHS-01) under the age of 65. The target percentage is 92.4% of people with health insurance. The percentage of the population with health insurance is higher in all 4 regions is higher than in Connecticut and the United States. About 95% of individuals in all regions are covered by health insurance.

Table 12. Health Insurance Coverage (2018 - 2022)

	United States	Connecticut	Capitol Region	Northeastern Connecticut Region	Southeastern Connecticut Region	Lower Connecticut River Valley
% of population with health insurance coverage	91.3%	94.8%	96.0%	95.7%	95.6%	96.8%
With private health insurance	74.0%	73.9%	74.3%	73.8%	74.0%	78.2%
With public coverage	39.3%	38.5%	38.2%	41.2%	41.3%	35.3%
% of population without health insurance	8.7%	5.2%	4.0%	4.3%	4.4%	3.2%

Source: U.S. Census Bureau

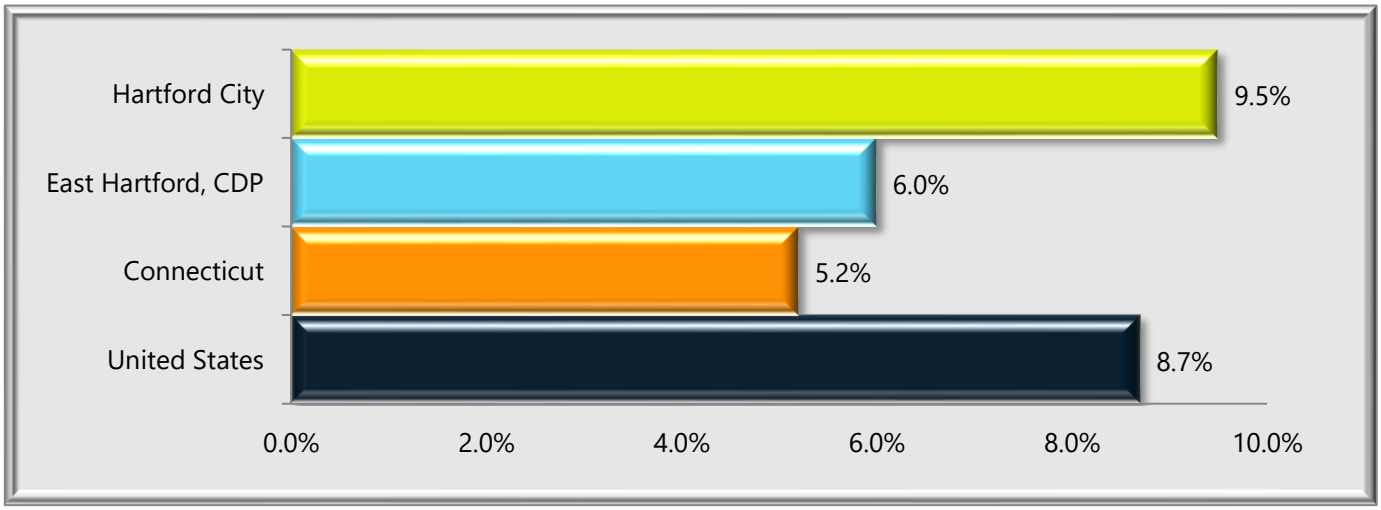
The Healthy People target related to health care access is "Increase the proportion of people with health insurance "(AHS-01) under the age of 65. The target percentage is 92.4% of people with health insurance. Connecticut demonstrates the highest percentage of population with health insurance followed by East Hartford and the nation. While Hartford City has the lowest percentage of population with health insurance coverage, the percentage of public coverage is the highest.

Table 12. Health Insurance Coverage (2018 - 2022)

	United States	Connecticut	East Hartford, CDP	Hartford City
% of population with health insurance coverage	91.3%	94.8%	94.0%	90.5%
With private health insurance	74.0%	73.9%	57.5%	46.2%
With public coverage	39.3%	38.5%	46.3%	53.0%
% of population without health insurance	8.7%	5.2%	6.0%	9.5%

Source: U.S. Census Bureau

Figure 8. Civilian non-institutionalized population without health insurance, 2018 - 2022



Medically Underserved Area/Mental Health Professional Shortage Area (HPSA)

Medically Underserved Area (MUA)

Medically Underserved Areas (MUAs) detect geographic areas with a lack of access to primary care services. There is a shortage of primary care health services for residents within the specific geographic area. The designations are based on the Index of Medical Underservice (IMU), which is calculated based on 4 demographic and health indicators:

- Provider per 1,000 population ratio
- Percent of the population below the federal poverty level
- Percent of the population over age 65
- Infant mortality rate

The IMU scale can range from 0 to 100, where 0 represents the completely underserved. To qualify for a designation, the IMU score must be less than or equal to 62.0.

Source: Health Resources and Services Administration

Health Professional Shortage Areas (HPSAs) are geographic areas of populations that lack enough health care providers to meet the health care needs of that population. The Health Resources and Services Administration (HRSA) designates primary care and mental health areas as HPSAs based on census tracts, townships, or counties. There are three categories of HPSA designation based on the health discipline that is experiencing a shortage: 1) primary medical; 2) dental; and 3) mental health. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. Federal regulations stipulate that, in order to be considered as having a shortage of providers, an area must have a population-to-provider ratio of a certain threshold. For primary medical care, the population to provider ratio must be at least 3,500 to 1 (3,000 to 1 if there are unusually high needs in the community).

The table identifies specific areas in each county which are designated as either MUAs or HPSAs (for mental health providers). There are no MUAs within Tolland and Windham counties. Hartford County appears to have more areas designated as MUAs and HPSAs than the other counties in the CHR service area. All counties have some areas of shortage for mental health professional shortages.

Table 13. Medically Underserved/Mental Health Professional Shortage Area (HPSA)

	Hartford County	Middlesex County	New London County	Tolland County	Windham County
Medically Underserved Areas	Bristol Service Area (04013) Hartford Service Area (00480, 00481, 00488, 00489), East Hartford Service Area (00469)	Middlesex Service Area (00479)	New London Service Area (00486, 00487))	Not applicable	Not applicable
Mental Health Professionals Shortage Area	Mental Health Catchment Area 16, 18 (West Hartford), 23 (Hartford) and Region 5	Region 2 Mental Health Catchment Area	Region 2 and 3 Mental Health Catchment Area	Region 3 Mental Health Catchment Area	Region 3 Mental Health Catchment Area
Mental Health Professionals FTE Shortage	6.9 (Region 5) 3.74 (Area 23) 1.16 (Area 18) 1.16 (Catchment Area 16 – East Hartford)[1]	7.97 (Region 2)	4.08 (Region 3)	4.08 (Region 3)	4.08 (Region 3)

Source: Health Resources and Services Administration

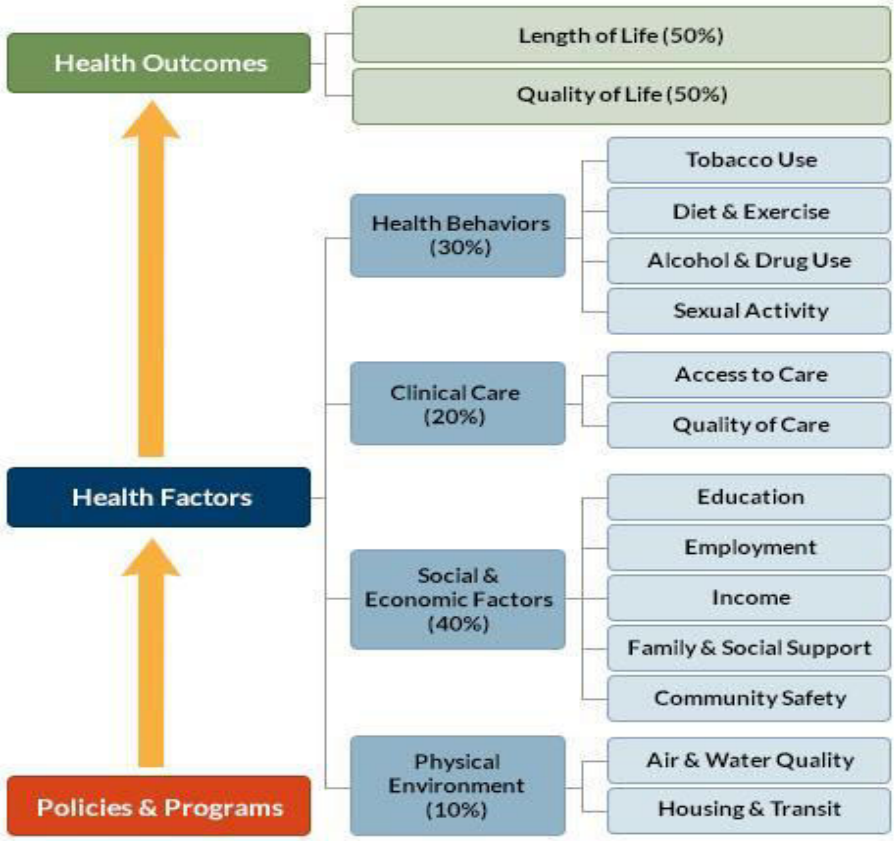
County Health Rankings

The University of Wisconsin Population Health Institute (UWPHI) created County Health Rankings and Roadmaps (CHR&R) for communities across the nation, with funding from the Robert Wood Johnson Foundation. County Health Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. The County Health Rankings measure the health of nearly all counties in the nation and rank them within states. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. The figure below represents the County Health Rankings model based on a conceptual model of population health that includes both Health Outcomes (length and quality of life) and Health Factors (determinants of health).

County Health Rankings measures the health of nearly all counties in each state for 2023. In Connecticut, 8 counties are ranked. The rank of "1" is the best. Rankings are based on factors that, if improved, can help make communities healthier places to live, learn, work and play. The County Health Rankings are based on a conceptual model of population health that includes both Health Outcomes (length and quality of life) and Health Factors (determinants of health). Health Outcomes include two sub-areas: Length of Life. Quality of Life.

[1] In addition to East Hartford, this catchment area includes East Glastonbury, Glastonbury, Maple Hill, Marlborough, Newington, Rocky Hill, South Glastonbury and Wethersfield.

Figure 9. County Health Rankings Conceptual Model of Population Health
Health Outcomes and Health Factors



Source: County Health Rankings & Roadmaps

Middlesex and Tolland counties rank the highest in terms of both overall Health Outcomes and Health Factors. For Health Outcomes, Hartford and Windham counties rank lowest (7 and 8 respectively). As it relates to Health Factors, Windham continues to rank the lowest.

Table 14. Health Outcomes and Health Factors Rankings by County (2023)

	National Benchmark	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
Health Outcomes	Not applicable	Not applicable	7	2	5	3	**8**
Health Factors			5	2	6	1	**8**

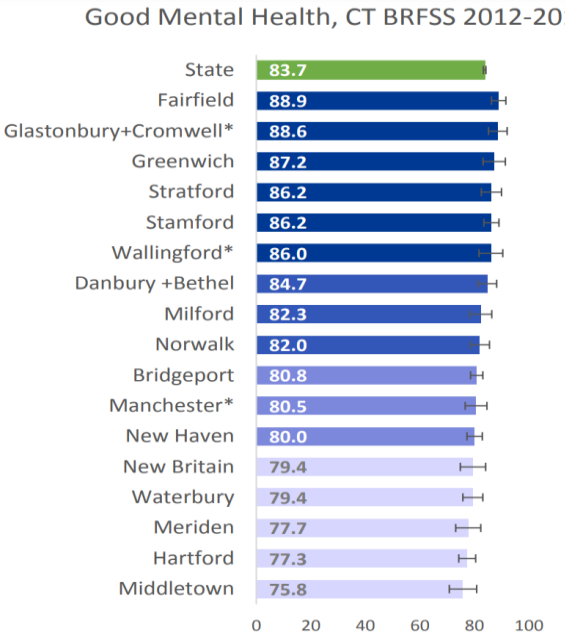
Source: County Health Rankings: 2023 Data are based upon a ranking in 8 counties with a ranking of "1" being the best.

Note: Bold represents the "worst performing" geography.

Adult Mental Health

In Connecticut during 2012 to 2016[2], 83.7% of adult residents reported being in good mental health. During 2016, this was greatest among younger adults, men, Hispanic adults, adults with higher incomes and educational levels and adults without disabilities. Compared to the statewide average, adults in Hartford (city) had a lower good mental health percentage than the average (77.3%). Data for select towns is provided below.

Figure 10. Adults Reported Good Mental Health (2012 – 2016)



County Health Rankings reports more recent data related to Fair or Poor Health and Mentally Unhealthy Days. Once again, Middlesex (8.9%) and Tolland (9.4%) counties have slightly fewer adults who report being fair or poor health than the other counties, the state and the nation. Nationally, the average number of mentally unhealthy days in the past month reported is 4.0 days and in Connecticut is 4.3 days. The number of days is higher in all counties and is highest in Windham County (4.8 days).

Table 15. Age-adjusted Percentage of Adults Reporting Fair or Poor Health and Mentally Unhealthy Days (2023)

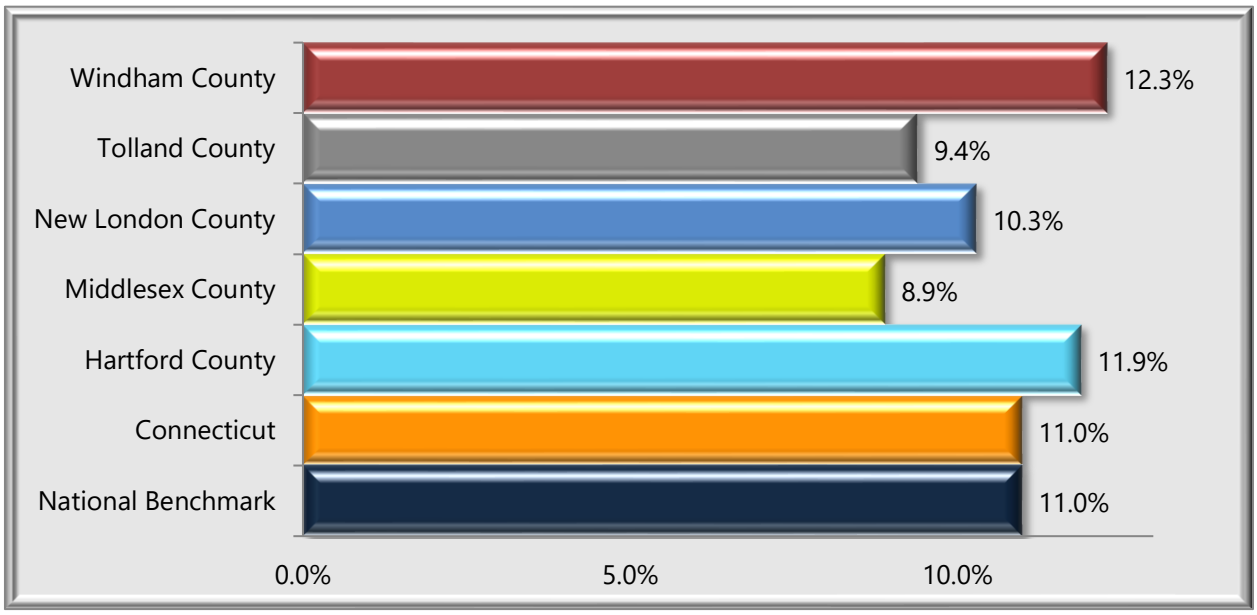
	National Benchmark (10th Percentile)	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
% Fair or Poor Health	11.0%	11.0%	11.9%	8.9%	10.3%	9.4%	**12.3%**
Average Number of Mentally Unhealthy Days in Past 30 days	4.0	4.3	4.7	4.7	4.7	4.5	**4.8**

Source: County Health Rankings: 2023

Note: **Bold** represents the "worst preforming" geography.

[2] More recent data were not found.

Figure 11. Percentage of Fair and Poor Health (2023)



In Connecticut, there is 1 mental health provider for every 218 individuals (population). The ratio is better in Hartford County (168 individuals per provider) but far worse in Tolland County (347 individuals per mental health practitioner). The national benchmark is 240:1.

Table 16. Mental Health Provider Density (2023)

	National Benchmark (10th Percentile)	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
Mental Health Provider Ratio	240:1	218:1	168:1	206:1	230:1	**347:1**	246:1

Source: County Health Rankings: 2023

Note: **Bold** represents the "worst preforming" geography.

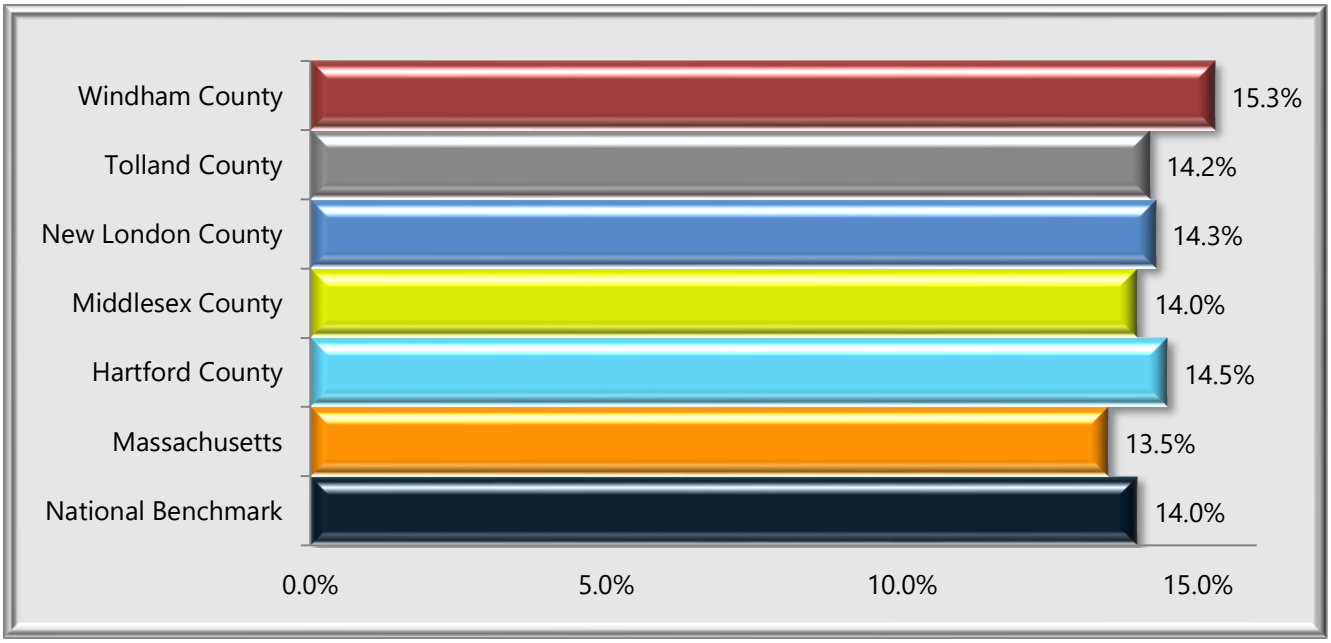
Table 17. Percentage of Adults Reporting 14 days of frequent mental distress (age-adjusted) (2023)

	National Benchmark (10th Percentile)	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
% Frequent Mental Distress	14.0%	13.5%	14.5%	14.0%	14.3%	14.2%	**15.3%**

Source: County Health Rankings: 2023

Note: **Bold** represents the "worst preforming" geography.

Figure 12. Percentage of Frequent Mental Distress (2023)



Disconnected youth are defined as being ages 16 to 19 and neither in school nor working. The National Benchmark is 7.0%. Connecticut boasts a much lower percentage (4.8%). However, Windham County is similar to the nation at 6.9% disconnected youth. Tolland County has far fewer (3.1%).

Table 18. Percentage of teens and young adults ages 16 – 19 not in school and not working (2023)

	National Benchmark (10th Percentile)	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
% Disconnected Youth	**7.0%**	4.8%	5.2%	4.4%	4.8%	3.1%	6.9%

Source: County Health Rankings: 2023

Note: **Bold** represents the "worst preforming" geography.

Food Environment and Obesity

The ability to maintain a healthy weight through diet and physical activity is influenced by both behavioral and environmental indicators. Environmental indicators include, but are not limited to, access to healthy foods and access to exercise opportunities.

The Food Environment Index measures overall food access based on 2 indicators, limited access to healthy foods and food insecurity. The index is based on a score of 0 (worst) to 10 (best). The first factor, limited access to healthy foods, measures the proportion of the population that is low income and does not live close to a grocery store. The second factor, food insecurity, measures the percentage of the population that did not have access to a reliable source of food during the past year. The Food Environment Index is better in Middlesex and Tolland counties than in the other counties and Connecticut, but worse than the National Benchmark of 8.7. New London County has the

worst Food Environment Index (7.6), followed by Windham County (7.9). However, in Windham County, 12.8% of people did not have a reliable source of food which is worse when compared to the other counties, the state (10.2%) and the National Benchmark (12.0%).

The Healthy People 2030 target for the Leading Indicator called Food Insecurity is 6.0%. A goal has been established which is "Reduce household food insecurity and hunger" (NWS – 01). The counties, state and National Benchmark are much higher than the Healthy People 2030 goal.

Body Mass Index (BMI) is a factor of diet and physical activity and is correlated with chronic health conditions. It is calculated based on the height and weight of an individual and a BMI equal to or greater than 30 is defined as obese. Obesity is highest in Windham County. This coincides with the percentage of age-adjusted percentage of adults 18 years and older who report having no leisure time physical activity in the county (22.6%).

Table 19. Food Environment and Obesity (2023)

	National Benchmark (10th Percentile)	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
Food Environment Index	8.7*	8.1	8.1	8.2	**7.6**	8.2	7.9
% Food Insecure	12.0%	10.2%	11.6%	9.8%	12.2%	9.4%	**12.8%**
% Adults with Obesity	30.0%	29.5%	31.8%	28.4%	31.3%	28.2%	**33.6%**
% Physically Inactive (no leisure time physical activity)	19.0%	20.2%	21.3%	15.7%	17.4%	17.9%	**22.6%**

Source: County Health Rankings: 2023
*Data are reverse coded and represent the 90th percentile.
Note: **Bold** represents the "worst preforming" geography.

Figure 13. Food Environment Index (2023)

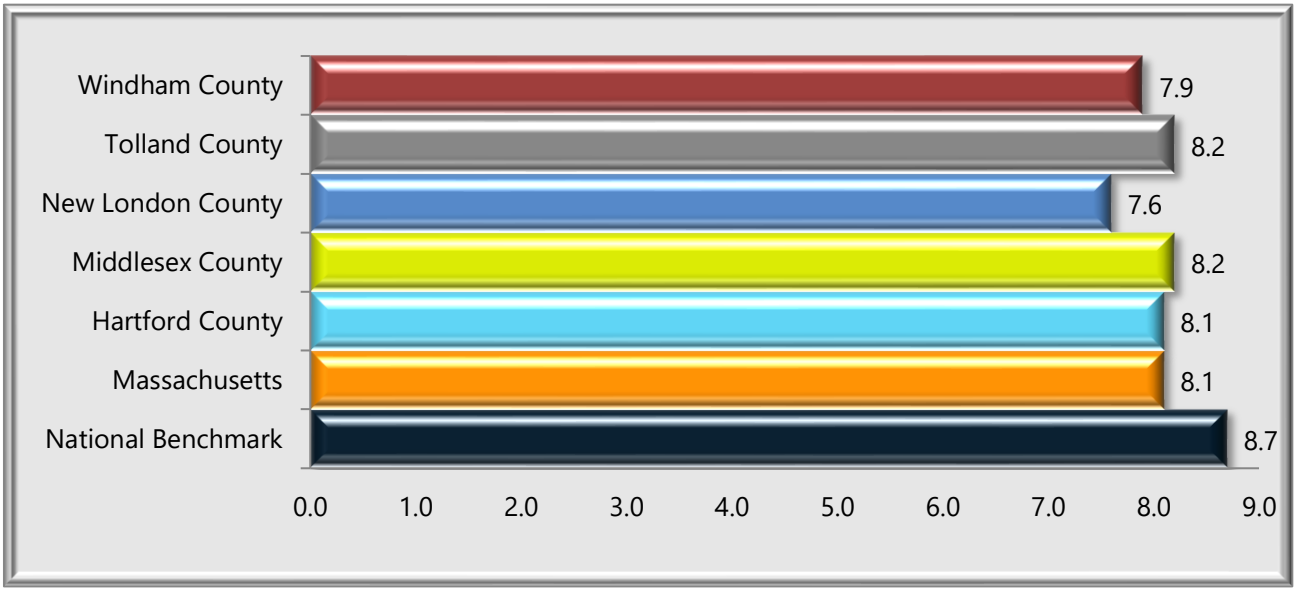
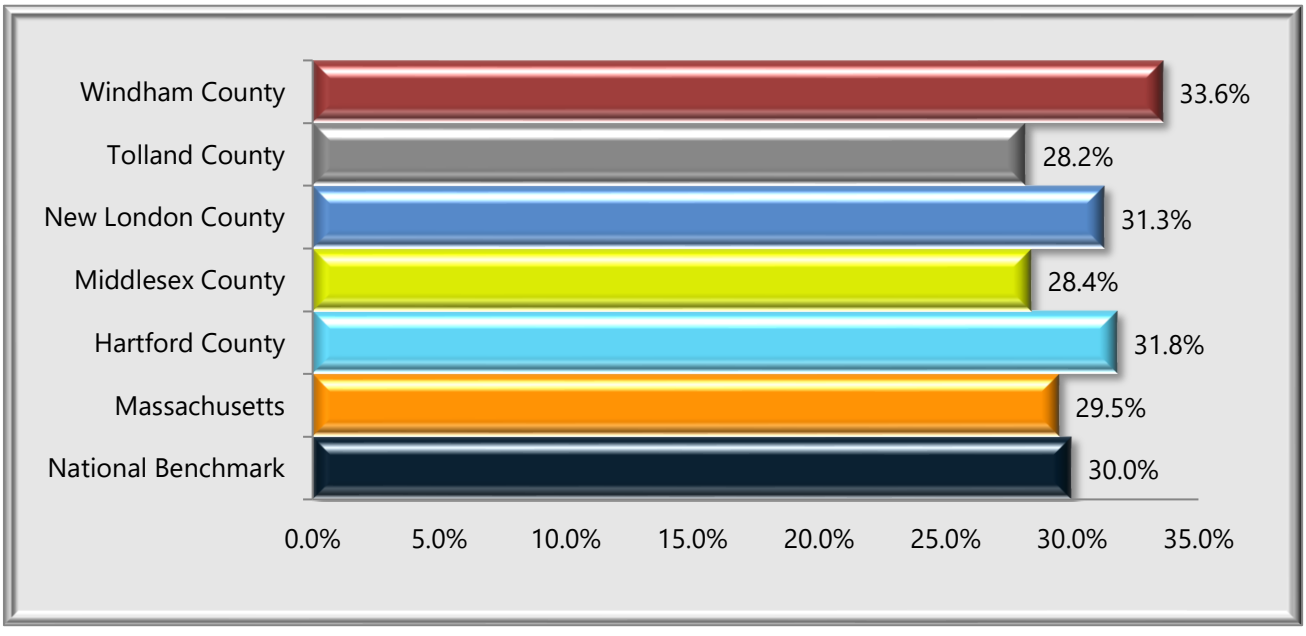


Figure 14. Adult Obesity (2023)



1.9% of the population in Connecticut experiences overcrowding while 0.7% have inadequate facilities. These are classified as severed housing problems. Fortunately, few households in the service area experience this issue. Fewest households are in Middlesex County (0.9%) and most are in Hartford County.

Table 20. Severe Housing Problems - Overcrowding (2019)

	National Benchmark (10th Percentile)	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
% Overcrowded	Not available	**1.9%**	1.8%	0.9%	1.2%	1.2%	1.4%
% Inadequate Facilities		**0.7%**	**0.7%**	0.3%	0.5%	0.1%	0.2%
% Households with Severe Cost Burden	14.0%	**16.3%**	15.6%	12.9%	13.2%	14.3%	12.2%

Source: County Health Rankings: 2023
Note: **Bold** represents the "worst preforming" geography.

Alcohol and Drug Use

Excessive drinking includes binge drinking (defined as adult males having 5 or more alcoholic drinks and adult females having 4 or more drinks on 1 occasion) and/or heavy drinking (adult males having more than 2 alcoholic drinks and adult females having more than 1 drink per day). Windham County has the highest percentage of excessive drinking among adults (21.7%). In the United States this is much lower (15.0%). Windham County also has the highest percentage of adult smokers (17.7%), far exceeding Connecticut (12.6%).

It is important to note that County Health Rankings obtains this data from BRFSS (Behavioral Risk Factor Surveillance System). Since 2011, adult students living in college housing have been included in the adult count for those engaging in excessive drinking.[3]

Table 21. Drinking and Smoking (2023)

	National Benchmark (10th Percentile)	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
% Excessive Drinking	15.0%	17.4%	18.2%	21.3%	20.8%	17.4%	**21.7%**
% Adults Reporting Currently Smoking	15.0%	12.6%	15.0%	14.2%	15.5%	13.5%	**17.7%**

Source: County Health Rankings: 2023
Note: **Bold** represents the "worst preforming" geography.

The drug overdose mortality rate per 100,000 population is highest in Windham County (42.0), followed by New London County (41.0). Tolland County, where the rate is much lower (28.1) compares most closely to the National Benchmark (23.0). Healthy People 2030 has established a goal for Drug Overdose Deaths. The goal is "Reduce Drug Overdose Deaths (SU-03) and a target has been set at 20.7 per 100,000 (age-adjusted population).

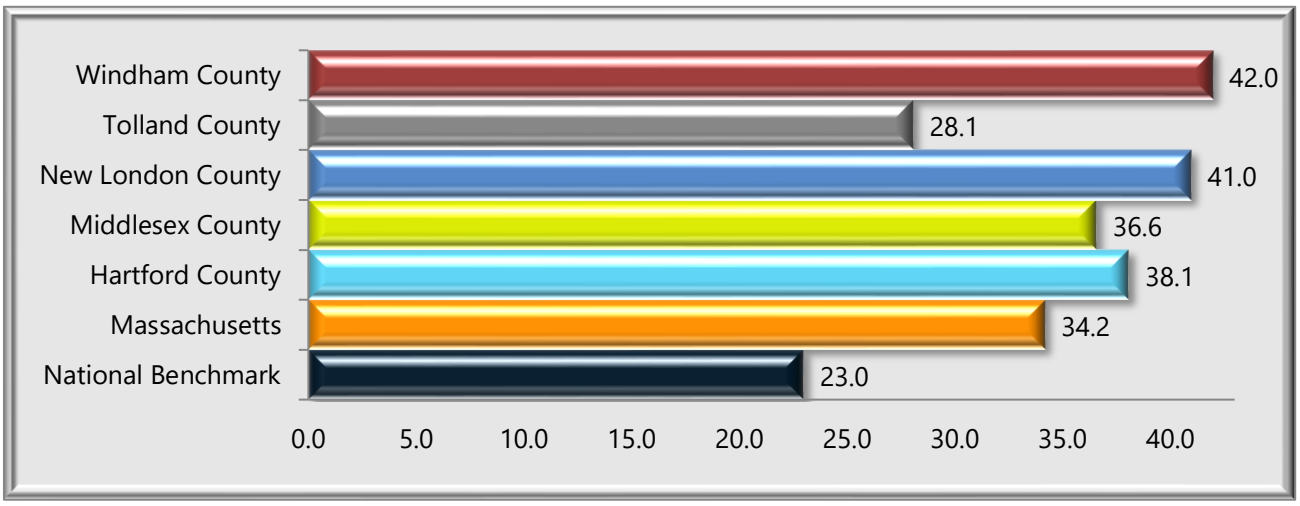
[3] https://www.cdc.gov/brfss/data_documentation/pdf/UserguideJune2013.pdf

Table 22. Drug Overdose Mortality Rate per 100,000 (2023)

	National Benchmark (10th Percentile)	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
Drug Overdose Mortality Rate	23.0	34.2	38.1	36.6	41.0	28.1	**42.0**

Source: County Health Rankings: 2023
Note: **Bold** represents the "worst preforming" geography.

Figure 15. Drug Overdose Mortality Rate per 100,000 Individuals (2023)



Severe Mental Illness

The Substance Use and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use disorders, and their families. SAMHSA utilizes data from The National Survey on Drug Use and Health (NSDUH). NSDUH specifies that "persons excluded from the survey include individuals experiencing homeless who do not use shelters, active military personnel, and residents of institutional group quarters such as jails, nursing homes, mental institutions and long term care hospitals."[4] Services within Connecticut and data collected are based on location within 5 Regions (Eastern, North Central, Northwestern, South Central and Southwest). Based on CHR's service areas, data for North Central, South Central and Eastern Connecticut are provided in the tables related to mental health and substance use that follow.

SAMHSA tracks several indicators related to mental illness, suicide and depression. Compared with all other geographies, Eastern Connecticut has the highest percentage in the past year of mental illness (20.2%), serious thoughts of suicide (4.63%) and a major depressive episode (7.3%). This

[4] https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

region includes Windham and New London counties. North Central Connecticut (parts of Tolland and Hartford counties) also has the highest percentage of a major depressive episode (7.3%). Overall, the United States has the highest percentage of a serious mental illness in the past year (4.5%).

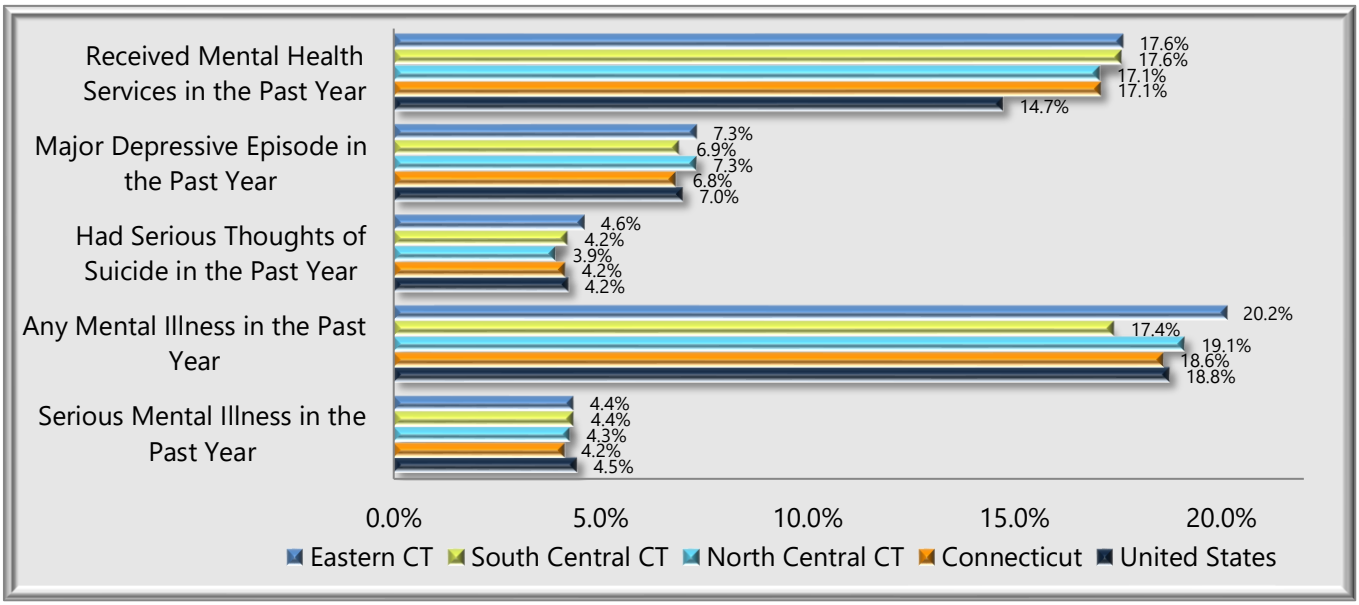
However, Eastern and South Central Connecticut also have the highest percentage of its population that has received mental health services in the past year (17.6%). In the state, the percentage is 17.11%, but nationally it is lower (14.7%). Healthy People 2030 has an established goal to "Increase the proportion of adults with serious mental illness who get treatment" (MHMD-04). The target is 68.8%. It is important to note that the indicator in the table below is for individuals with any mental illness who received mental health services in the past year. The two indicators cannot be directly compared. Data for Connecticut towns for 2015 to 2019 indicate that the suicide rate for Hartford is 6 per 100,000 (37 suicides during that time period). Data for East Hartford is suppressed as there are fewer than 20 suicides.

Table 23. Mental Illness, Suicide, Depression and Utilization of Services (2016-2018)

	United States	Connecticut	North Central Connecticut	South Central Connecticut	Eastern Connecticut
Serious Mental Illness in the Past Year	**4.5%**	4.2%	4.3%	4.4%	4.4%
Any Mental Illness in the Past Year	18.8%	18.6%	19.1%	17.4%	**20.2%**
Had Serious Thoughts of Suicide in the Past Year	4.2%	4.2%	3.9%	4.2%	**4.6%**
Major Depressive Episode in the Past Year	7.0%	6.8%	7.3%	6.9%	**7.3%**
Received Mental Health Services in the Past Year	14.7%	17.1%	17.1%	17.6%	**17.6%**

Source: SAMHSA https://pdas.samhsa.gov/saes/substate
Data for substate regions are only available through 2018.

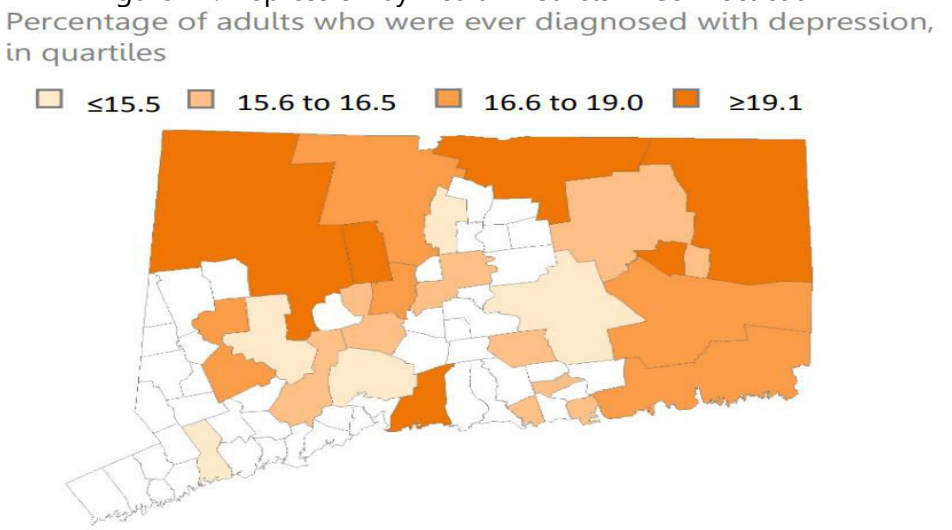
Figure 16. Mental Illness in the Past Year (2016 – 2018)



Source: SAMHSA https://pdas.samhsa.gov/saes/substate

Depression is a common and serious illness that can take several forms, with symptoms including persistent feelings of sadness, anxiety, emptiness and hopelessness as well as fatigue, irritability and restlessness. Respondents were asked if they were ever told they had a depressive disorder including depression, major depression, dysthymia or minor depression. In Connecticut, one in 6 adults in 2020 was diagnosed with depression (17.7%). The risk of depression is highest among adults aged 18 to 34 (22.5%), females (22.8%), non-Hispanic White (19.0%), adults from households earning less than $35,000 (26.0%) and $335,000 to $74,999 (18.4%), adults with health insurance (18.5%) and adults with a disability (35.9%). The prevalence of depression in Connecticut has climbed since 2016 when it was 15.9%. Data were not found for counties however, the chart below details depression statistics in Health Districts from the Behavioral Risk Factors Surveillance Survey 2012 to 2016.

Figure 17. Depression by Health Districts in Connecticut



The age-adjusted suicide rate per 100,000 is highest in Tolland County and lowest in Hartford County (10.3). (Windham County data are unreliable according to SAMSHA.) In all counties, the suicide rate is higher than in Connecticut (11.1) with the exception of Hartford County (10.3). The Healthy People 2030 target related to suicide is "Reduce the Suicide Rate" (MHMD – 01). The defined target is 12.8 per 100,000 age adjusted population. Hartford, Middlesex and Connecticut meet this target.

Table 24. Intentional Self-harm (Suicide) Age-Adjusted Rate per 100,000 (2021)

	United States	Connecticut	Hartford County	Middlesex County	New London County	Tolland County	Windham County
Intentional Self-harm (suicide)	14.5	11.1	10.3	12.1	13.0	**16.0**	Unreliable

Source CDC Wonder, Underlying Cause of Death

Substance Use

SAMHSA tracks several indicators related to alcohol, marijuana, cocaine and heroin use in the past year by individuals 12 years of older. In the case of marijuana use, the time period is within the past month. The region, North Central Connecticut, has the highest percentage of alcohol use disorder (6.25%), marijuana use (11.83%) and heroin use (0.67%). Across the board, the percentage of the use of various substances is higher in Connecticut and the 3 regions than in the United States. Substance use in Connecticut is generally less (albeit slightly) than in the 3 regions.

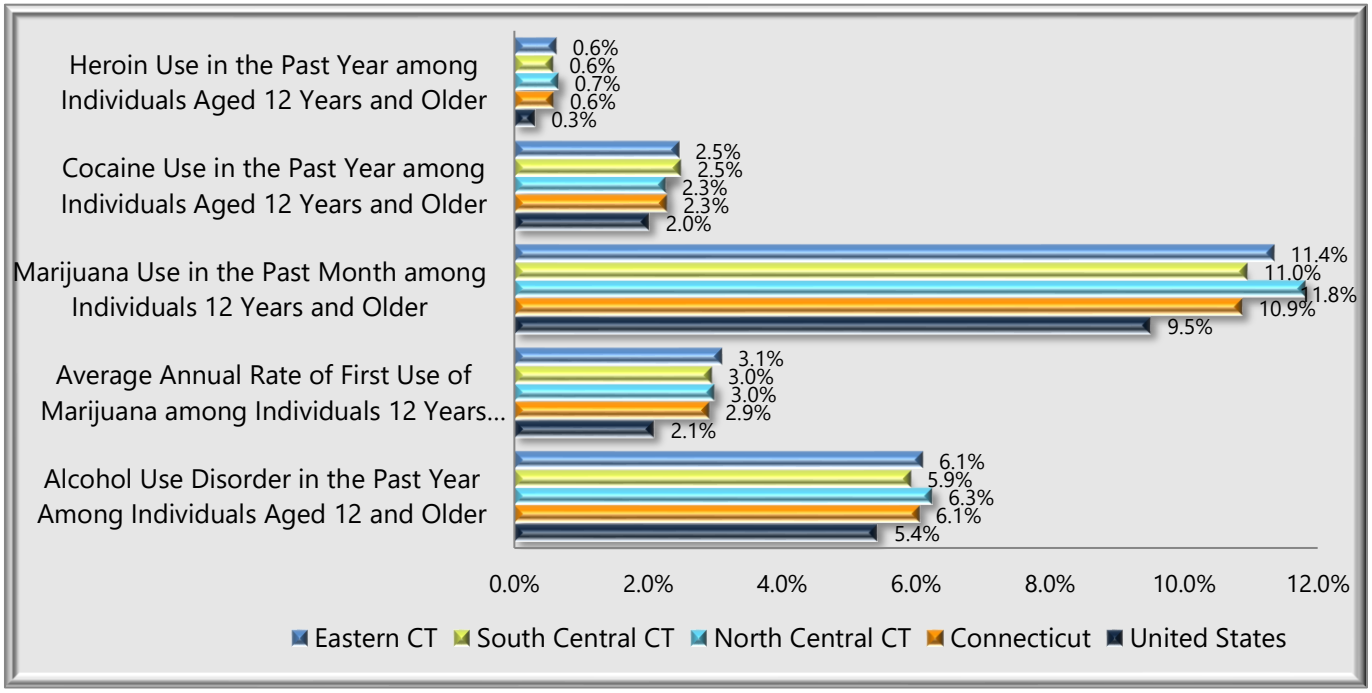
Table 25. SAMHSA Substance Use Data (2018)

	United States	Connecticut	North Central Connecticut	South Central Connecticut	Eastern Connecticut
Alcohol Use Disorder in the Past Year Among Individuals Aged 12 and Older	5.44%	6.06%	**6.25%**	5.93%	6.11%
Average Annual Rate of First Use of Marijuana among Individuals 12 Years and Older	2.10%	2.92%	3.00%	2.96%	**3.11%**
Marijuana Use in the Past Month among Individuals 12 Years and Older	9.52%	10.88%	**11.83%**	10.96%	11.36%
Cocaine Use in the Past Year among Individuals Aged 12 Years and Older	2.03%	2.29%	2.27%	**2.50%**	2.47%

	United States	Connecticut	North Central Connecticut	South Central Connecticut	Eastern Connecticut
Heroin Use in the Past Year among Individuals Aged 12 Years and Older	0.32%	0.60%	**0.67%**	0.59%	0.64%

Source: SAMHSA Substate Data
Data for substate regions are only available through 2018.

Figure 17. Alcohol and Drug Use in Individuals Aged 12 and Older (2016-2018)



KEY INFORMANT SURVEY FINDINGS

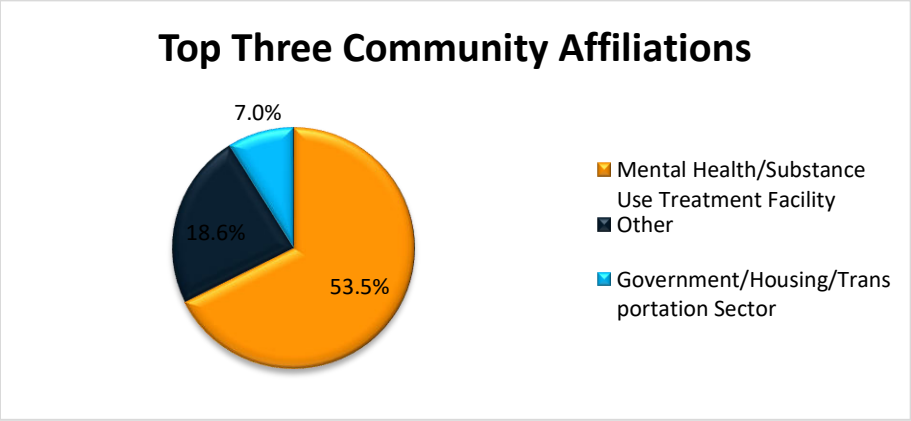
Key informants (defined as community stakeholders with expert knowledge about the needs of older adults and identified by CHR) were invited to participate in a survey focused to gather a combination of quantitative ratings and qualitative feedback through closed and open-ended questions. Questions focused on the most significant mental health and substance use issues in the service areas, awareness of the availability of services, access to services, underserved populations and top health issues. Key informants included participants from mental health and substance use treatment facilities government/housing and transportation sector, social services, youth services, community members and hospitals.

Holleran worked closely with CHR to identify key informant participants. One hundred and eighty informants were asked to complete the survey. Three reminder emails during March 2024 as well as a personal letter (emailed) from the Chief Executive Officer at CHR were sent to elicit participation. A total of 47 of 180 participated for a response rate of 26.1%. A large majority (53.5%) of respondents are affiliated with a mental health/substance use treatment facility. Government and social services and youth services comprise the next greatest number of participants.

Table 26. Key Informant Affiliations

	Number of Participants	Percent of respondents
Mental Health/Substance Use Treatment Facility	23	53.5%
Other	8	18.6%
Government/Housing/Transportation Sector	3	7.0%
Social Services	3	7.0%
Youth Services	3	7.0%
Community Member	2	4.7%
Hospital	1	2.3%
Aging Services	0	0.0%
Education/School	0	0.0%
Faith-Based/Cultural Organization	0	0.0%
Public Health Organization	0	0.0%

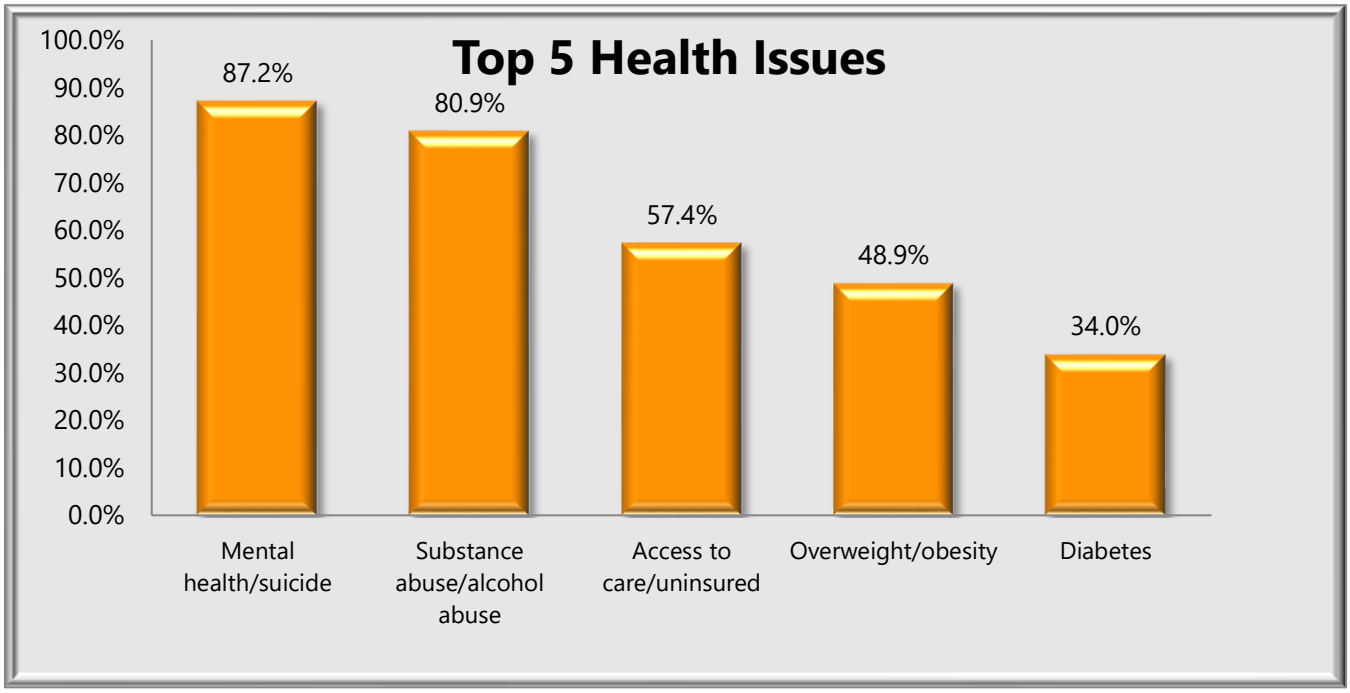
Figure 18. Key Informant affiliations



Health Issues

Key Informant survey respondents were asked to identify the Top 5 Health Issues affecting their service area. The health issue ranked by most respondents as number one is Mental Health/Suicide. 87.2% of respondents selected this issue. Next, Substance Use/Alcohol Use is ranked by many as very high on the list (80.9%). Ranked by fewer respondents (57.4%) as a Top 5 Health Issue is Access to care/Uninsured. Obesity and Diabetes were also ranked in the top. These rankings are displayed in the graph.

Figure 19. Top 5 Health Issues



Mental Health

Key Informants were asked to rank the Top 3 most pressing mental health issues in the community. An overwhelming majority stated that Trauma (68.1%) is the top mental health issue. The second is Anxiety with 57.4% of Key Informants choosing this issue. This is followed by Depression (51.1%). Opioid Overdose was chosen by 42.6% as the fourth most pressing mental health issue. When asked to select the most significant mental health issues, again respondents selected Opioid Overdose, (26.2%), Trauma (26.2%) and Anxiety (23.8%).

Figure 20. Ranking of key mental health issues by Key Informants

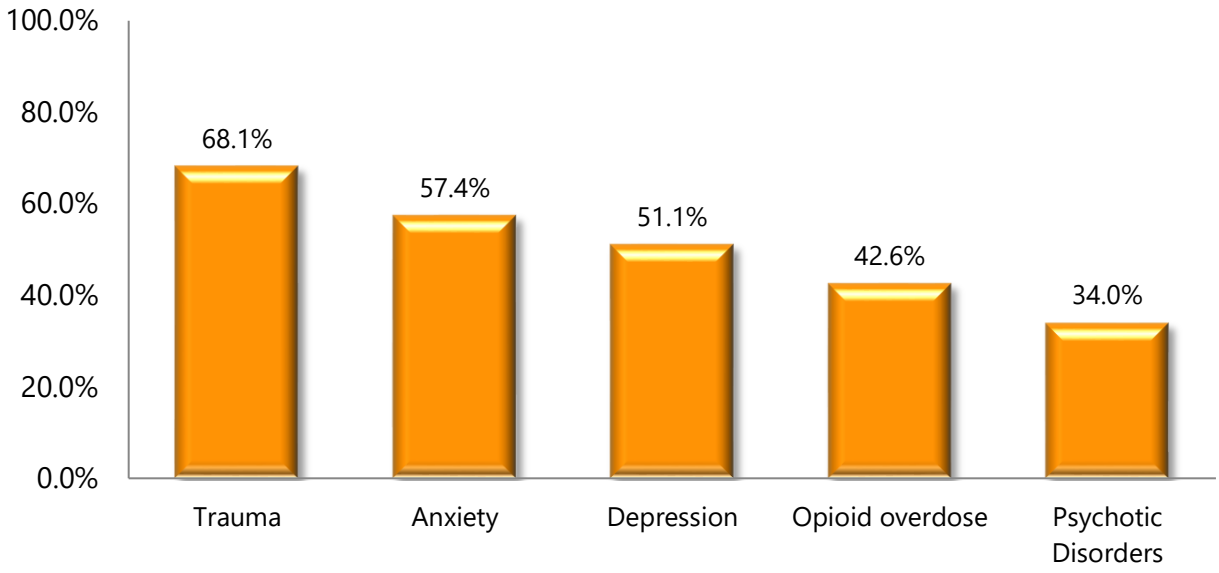


Table 27. Most Significant Mental Health Issue

	Count	Percent of respondents who selected the issue*
Opioid Overdose	11	26.2%
Trauma	11	26.2%
Anxiety	10	23.8%
Psychotic Disorders	4	9.5%
Suicide	3	7.1%
Depression	2	4.8%
Other	1	2.4%
Personality Disorders	0	0.0%
Self-harming behaviors	0	0.0%

Substance Use

Key Informants were asked to rank the top Substance Use issues. Seventy percent(70.2%) selected Alcohol use as the top issue, followed by Opioid use (51.1%) and then the use of illicit drugs (38.3%). Of these issues, the most significant issues are Opioid Use, the use of illicit drugs and alcohol use. This is followed by e-cigarette/vaping.

Figure 21. Ranking of key substance use issues by Key Informants

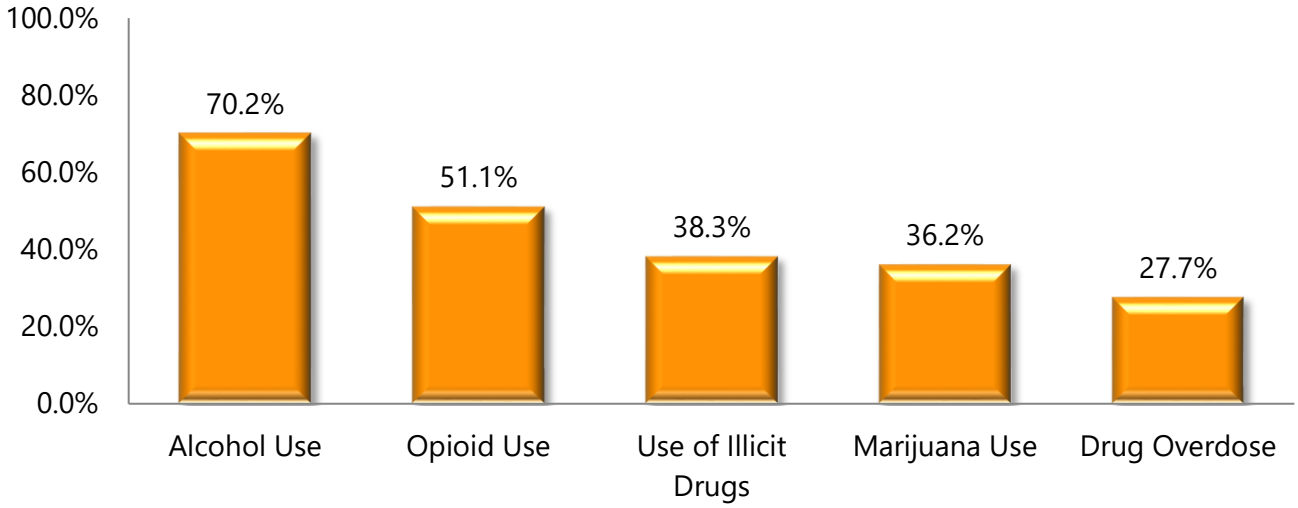
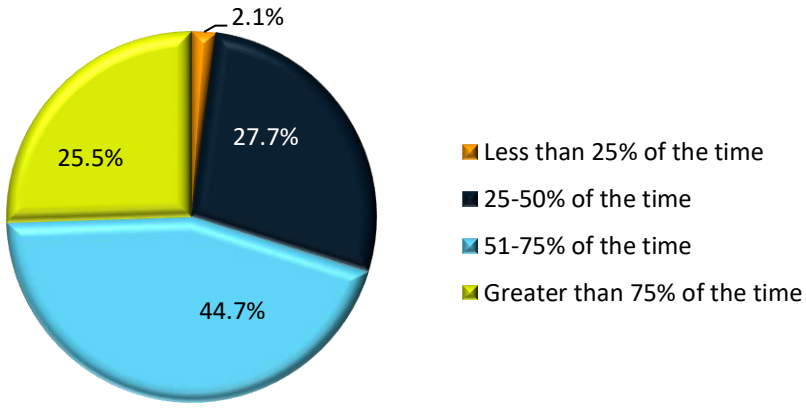


Table 28. Most Significant Substance Use Issue

	Count	Percent of respondents who selected the issue*
Opioid Use	11	25.0%
Use of Illicit Drug	10	22.7%
Alcohol Use	9	20.5%
E-cigarette/Vaping	5	11.4%
Marijuana Use	4	9.1%
Drug Overdose	3	6.8%
Impaired Driving	1	2.3%
Misuse of Prescription Drugs	1	2.3%
Alcohol Poisoning	0	0.0%
Tobacco Use	0	0.0%
Underage Drinking	0	0.0%
Other	0	0.0%

Key Informants were also asked to estimate the percentage of cases where a mental health diagnosis is also accompanied by a substance use or addition problem, known as co-occurring disorders. Almost 45% estimate that this happens 51% to75% of the time.

Figure 22. Perceived prevalence of co-occurring disorders



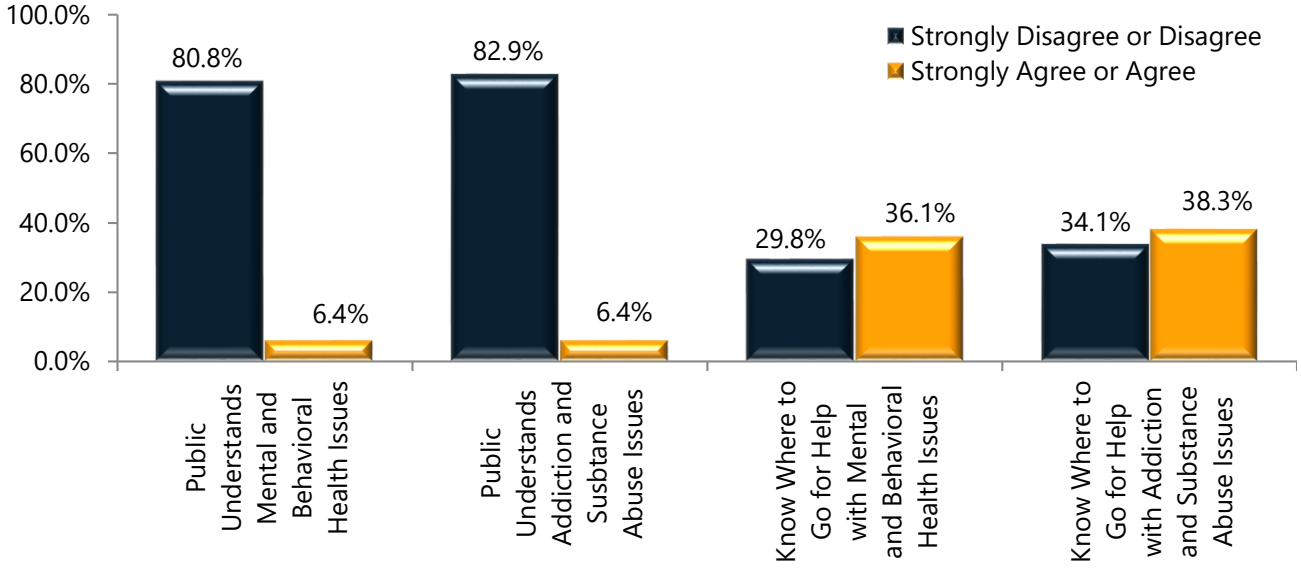
Select Feedback About the Mental Health and Substance Use Issues

- *Many people I work with come in abusing heroin, cocaine, PCP, Fentanyl. I still issue of prescription drug abuse and a significant problem with individuals abusing Alcohol.*
- *Illicit drugs including heroin, benzos, cocaine, fentanyl, crack, PCP, stimulants, alcohol are all a huge issue among the populations we serve. Addiction to alcohol, opiates and benzos are deadly and yet these 3 substances are typically the ones that folks use. Significant increase in juvenile use of vaping products: both THC and nicotine.*
- *Ever since the legalization of marijuana, I feel people are now more willing to divulge information about their use. I also feel that it is more widely accepted that people try and use marijuana recreationally.*
- *Youth in the program use drinking, marijuana and vaping to cope with their trauma and depression.*
- *Trauma at the individual and community level is endemic and often the root of other MH and SA issues. Alcohol use continues to be an issue which we are seeing more and more with drunk driving. I think prescription drug use is a big issue for our youth who are experimenting. This is concerning because pills may look like the prescription medication and they may not be and may contain life threatening fentanyl and xylazine.*
- *The individuals I work with have experienced trauma from a young age; affecting their basic development which has an impact of their thinking, emotional regulation and abilities to interact with others in a healthy way.*
- *The population served now has more co-occurring issues than ever. Psychiatric issues and substance use issues feed off each other making the challenges extreme.*

Awareness of Issues and Services

Key Informants were asked about the community's awareness of mental health and substance use issues, on a five-point scale of Strongly Disagree to Strongly Agree. In general, the vast majority of respondents perceive that the public does not understand mental health (80.8%) or substance use (82.9%) issues. Responses were mixed as they relate to community residents knowing where to get treatment for mental health and substance use issues. About one-third Agree and Strongly Agree and one-third Disagree or Strongly Disagree.

Figure 23. Percentage of key informants' agreement/disagreement with awareness statements



Select Issues Regarding the Awareness of Mental Health and Substance Use Issues

- *There are gross misunderstandings about mental health and addiction. What folks think they know is fueled by fear.*
- *Mental health and substances abuse is talked about more frequently than it has been in the past, which is wonderful. However, due to limited resources or bad experiences or fear of services and what they mean people struggle to engage.*
- *I believe most people know where to start to get services for MH/SA issues.*
- *I find that the general public are talking more openly about anxiety, depression, ADHA or even Autism; but I find that their understanding of those topics are limited.*
- *Clinical services are not advertised in the town.*

Access to Services

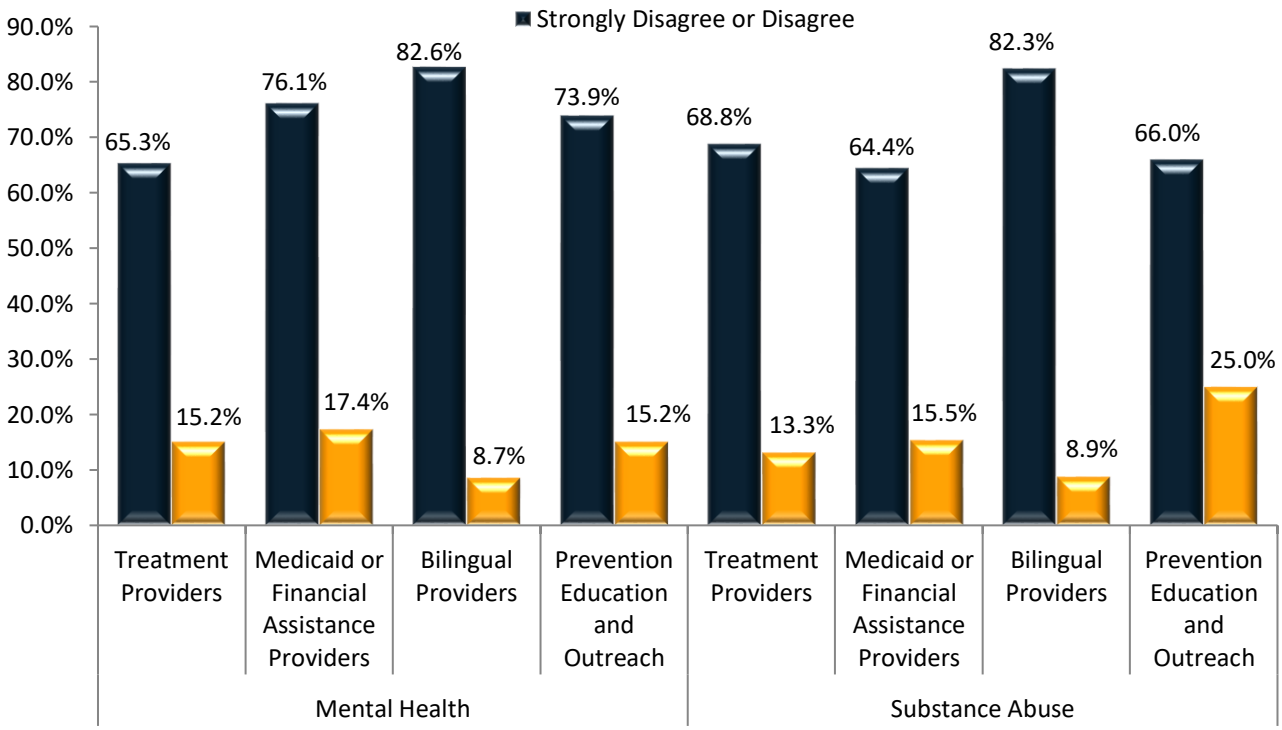
The next series of questions asked participants to agree or disagree with statements that address access to providers and services in the community that provide mental health/substance use services, accept Medicaid or provide financial assistance, are bilingual and offer prevention education and outreach frequently. The lack of bilingual providers is particularly strong as is the perceived lack of providers who accept Medicaid or provide financial assistance.

For both mental health and substance use, an overwhelming majority disagree with the availability of these services as seen in Figure 24. These include Treatment Providers, Medicaid or Financial Assistance Providers, Bilingual Providers and Prevention, Education and Outreach.

Select Comments about Access to Mental Health and Substance Use Services

- *Time lack of counseling services after 5pm and/or weekends. Need more clinical staff who are of color who are serving the community they represent.*
- *Providers in this field are overworked, underpaid and overregulated, which is why more and more providers are leaving the field. Reimbursement rates have barely changed in over a decade yet cost of living has skyrocketed. People are leaving the field. This will result in it being harder and harder for people in need to find the help they need, which in turn will put a strain on hospitals and cost taxpayers more money and/or result in more client deaths.*

Figure 24. Percentage of key informants' agreement/disagreement with access statements for Mental Health and Substance Use



When asked where the majority of individuals go first when they are in need of mental health/substance use treatment, 41.3% of respondents selected Hospital Emergency Department as the first stop. Far fewer respondents (15%) selected their Primary Care Provider or Family Doctor (19.6%). Social Service Agency/Non-Profit Community Provider follow closely behind (17.4%).

Table 29: Ranking of Where Community Residents Go First for Help with Mental Health and/or Substance Use Issues

	Count	Percent of respondents who selected the issue*
Hospital Emergency Department	19	41.3%
Primary Care Provider/Family Doctor	9	19.6%
Social Service Agency/Non-Profit Community Provider	8	17.4%
Community Health Center/FQHC	4	8.7%
Other	3	6.5%
Religious Institutions	1	2.2%
School	1	2.2%
Self-Help Group (i.e. Alcoholics Anonymous, NAMI, etc)	1	2.2%

*Respondents were able to select more than one answer.

Respondents were asked their opinions on what system gaps currently exist in the community related to mental health and substance use services. According to 85.1% of respondents, Long Waiting Lists create a gap in services. Insurance Barriers was selected by 70.2% of as a serious system gap. The Lack of Providers and Support to Navigating the Mental Health System are also at the top of the list.

Table 30: Ranking of the System Gaps by Key Informants

	Count	Percent of respondents who selected the issue*
Long Waiting List	40	85.1%
Insurance Barriers	33	70.2%
Lack of Providers	29	61.7%
Lack of Support in Navigating Mental Health System	29	61.7%
Language/Cultural Barriers	23	48.9%
Limited Coordination Between Providers and Services	23	48.9%
Lack of Community-Wide Prevention Efforts	22	46.8%
Limited Assistance with Medication Management	22	46.8%
Other	7	14.9%
None	0	0.0%

* Respondents could select more than one option; therefore the percentages may sum to more than 100.0%.

Key Informants were asked what they felt were the most common reasons individuals in the community do not seek treatment for mental health/substance use issues. As depicted in Table 30, the most commonly identified reason is Not Ready for Treatment (72.3%). Financial issues, Inability to Pay out of Pocket Expenses (68.1%) and Lack of or Insufficient Health Insurance Coverage (66.0%) follow. The Lack of Transportation and Social Stigma were also selected as reasons that individuals do not seek treatment. Only immigration status (25.5%) was selected by less than 50% of respondents.

Table 31: Common Reasons Individuals do not Seek Treatment

	Count	Percent of respondents who selected the issue*
Not Ready for Treatment	34	72.3%
Inability to Pay Out of Pocket Expenses	32	68.1%
Lack of or Insufficient Health Coverage	31	66.0%
Lack of Transportation	30	63.8%
Social Stigma	29	61.7%
Don't Know Where to Go For Treatment	26	55.3%
Lack of Programming/Providers	22	46.8%
Language Barrier	16	34.0%
Immigration Status	12	25.5%
Other	4	8.5%

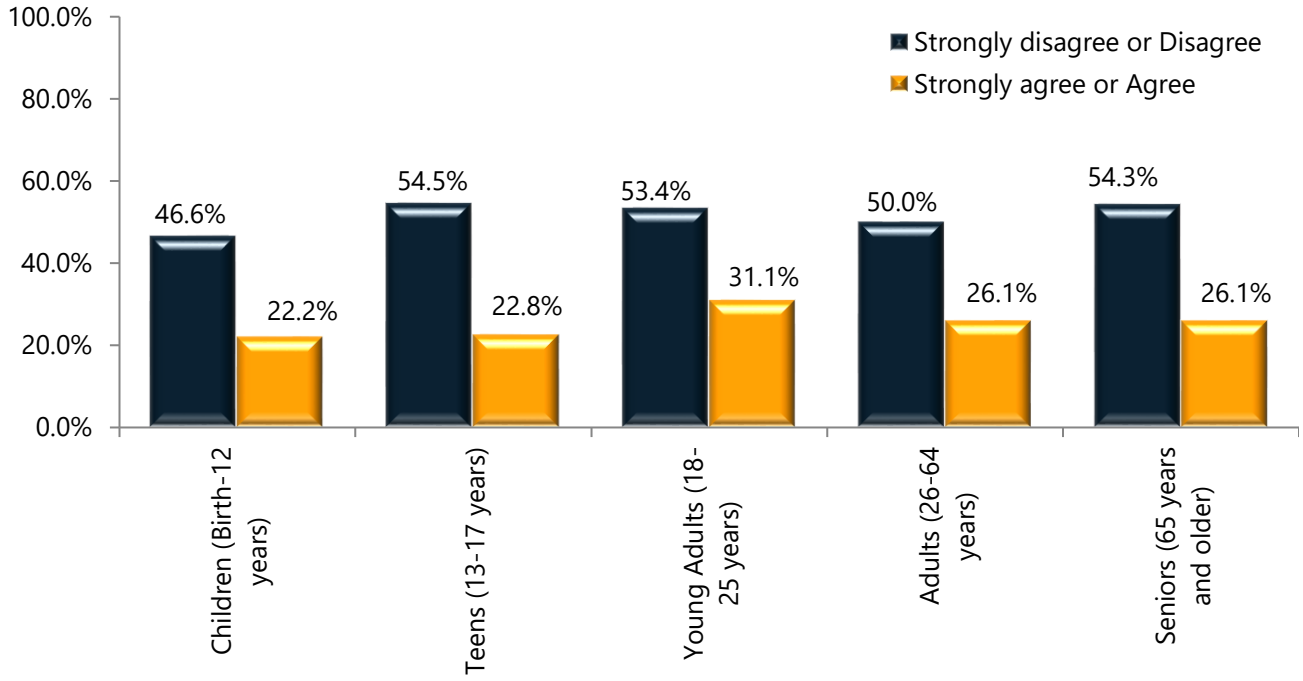
* Respondents could select more than one option; therefore the percentages may sum to more than 100.0%.

Underserved Populations

Key Informant participants were asked about specific population groups that may be underserved by local mental health and substance use services. First, respondents were asked which groups were most underserved based on their health insurance status. Although 63.8% of Key Informants felt those without insurance are the most underserved group, there are still more than half (51.1%) who felt those with private health insurance who are unable to afford their out-of-pocket expenses are also underserved. Over one-third (38.3%) selected those with public health insurance (Medicaid) as also underserved. Whether uninsured or underinsured, these populations are perceived to be underserved.

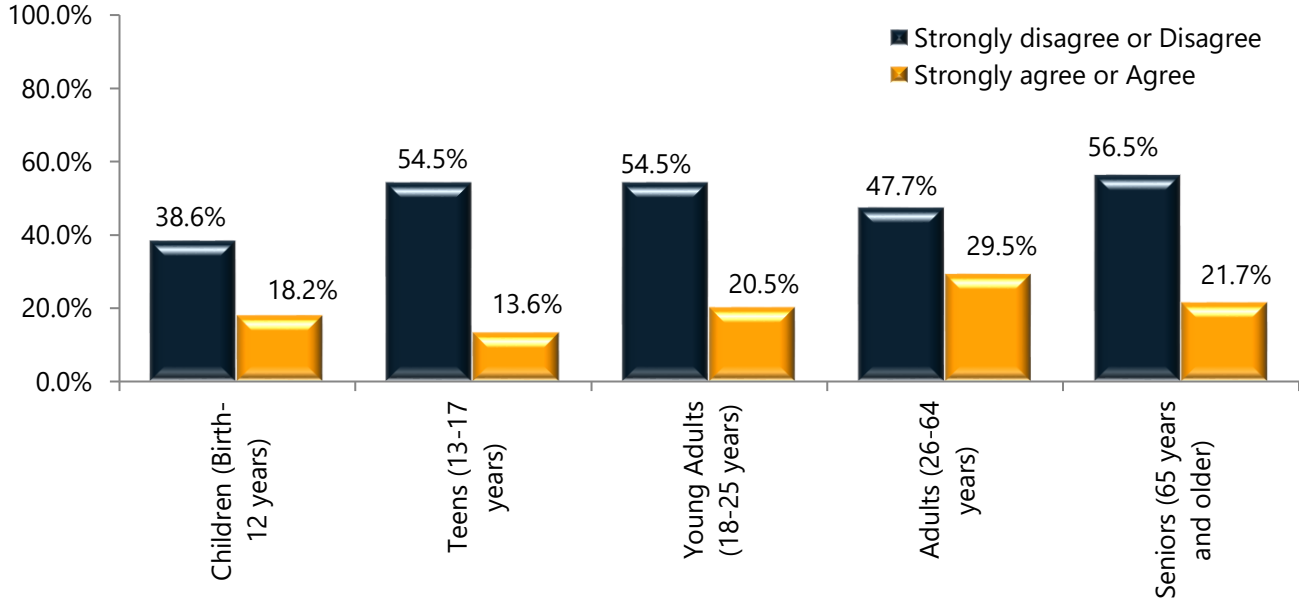
Survey respondents were asked to rate their level of agreement, on a scale of Strongly Disagree to Strongly Agree, on the adequacy of both mental health services and substance use services in the community for particular age groups. Half or more of Key Informants disagree that mental health services are adequate for teens (ages 13 to 17), young adults (ages 18 to 25), adults (ages 26 to 64), and seniors (ages 65 and over). Almost half of respondents (46.6%) disagree that there are adequate mental health services for children (birth to age 12).

Figure 25. Ratings of Adequacy of Mental Health Services by Age Group



As it pertains to substance use, a majority of respondents (more than 50%) disagree or strongly disagree that services are adequate for teens, young adults and seniors. Responses are mixed as to whether or not substance use services are adequate for adults. A smaller percentage of respondents disagree that services are adequate for children.

Figure 24. Ratings of Adequacy of Substance Use Services by Age Group



Key Informants were asked if there are specific Racial/Ethnic Populations, as well as any other population groups, such as Homeless, Disabled, etc., who are underserved in terms of receiving mental health and substance use services. Black/African American (70.2%) is perceived by most to be underserved. This is followed by Latino/Hispanic (57.4%). The Homeless, those who are Uninsured or Underinsured and those with Low Incomes are also perceived by most to be underserved.

Table 32: Most Underserved Racial Groups

	Count	Percent of respondents who selected the group*
Black/African-American	33	70.2%
Latino/Hispanic	27	57.4%
Asian	24	51.1%
White	5	10.6%
None	4	8.5%
Other	2	4.3%

* Respondents could select more than one option; therefore the percentages may sum to more than 100.0%.

Table 33: Most Underserved Populations

	Count	Percent of respondents who selected the group*
Homeless	39	83.0%
Uninsured/Underinsured	28	59.6%
Low-income/Poor	27	57.4%
Immigrant/Refugee	21	44.7%
Disabled	17	36.2%
Other	4	8.5%
None	1	2.1%

* Respondents could select more than one option; therefore the percentages may sum to more than 100.0%.

Select Comments Regarding Underserved Populations

- *It is often the Emergency Rooms that get inundated with the underserved populations, making themselves more vulnerable and invisible to the EDs because they are now 'frequent flyers' that aren't taken seriously anymore.*
- *Often times when individuals seek help they get placed in boxes and are unable to seek all the resources that are needed to help support them. The systems are hard to navigate, the forms are confusing to complete and collaboration struggles to occur.*
- *I believe the mental health/substance use and child welfare systems of care are all currently inadequate to meet the needs/demands of the child/adult populations served. I believe a good portion of that is due to lack of staffing and workforce issues that escalated during COVID and have not resolved.*

Missing or Lacking Services

Lastly, Key Informants were asked to rank key community services that may be missing, lacking, not affordable, or need being met in the service area. Housing assistance and Transportation were chosen as missing services by the greatest percentage of respondents.

Table 34. Services that are Missing in the Service Area

	Count	Percent of respondents who selected the issue*
Housing assistance	10	21.7%
Transportation	8	17.4%
Advocacy for social needs (food security, housing, education, employment, etc.)	3	6.8%
Support group services	2	4.3%
Preventive health screenings (blood pressure, diabetes, stroke, etc.)	1	2.2%
Primary care services	0	0.0%
Substance use services	0	0.0%

Once again, Housing Assistance and Transportation were selected as services that are lacking in the service area. All other services were selected far less frequently.

Table 35. Services that are Lacking in the Service Area

	Count	Percent of respondents who selected the issue*
Housing assistance	10	21.7%
Transportation	8	17.4%
Advocacy for social needs (food security, housing, education, employment, etc.)	3	6.8%
Support group services	2	4.3%
Preventive health screenings (blood pressure, diabetes, stroke, etc.)	1	2.2%
Primary care services	0	0.0%
Substance use services	0	0.0%

Finally, 18.6% of Key Informants perceived Primary Care Services to be unaffordable. Support group services (28.3%) and Primary Care Providers (25.6%) are believed to be needs that are being met in the community.

Select Comments About Challenges the Community Faces in Addressing Mental Health and Substance Use Issues

- *Lack of providers and lack of capacity in a number of community-based programs. Homelessness and insecure housing is pervasive and creates the need for community-based and outreach-based services.*
- *Lack of capacity in 28 & 30-day substance treatment programs means that clients are often discharged from detox to the streets, or often can't access rehabilitation programs if they're not abusing a substance that requires a medically monitored detox.*
- *Current providers are overworked (unrealistic caseloads) and underpaid. No incentives to take care of oneself or patients.*
- *Socio-economic status, political climate, education and closing of support services due to little or no funding.*
- *I would imagine that this added stress and trauma of not being able to afford basic needs is impacting people's mental and physical well-being, and people may be deciding to not access health care in order to pay for other essentials.*
- *Behavioral health organizations like CHR are struggling to recruit and retain enough qualified staff.*
- *There is still a very strong stigma about those who use. Often, we see individuals who are self-medicating with substances because they don't have insurance or can't afford proper treatment.*
- *Not enough providers to provide adequate care, applying band aids instead of addressing the main concerns due to the shortages.*
- *I believe the biggest barrier is a demand that is greater than the resources.*
- *Significant staffing issues causes waitlists where program become more severe while waiting on services.*
- *There are not enough prevention or support programs available. The system is set up to be more reactive vs proactive.*
- *Many are not aware of the services that are being offered, need education about these topics, and informed about the resources. There has to be more outreach: educating in their communities, schools, and churches.*
- *Continuation of care for patients as they transition from incarceration to the community. Long term follow-up care is sorely missing.*
- *The community faces challenges with providers and the availability of providers as funding and reimbursement rates shift and change which impacts an organization's ability to provide services to communities.*
- *Often times, the system is too rigid, and organizations need to be able to meet the person where they are, and the system does not allow for this fluidity in care.*
- *Medications like anti-depressants may have limited benefits for certain patients; inadequate availability of cognitive behavioral therapy.*
- *We are struggling every day to try to figure something out for a handful of clients in my programs that are homeless and on the street.*
- *Increasing behavioral health concerns among teenagers and young adults. Lack of insight about the danger of racism, sexism, antisemitism and hate towards LGBTQ+ individuals.*
- *The drug supply is becoming increasingly dangerous and toxic; harm reduction interventions should be incorporated into treatment settings so that a continuum of services is available.*

Select Comments About What is Being Done Well in the Community

- *Same-day appointments at many community agencies are a big improvement - ideally these would include an opportunity to see a doctor or a medical provider as well. Harm-reduction models have begun to shape more services.*
- *Schools are trying to instill more awareness programs, and many agencies are improving awareness and working to empower individuals.*
- *YALE and DMHAS are partnering with LMHAs around educating the CT communities about First Episode Psychosis through the MindMap initiative.*
- *There is really good effort in educating the public about the danger of the opioid epidemic and other illicit drugs. The state is doing a good job in implementing substance use treatment in communities where they need the services, such as jails and prisons.*
- *There are many dedicated providers who need more resources and support to accomplish their goals.*
- *Movement towards client centered treatment and working on community collaboration.*
- *Social emotional learning, funding peer recovery resources, diversity and equity training, gender affirming care, accessibility to holistic alternatives to clinical treatment.*

Select Comments for Recommendations to Improve Mental Health and Substance Use Issues in the Community

- *Reliable (not through insurance) transportation services and/or in-home services to rural individuals in need of help. If they don't have a license or are not allowed or okay to drive, then they cannot access services.*
- *Start earlier education in the schools, elementary. More intervention services with the hospital emergency rooms and first responders, police and EMS.*
- *Higher pay rates for those doing the work, hirer more services providers to prevent burn out.*
- *Increases funding for community mental health to provide sustainable services.*
- *After-hours care continues to be important.*
- *We need to have more of a Trauma informed practice in all of our programs and educate our staff and clients on the effect of past trauma on their current behaviors/symptoms.*
- *Have bilingual workers who know the community, not fearful of reaching out and answering questions.*
- *Making harm reduction more readily available including safe injection sites.*
- *Fund peer recovery resources, invest directly into communities.*

APPENDIX A. SECONDARY DATA SOURCES

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SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (2016 - 2018). Retrieved from https://pdas.samhsa.gov/saes/substate

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APPENDIX B. DEFINITIONS

Alcohol Dependence **–** A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress.

Illicit Drugs **–** Include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

Tobacco **–** Includes products such as cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

Serious Mental Illness **–** Defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. It also refers to individuals with diagnoses resulting in serious functional impairment.

Social Determinants of Health **-** are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. These include access and quality of education and health care, economic stability, social and community context and neighborhood and built environment.

APPENDIX C: KEY INFORMANT SURVEY TOOL

Key Informant Online Questionnaire

INTRODUCTION: As part of its ongoing commitment to improving the health of the communities it serves, CHR is conducting a comprehensive Community Needs Assessment.

You have been identified as an individual with valuable knowledge and opinions regarding community health needs, and we appreciate your willingness to participate in this survey.

The survey should take about 10-15 minutes to complete. Please be assured that all of your responses will go directly to our research consultant, Holleran Consulting, and will be kept strictly confidential. Please note that while your responses, including specific quotations, may be included in a report of this study, your identity will not be directly associated with any quotations.

When answering the questions, please consider the community and area of interest to be the county(ies) in which you provide your services.

KEY ISSUES

1. What are the top 3 issues related to mental health that you see in your community? (CHOOSE 3)

☐ Anxiety	☐ Self-harming behaviors
☐ Depression	☐ Suicide
☐ Opioid overdose	☐ Trauma
☐ Personality Disorders	☐ Other (specify):
☐ Psychotic Disorders	

2. Of those mental health issues mentioned, which **1** is the most significant? (CHOOSE 1)

☐ Anxiety	☐ Self-harming behaviors
☐ Depression	☐ Suicide
☐ Opioid overdose	☐ Trauma
☐ Personality Disorders	☐ Other (specify):
☐ Psychotic Disorders	

3. What are the top 3 issues related to substance use that you see in your community? (CHOOSE 3)

☐ Use of Illicit Drugs (i.e. heroin, cocaine)	☐ Marijuana Use
☐ Alcohol Use	☐ Misuse of Prescription Drugs
☐ Alcohol Poisoning	☐ Opioid Use
☐ Drug Overdose	☐ Tobacco Use
☐ E-cigarette/Vaping	☐ Underage Drinking
☐ Impaired Driving	☐ Other (specify):

4. Of those substance use issues mentioned, which **1** is the most significant? (CHOOSE 1)

☐ Use of Illicit Drugs (i.e. heroin, cocaine)	☐ Marijuana Use
☐ Alcohol Use	☐ Misuse of Prescription Drugs
☐ Alcohol Poisoning	☐ Opioid Use

☐ Drug Overdose	☐ Tobacco Use
☐ E-cigarette/Vaping	☐ Underage Drinking
☐ Impaired Driving	☐ Other (specify):

5. Please share any additional information regarding these mental health and substance use issues and your reasons for ranking them this way in the box below:

AWARENESS

6. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate your level of agreement with each of the following statements about the public's awareness of mental health and substance use issues in the area.

Strongly Disagree←→Strongly Agree

The majority of the public understands mental and behavioral health issues.	☐1	☐2	☐3	☐4	☐5
The majority of the public understands addiction and substance use issues.	☐1	☐2	☐3	☐4	☐5
In general, residents in the community know where to go to get help with mental or behavioral health issues.	☐1	☐2	☐3	☐4	☐5
In general, residents in the community know where to go to get help with addiction and substance use issues.	☐1	☐2	☐3	☐4	☐5

7. If you had to estimate the percentage of cases where a mental health diagnosis is also accompanied by a substance use or addiction problem (co-occurring disorders), what would that figure be?

☐ Less than 25% of the time
☐ 25-50% of the time
☐ 51-75% of the time
☐ Greater than 75% of the time

8. Please share any additional information regarding awareness of mental health and substance use issues in the community in the box below:

ACCESS

9. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about **Access to Mental Health** in the area.

Strongly Disagree←→Strongly Agree

There are a sufficient number of organizations/providers in the community that provide treatment for mental health issues.	☐1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of mental health providers that accept Medicaid or provide financial assistance for low-income patients and families.	☐1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of mental health providers that are bilingual.	☐1 ☐2 ☐3 ☐4 ☐5
Prevention education and outreach regarding mental health occurs frequently in the community.	☐1 ☐2 ☐3 ☐4 ☐5

10. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about **Access to Substance Use Services** in the area.

Strongly Disagree←→Strongly Agree

There are a sufficient number of organizations/providers in the community that provide treatment for substance use issues.	☐1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of substance use providers that accept Medicaid or provide financial assistance for low-income patients and families.	☐1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of substance use providers that are bilingual.	☐1 ☐2 ☐3 ☐4 ☐5
Prevention education and outreach regarding substance use occurs frequently in the community.	☐1 ☐2 ☐3 ☐4 ☐5

11. In your opinion, where is the FIRST place that the majority of community residents go for help with mental health and/or substance use issues? (CHOOSE 1)

☐ Mental Health Clinic	☐ School
☐ Community Health Center/FQHC	☐ Self-Help Group (i.e. Alcoholics Anonymous, NAMI, etc.)
☐ Hospital Emergency Department	☐ Social Service Agency/Non-Profit Community Provider
☐ Primary Care Provider/Family Doctor	☐ CCBHC
☐ Religious Institutions	☐ Other (specify):

12. What are the system gaps that currently exist in the community in regard to mental health and substance use services? (Check all that apply)

☐ Insurance Barriers	☐ Limited Assistance with Medication Management
☐ Lack of Community-Wide Prevention Efforts	☐ Limited Coordination Between Providers and Services
☐ Lack of Providers	☐ Long Waiting List
☐ Lack of Support in Navigating Mental Health System	☐ None
☐ Language/Cultural Barriers	☐ Other (specify):

13. In your opinion, what are the most common reasons individuals in the community do not seek treatment for mental health/substance use issues? (Check all that apply)

☐ Don't Know Where to Go For Treatment	☐ Lack of Transportation
☐ Homelessness	☐ Could Not Get an Appointment
☐ Immigration Status	☐ Language Barrier
☐ Inability to Pay Out of Pocket Expenses	☐ Not Ready for Treatment
☐ Lack of or Insufficient Health Coverage	☐ Social Stigma
☐ Lack of Programming/Providers	☐ Other (specify):

14. Please share any additional information regarding access to mental health and substance use services in the community in the box below:

UNDERSERVED POPULATIONS

15. Which of the groups with the following health insurance status do you see as **most underserved** in regard to receiving mental and substance use services? (Check all that apply)

☐ Those without insurance
☐ Those with public health insurance (i.e., Medicaid)
☐ Those with private health insurance who cannot afford their out-of-pocket expenses
☐ Those who are unhoused

16. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate your level of agreement on the adequacy of mental health services in the community for each of the following age groups:

	Strongly Disagree ← → Strongly Agree					Don't Know
Children (Birth-12 years)	☐1	☐2	☐3	☐4	☐5	☐6
Teens (13-17 years)	☐1	☐2	☐3	☐4	☐5	☐6
Young Adults (18-25 years)	☐1	☐2	☐3	☐4	☐5	☐6

Adults (26-64 years)	☐1	☐2	☐3	☐4	☐5	☐6
Seniors (65 years and older)	☐1	☐2	☐3	☐4	☐5	☐6

17. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate your level of agreement on the adequacy of substance use services in the community for each of the following age groups:

	Strongly Disagree←→Strongly Agree					Don't Know
Children (Birth-12 years)	☐1	☐2	☐3	☐4	☐5	☐6
Teens (13-17 years)	☐1	☐2	☐3	☐4	☐5	☐6
Young Adults (18-25 years)	☐1	☐2	☐3	☐4	☐5	☐6
Adults (26-64 years)	☐1	☐2	☐3	☐4	☐5	☐6
Seniors (65 years and older)	☐1	☐2	☐3	☐4	☐5	☐6

18. Which of the following racial or ethnic groups do you see as **most underserved** in regards to receiving mental health and substance use services? (Check all that apply)

- ☐ Latino/Hispanic
- ☐ Asian
- ☐ Black/African-American
- ☐ White
- ☐ None
- ☐ Other (specify):

19. Which of the following other population groups do you see as **most underserved** in regards to receiving mental health and substance use services? (Check all that apply)

- ☐ Disabled
- ☐ Homeless
- ☐ Immigrant/Refugee
- ☐ Low-income/Poor
- ☐ Uninsured/Underinsured
- ☐ None
- ☐ Other (specify):

20. Please share any additional information regarding underserved populations in regard to mental health and substance use services in the community in the box below:

21. What are the top **5** health issues you see in the community? *(Please select only FIVE)*

- ☐ Access to care/uninsured
- ☐ Cancer
- ☐ Dental health
- ☐ Diabetes
- ☐ Heart disease/Hypertension
- ☐ Overweight/obesity
- ☐ Sexually transmitted diseases
- ☐ Stroke
- ☐ Substance use/alcohol use
- ☐ Tobacco

☐ Maternal/infant health
☐ Mental health/suicide
☐ Other (specify)

22. For each **Healthcare Resource/Service** listed, please select whether you think it is missing (not available), lacking (available but not enough to meet needs) or not affordable (price may be a barrier in accessing service) within the community. If you think the service is available and affordable, please select the need being met.

Healthcare Resources/Services	Missing	Lacking	Not Affordable	Need Being Met	Don't Know
Advocacy for social needs (food security, housing, education, employment, etc.)					
Housing assistance					
Preventive health screenings (blood pressure, diabetes, stroke, etc.)					
Primary care services					
Substance use services					
Support group services					
Transportation					

CHALLENGES & SOLUTIONS

23. What effect has COVID-19 had on the health needs of the community? Did COVD-19 highlight any specific gaps/barriers in community health services?

24. What challenges does the community face in regard to addressing mental health and substance use issues?

25. In your opinion, what is being done ***well*** in the community in regard to mental health and substance use? (Community Assets/Strengths/Successes)

26. What new, emerging issues or trends in mental health and/or substance use should the community have on their radar?

27. What recommendations or suggestions do you have to improve mental health and substance use issues in the community?

CLOSING

28. Which one of these categories would you say BEST represents your community affiliation? (CHOOSE 1)

☐	Aging Services
☐	Community Member
☐	Education/School
☐	Faith-Based/Cultural Organization
☐	Government/Housing/Transportation Sector
☐	Hospital
☐	Mental Health/Substance use Treatment Facility
☐	Public Health Organization
☐	Social Services
☐	Youth Services
☐	Other (specify):

29. CHR and its partners will use the information gathered through this survey in guiding their community health improvement activities. Please share any other feedback you may have for them below:

Thank you! That concludes the survey.

APPENDIX D: KEY INFORMANT PARTICIPANTS

Name	Agency
Eben Lieberman	Institute of Living Hartford Healthcare
David Ruutel	State of Connecticut Department of Corrections
Lisa Cato	State of Connecticut
Lauren Rooney, LPC	Community Health Resources
Courtney Dollar	CT Harm Reduction Alliance
Sherrie Gaudet	State of Connecticut Department of Corrections
Catherine Haugh	Covenant to Care
Tracie Compositor RCP, RSS	Community Health Resources
Sgt Brian Lovell	CT State Police
Miranda Muro	CT Foodshare
Diana Giordano, LPC	Community Health Resources
Elizabeth Smith, LCSW	Community Health Resources
Robin Sampson-Powell, LMFT	Community Health Resources
Jennifer Greer, LCSW	Community Health Resources
Michael Asinas, LCSW	Community Health Resources
Lori Bergstrom	United Services, Inc .
Wendy Knowles	Windsor Locks Police
Amanda Gordon	Community Housing Advocates
Benjamin Grippo, LPC	Community Health Resources
Courtney Sheehan, LPC	Community Health Resources
Andrea Hakian, LCSW	Community Health Resources
Aly Crouse , LMSW	Community Health Resources
Rosemarie Bessette	Lebanon Children's Clothing Wardrobe
Suzanne Chayes, LCSW	Community Health Resources
Miranda Mahoney	Griswold Pride
Jeanna Grimes Ogbar	Jeanna Grimes Consulting
Jill Bourbeau	Teeg
Bisrat Abebe, LCSW	Community Health Resources
Jennifer Nadeau, LCSW	Community Health Resources
Nicole Belding	Fiondella, Milone & LaSaracina, LLP
Scott Mueller	State of Connecticut Department of Corrections
Malika Nelson	Community Health Resources
Andrea Rosario	Sweeney Elementary School
Sara Aliaj	State of Connecticut
Kristina Glaude	United Services, Inc .

Name	Agency
Kidd Collings	State of Connecticut Department of Corrections
Angela Rizzolo	Community Health Resources
Julie Higgins	State of Connecticut Department of Corrections
Sheldon Bustow	CHR Board
Dr. Robin Deutsch	Community Health Resources
Michaela Fissel	Advocacy Unlimited

APPENDIX E: KEY INFORMANT COMMENTS

Please share any additional information regarding these mental health and substance use issues and your reasons for ranking them this way in the box below:
A lot of overlap between these categories makes it difficult to prioritize.
I see illicit drug use as number one because it is the most prevalent problem I see daily. Many people I work with come in abusing heroin, cocaine, PCP, Fentanyl. I still issue of prescription drug use and a significant problem with individuals abusing Alcohol.
Fentanyl replacing heroin in our drug supply has changed the way that people are able to engage in services due to the length of duration.
The youth and adolescents tend to use this as what they deem a coping mechanism for anxiety and stress.
Illicit drugs including heroin, benzos, cocaine, fentanyl, crack, PCP, stimulants, alcohol are all a huge issue among the populations we serve. Addiction to alcohol, opiates and benzos are deadly and yet these 3 substances are typically the ones that folks use.
Significant increase in juvenile use of vaping products: both THC and nicotine.
Ever since the legalization of marijuana, I feel people are now more willing to divulge information about their use. I also feel that it is more widely accepted that people try and use marijuana recreationally.
Youth in the program use drinking, marijuana and vaping to cope with their trauma and depression.
Vaping Marijuana and the fact that parents are providing it.
While some MH and SA issues are more 'visible' or in the media more, other types are more pervasive. Trauma at the individual and community level is endemic and often the root of other MH and SA issues. Alcohol use continues to be an issue which we are seeing more and more with drunk driving. I think prescription drug use is a big issue for our youth who are experimenting. This is concerning because pills may look like the prescription medication and they may not be and may contain life threatening fentanyl and xylazine.
Our ACTT clients use everything but the most prevalent is drinking and cannabis, especially with the 50+ crowd.
I can only answer the questions as they relate to how I have seen them over the last 20 years in Willimantic. I ranked trauma high because over 85% of the SUD clients I have worked with have had a correlational history of trauma and use of AOD as stress release or trauma response.
Opioid epidemic is high in the state of CT.
I selected Trauma as most significant as it is experienced by such a large population. The individuals I work with have experienced trauma from a young age; affecting their basic development which has an impact of their thinking, emotional regulation and abilities to interact with others in a healthy way. In my work this is in addition to other mental health diagnosis which require an integrated, trauma informed multi-disciplinary team of professionals to assist in each individual's path of recovery. I would have also selected Psychotic Disorders as individuals with this diagnosis seem to be the most challenged with finding medications to reduce symptoms, have difficulty remaining in treatment, again requiring a team approach to provide a diversity of supports. I realize that Opioid use has increased, and fentanyl as increased the risk of death, but the majority of my clients who have the most complex medical conditions and highest rate of death are the individuals who struggle with alcohol use.
I chose 'Trauma' as the most significant MH issue as it tends to be the root cause of many of the MH/SA symptoms we see e.g. Anxiety, depression, self-harm, substance use. The number one Substance related issue was a tough choice. A very high percentage of clients seeking MH and/or Substance use treatment use tobacco. We see many health-related conditions develop from the chronic use of tobacco (e.g. heart disease, pulmonary disease) and lead to early deaths. Tobacco use also affects a person's ability to be physically active and limits financial resources that could be put towards healthy food choices if not used on tobacco. Therefore, I do see Tobacco as a major issue for the clients we serve. However, the combination use of cocaine/opioids are often immediately lethal so I see that as a more urgent issue to address. I am responsible for facilitating critical incident reviews on deaths for my service area (Enfield/Bloomfield) and we see a high percentage of overdose deaths that have accidental cause of death due

to combination of substances e.g. opioids, fentanyl, benzodiazepines, alcohol. We have far more deaths due to this cause than we do from suicide. I believe the LOC missing from our services is an outreach team for high risk Substance users that can offer assertive engagement and outreach to this at-risk population with the goal of preventing these accidental overdose deaths.
Griswold is a small rural town that had a fatal overdose rate (2021) twice the state average, and comparable to big cities, (New Haven, Bridgeport, Hartford, etc).
The population served now has more co-occurring issues than ever. Psychiatric issues and substance use issues feed off each other making the challenges extreme.
Systematically we are not doing enough to address the opioid problem in our community. We need to address individual's exposure to trauma, poverty, discrimination, racism, classism, and significant stigma, and overall poor access to medical care. The behavioral health issues are often just symptoms of our bigger, systemic and structural issues.
So much of the issues we see also stem from issues of poverty; the lack of affordable, safe housing, food, etc. it exacerbates mental health and substance use disorders. Clients are often trapped in poverty because of they work, they will lose access to their healthcare/medications because the wages won't allow them to afford insurance, food, medications and rent.
Impaired driving has the widest potential impact on self and others.
Fentanyl use . Crack Cocaine use. Alcohol use used in many situations to self-medicate from history of trauma/unmedicated MH.
Although alcohol and marijuana are legal I think it is important to address the concerns and impacts that it does have on individuals. Because of the substance being legal it makes others view it differently when they are seeking help in these areas. In regards to mental health services are challenging to obtain as the provider options and opportunities are limited in many areas of the state. Often clients have to wait to get to specific providers such as trauma therapists. By the time the client gets to the provider they are no longer interested or as invested as they were when they first came for services.
Alcohol use is the most prevalent; fentanyl use is the most dangerous.
Misuse to avoid feelings and psychiatric oppression are real. Our priority as a society is to end drug use, find a cure for mental illness, and other areas that keep us stuck within an institutional framework that centers a problem. The issues, when viewed through a growth mindset perspective shifts us toward possibility and a solution-orientation. Describing recovery as an ongoing process through which a person rediscovers their innate capacity to grow through turbulence makes a difference. Teaching strategies and offering perspective to support a person regain the belief in themselves and ability to create a life worth living changes the game. However, this is outside the box.
Please share any additional information regarding awareness of mental health and substance use issues in the community in the box below:
Still an oppressed and stigmatized population. I do not feel that there are enough resources available to everyone who is in need, especially those who do not live in the cities.
As a person in recovery, it has been my experience that no one wakes up one day and says to themselves 'Self, let's become an addict.' I have worked with hundreds and hundreds of folks and have never encountered anyone who has a SUD dx and has never experienced trauma and/or MH challenges. It has also been my experience that both MH and SUD need to be treated at the same time and it rarely is.
I feel there is and will continue to be a large increase in substance use with mental health disorders because of the new laws pertaining to marijuana use and the ease of access to it.
There is still a pervasive mentality that addiction is an individual failing instead of a disease. I think empathy has grown as more and more families are personally impacted by it, but the stereotypes are still in the majority. I believe most people believe those with addictions are not 'deserving'. While I think awareness of mental health has

increased, I don't believe there is a common understanding of 1) how to respond to it and 2) the myriad of ways in which mental health presents itself.
Clinical services are not advertised in the town.
It would be beneficial for more people to understand addiction and as it relates to trauma and it's impact on the brain and related behaviors.
I think more awareness of MAT services and more access to tx services on weekend and night hours would help.
I find that the general public are talking more openly about anxiety, depression, ADHA or even Autism; but I find that their understanding of those topics are limited. I also don't feel that the general public know about or understand psychotic disorders beyond how those individuals are viewed in society or in media. I think that people generally know how to seek help like utilizing 211 or getting referrals from their primary care doctors but I have found they don't know about most services. The systems is vast and there is no one platform to find services to fit individual needs.
I believe most people know where to start to get services for MH/SA issues. However, the system is not able to quickly provide care/services due to lack of resources (staffing) not keeping up with demand. People seeking services have long waits, lack of beds and insurance issues to contend as barriers. I think these barriers lead to lack of timely care and/or lack of care at all. I think there is still a fair amount of misunderstanding about MH conditions and addiction amongst the general public.
This is a many layered problem. Mental health and substances use is talked about more frequently than it has been in the past, which is wonderful. However, due to limited resources or bad experiences or fear of services and what they mean people struggle to engage. Or at times they do engage do better then things start to fall apart again and they don't reengage again.
A majority of my patients have substance use issues and of those, 95% have mental health issues.
There are gross misunderstandings about mental health and addiction. What folks think they know is fueled by fear. It is absolutely social conditioning, or what can be considered social marketing. As a person who trained thousands in Mental Health First Aid within DMHAS Region 4, and across the state, and in QPR, we are literally prescribing the formula: Know the symptoms Know where the help is Know how to get someone the help they need That is NOT understanding mental health challenges and addiction. Where is the conversation about trauma, stress management, and holistic approaches to support whole person wellbeing?
Please share any additional information regarding access to mental health and substance use services in the community in the box below:
When someone decides to make a change in their lives it is a critical and delicate decision/moment. If they are met with an unskilled provider who is not experienced and does not understand how to motivate them to continue treatment, we can lose them. It is important that people understand the significance of the decision.
Time lack of counseling services after 5pm and/or weekends need more clinical staff who are of color who are serving the community they represent.
Providers in this field are overworked, underpaid and overregulated which is why more and more providers are leaving the field. Reimbursement rates have barely changed in over a decade, yet cost of living has skyrocketed. People are leaving the field. This will result in it being harder and harder for people in need to find the help they need, which in turn will put a strain on hospitals and cost tax payers more money and/or result in more client deaths.
Lack of knowledge about treatment options.
Please share any additional information regarding underserved populations in regard to mental health and substance use services in the community in the box below:
It is often the Emergency Rooms that get inundated with the underserved populations, making themselves more vulnerable and invisible to the EDs because they are now 'frequent flyers' that aren't taken seriously anymore. There needs to be more outreach to these populations and education, as well.

The only reason I did not select substance treatment for child is that I don't know much about the services available. However based upon the lack of services for other ages I could assume they have limited access as well.
I believe the mental health/substance use and child welfare systems of care are all currently inadequate to meet the needs/demands of the child/adult populations served. I believe a good portion of that is due to lack of staffing and workforce issues that escalated during COVID and have not resolved. I also believe that there is a need for more resources that offer higher LOC including more residential programs, forever homes, long term inpatient care beds. The lack of these resources lead to people with the most serious MH/SA issues not getting care and often ending up homeless as they are unable to maintain in lower levels of care.
Often times when individuals seek help they get placed in boxes and are unable to seek all the resources that are needed to help support them. The systems are hard to navigate, the forms are confusing to complete and collaboration struggles to occur.
What effect has Covid-19 had on the health needs of the community? Did Covid-19 highlight any specific gaps/barriers in community health services?
Long-term effects on mental health across the community have included depression and anxiety. Increased difficulty engaging in in-person interactions, and in-person mental health treatment. Those without consistent access to technology suffered disproportionately.
Coordination and availability of services suffered during covid 19.
Increased use of substances and MH occurrences while in isolation.
It seems that our youth and adolescents are much more anxious and stressed, which in turn effects their ability to stay healthy in body and mind.
I feel that COVID had a negative impact on a lot of folks. It has increased mental health issues for children and adults. Many people still are not comfortable going into places and telehealth options have decreased.
It has limited residential providers to conduct more frequent visits.
I've noticed an increase in mental health and substance use since COVID-19, and we saw that people of color had greater barriers in accessing healthcare. We need more mental health and substance use providers that are from the communities we serve (people of color, multi-lingual, etc.). I am especially worried about the mental health of our children and youth since the pandemic.
The health needs of those in the community after Covid-19, I feel, has improved once it was mandatory for everyone to have insurance and to get vaccinated. I feel a lot of un/underdiagnosed individuals were going without proper care up to that point. It didn't solve the problems out there, but it made healthcare more accessible as well, such as with telehealth.
Less providers have been available. Many services, programs and providers closed during the pandemic and now can't provide services due to staffing shortages.
Many people delayed care. Isolation did a number on a lot of people's mental health.
Some access issues.
I think COVID 19 increased trauma and isolation and highlighted the importance of community connection and face to face care. Telemedicine is not appropriate for everyone. COVID 19 also highlighted a challenge we have about getting people to believe in and trust the science of disease and their solutions (vaccines).
The ACTT team stayed outreaching clients throughout Covid.
For some, it has created a lack of trust in the medical community and a reluctance to trust doctors and/or recommendations.
Empathetic boots on ground SEASONED trained professionals in the field doing mobile outreach case management and therapeutic support.
I think that Covid highlighted the population of individuals who cannot access healthcare, either because of lack of understanding, lack of transportation, lack of resources or insurance. I think that covid highlighted the barriers to communicating FACTS to the public; this translates into why the public is not educated about health prevention,

mental health or addiction services. Covid has left us with a large population of individuals who are not fulling engaged in treatment, many of our clients don't come in for appts yet we still call them on the phone and consider it quality care. Our population is limited when it comes to technology and many of our telehealth services are not with video which assists in our ability to assess someone in our care. Covid has affected our staffing retention, which is mirrored in every layer of the system. This has created larges gaps in accessible services as well as a decrease in quality of collaboration between providers. The system had gaps or cracks people fell into prior to COVID now it's just broken.
I believe the biggest effect that I see is how COVID has changed the workforce. It is extremely difficult to hire and to meet salary demands. My programs have no remote options for work since we provide higher LOC in the community and need to be Face to Face. We have not been able to fully staff the majority of our programs since COVID and this leads to the inability to meet the demand for a percentage of clients referred and I believe it has also affected the quality of the services we provide. We have had to decrease the qualification requirements for some of our positions (no longer require a BA degree) in order to meet salary. This is another factor in terms of a workforce not being as skilled and affecting both care and the demands on Supervisory staff to meet more of the direct care needs and provide more intensive oversight of staff.
Significant impact on staffing and ability towards providing resources. Housing is unobtainable due to price and resources to support are not available in the area.
Yes, it highlights the inequality that exist between those who have resources and those who do not and how the way these groups also receive medical care. Those who are poor are not receiving quality care.
COVID-19 has led to increased mental health and substance use issues in children, adolescents and adults.
The lack of basic needs (housing, food). The amount of providers leaving the field since Covid has made it difficult for many to get services.
The increase in telehealth services has been beneficial.
Yes, Covid did highlight and brought to the forefront the gaps that exist in the Black/African American community more so than ever before. The lack of resources, providers, care and standards of living was exposed.
Not everyone has consistent access/safe environment to conduct virtual treatment.
Covid 19 highlighted how the population as a whole benefits from engagement with others and when we isolate this increases problems. Throughout covid although telehealth was helpful it also is a hindrance because you cannot see the client as well as you can in person. During covid it was terrifying to see the substances use number go up so drastically. Supports such as grief groups and normalizing grief is a large gap for society as a group.
It increased hesitation in looking for healthcare due to increased skepticism of those in clinical and government positions. COVID-19 and the resulting information war left people not knowing who to trust.
Covid heightened mental health needs across a larger and broader population. As people remained in their homes and isolated potentially dormant mental health conditions sprouted and became an issue for people who may not have experienced these feelings and symptoms before. This caused strain on the mental health system as more people were seeking care than previously. What also came from this, is more awareness and acceptance of people living with mental health conditions. With acceptance there has been more discussion and recognition of those who are struggling in such a way we had never seen before.
COVID-19 has exacerbated diseases of despair- mental health disorders and substance use disorders have increased; isolation increased; providers have become harder to access as more work remotely via telehealth; most patients prefer in-person care; a lot goes missed with telehealth encounters; it is harder to hire providers.
Increased distress, grief, uncertainty, conflict.
What challenges does the community face in regard to addressing mental health and substance use issues?
Lack of providers and lack of capacity in a number of community-based programs. Homelessness and insecure housing is pervasive and creates the need for community-based and outreach-based services. Lack of capacity in 28 & 30-day substance treatment programs means that clients are often discharged from detox to the streets, or often can't access rehabilitation programs if they're not abusing a substance that requires a medically monitored detox.

There is still a noticeable division between many mental health services and substance treatment services, despite increasing volumes of research that proves that the most effective treatment engages both issues at the same time.
Lack of funding.
Lack of providers. Current providers are overworked (unrealistic caseloads) and underpaid. No incentives to take care of oneself or patients.
Education and dollars.
Stigma!
Socio-economic status, political climate, education and closing of support services due to little or no funding.
Cost of living is on the rise, and that's making it incredibly difficult for people to access their basic needs. There is not enough housing that people can afford, and groceries are really expensive. I would imagine that this added stress and trauma of not being able to afford basic needs is impacting people's mental and physical well-being, and people may be deciding to not access health care in order to pay for other essentials. Behavioral health organizations like CHR are struggling to recruit and retain enough qualified staff. Despite incredible effort from CHR leadership, people are looking elsewhere because they may be feeling overworked with less staff and challenging client situations. I know behavioral healthcare workers who are now working more than one job because one full time job in this line of work is not enough to afford rent, student loans and other essentials.
There is still a very strong stigma about those who use. Often, we see individuals who are self-medicating with substances because they don't have insurance or can't afford proper treatment.
Not enough providers to provide adequate care, applying band aids instead of addressing the main concerns due to the shortages.
Stigma, out of pocket expenses, wait times.
Lask of providers for families and children.
Turnover in staffing (case managers and therapists) has been an issue for people. It is hard and retraumatizing to rebuild connections to new staff constantly.
Understanding the need and proper diagnosis.
Lack of information. Many would benefit from knowing how common and treatable mental health and substance use conditions. Public figures sharing stories seem to have a positive effect.
Losing licensed experienced clinicians to burnout and competitive wages outside this field of work and/or bigger agencies outside of areas that need the most attention, have noticed decreased overdoses which seem quite high during covid but stigma around opioid use is still quite high. Need more effective interventions in addressing problematic alcohol use.
I believe the biggest barrier is a demand that is greater than the resources. I am seeing more MH/SA issues related to economic factors e.g. people's inability to meet their basic needs for housing, bills, food. This leads to increase in anxiety, depression, Substance use. We do not have adequate ways to assist people financially e.g. more subsidized housing, more FEMA monies. It is impossible to effectively treat MH/SU issues in someone who is living on the street and/or worried about their basic needs.
Significant staffing issues causes waitlists where program become more severe while waiting on services. Once able to serve issues are so large resources are not enough or take more time than would have before.
Implicit bias, not enough resources, slow reaction from those who are in charge of program implementation.
There are not enough prevention or support programs available. The system is set up to be more reactive vs proactive.
If clients do not have affordable, safe place to live it is hard to have positive outcomes.
The biggest challenge is the need for greater investment in prevention services. There are more people who developed Mental Health and Substance Use issues during Covid which is now bombarding the systems right now.
Many are not aware of the services that are being offered, need the education about these topics, and informed about the resources. There has to be more outreach: educating in their communities, schools, and churches.

Ongoing consistent access. Danielson and surrounding areas have NO sober living facilities or assisted living environments for substance users in recovery.
As a culture we need to talk more about mental health and how this looks different for everyone. We have to normalize how it is ok to struggle and ask for help. We can appear to be doing better then ask for help again and this is ok to do.
Continuation of care for patients as they transition from incarceration to the community. Long term follow-up care is sorely missing.
I think this will continue to evolve. There is a shortage of providers in the community who can provided the needed services so many are not being seen of left without care and support. I think there is still a misunderstanding about what mental health is and what substance use issues are and the long-term impact and lifelong challenges it can have on a person. The community faces challenges with providers and the availability of providers as funding and reimbursement rates shift and change which impacts an organization's ability to provide services to communities. Often times, the system is too rigid, and organizations need to be able to meet the person where they are, and the system does not allow for this fluidity in care. This population in particular is more impacted by this rigid system, as mental health needs can be an up and down battle and is not always linear path toward improvement.
Stigma, inadequate information about treatment options; behavioral health agencies that have a rigid approach, too many requirements, long wait time or other barriers to care; intakes can be re-traumatizing; care available might not be patient-centered; many clients want individual treatment and are put in groups; medications like anti-depressants may have limited benefits for certain patients; inadequate availability of cognitive behavioral therapy; staff/provider turnover is high and can be destabilizing for clients; lots of psychosocial issues related to housing, poverty, etc. acknowledging trauma, systems of oppression, including ableism, racism, sexism, and other -isms (such as psychiatric oppression). Financial disparities and other intersections. No safe spaces to experience distress without carceral response using things like 988. Diagnosing and drugging of children.
In your opinion, what is being done well in the community in regard to mental health and substance use? (Community Assets/Strengths/Successes)
Same-day appointment at many community agencies are a big improvement - ideally these would include an opportunity to see a doctor or a medical provider as well. Harm-reduction models have begun to shape more services.
A lot of inner-city work, but I feel that anyone who does not live with access to public transportation is treated disproportionately and there is certainly a disparity of treatment for those outside the cities.
Schools are trying to instill more awareness programs, and many agencies are improving awareness and working to empower individuals.
Coordination and access to resources by first responders to maintain the continuity of care for our frequent clients.
CHR is a data driven organization that centers it's decision making and program design around people served with evidenced based practices. They serve as a model for others in this field not only in Connecticut but nationwide.
I feel that now that there is a push toward more collaborative care and LMHA's becoming all-inclusive health providers, the gap is starting to close on those individuals who have previously fallen through the cracks.
More talk about anxiety/mental health (more mainstream) community events understanding how housing and health connect.
Some programs well established and are able to continue with financial support.
I hear a lot of ads for available services on the radio. More grassroots harm reduction work is being done. MAT is a great resource and needs to be expanded and normalized. Prevention councils are doing a lot more training with regards to MH First Aid and Narcan training at the community level.
Narcan.
Boots on ground and experienced staff working alongside RSS and case managers TCM model style.

There are good collaborations in place. we could improve on collaborations between all hospital and mental health providers. not all hospital systems participate in project notify. Increase use of CCT meetings.
YALE and DMHAS are partnering with LMHAs around educating the CT communities about First Episode Psychosis through the MindMap initiative. There has been a visible roll out of the 988 system. I am not sure of other things.
The police have become more educated and increased caring towards mental health issues.
There is really good effort in educating the public about the danger of the opioid epidemic and other illicit drugs. The state is doing a good job in implementing substance use treatment in communities where they need the services, such as jails and prisons.
There are a large number of community funded programs statewide for children and adults that accepts all types of clients.
There is more of a focus on harm reduction to address the opiate epidemic.
There are many dedicated providers who need more resources and support to accomplish their goals.
The Mental Health and Substance use community has increased advertisement and resources to the community.
Those in need are being received well and provided for.
Increase in 1-1 providers who provide Medicare services.
Movement towards client centered treatment and working on community collaboration. As we make more movement towards has continued to increase and we continue to work on system struggles. Surveys like this allow for feedback to occur and ability to make adjustments as needed.
There is more recognition and support in the community now more than ever. There are more ads, more marketing, and more effort being placed on overall mental health and the importance of it.
There are staff who are committed to the work; some community support programs do exist which help with supports and social issues.
Social emotional learning, funding peer recovery resources, diversity and equity training, gender affirming care, accessibility to holistic alternatives to clinical treatment.
What new, emerging issues or trends in mental health and/or substance use should the community have on their radar?
Increased opportunities for medication-assisted treatment induction in the community, in emergency departments, during medical admissions in hospital, etc.
More providers need to be advertised and promoted. I feel like it's always the same ones like CHR, Wheeler, APT, etc. yet those agencies have ridiculous caseloads and not enough staff to provide quality services. Outreach to more rural areas is a must.
Alternative therapy such as energy healing and music/sound therapy.
The positive impact of having 'peers' available for support, education and advocacy for those in need.
Juvenile use of illegal substances, addiction and lack of parental involvement for mental health related issues.
Vaping marijuana is a new increasing trend.
Homelessness in teen and young adults, substance use treatment in younger youths.
Various forms of treatment (telehealth, MAT). Connection between housing and health information/ opiate hot spots/Overdose prevention.
Fentanyl.
Prevalence of marijuana use. Impacts of social media on social skills, mental health etc. Emerging research on psychedelics and emerging treatments.
Depression, SI and stress related relationship and identity issues resulting from overuse of internet electronics causing emotional disconnect/distress. Trauma, informedness , new drugs, increase of SI and psychosis.
Autism seems to be a growing population. It is difficult to access service for these individuals, some can be successful in traditional private therapy but often times it is difficult to access additional services unless you meet

other criteria like having a Low IQ which falls under DDS services. I find that many staff are not educated enough about Autism in how to identify symptoms/behaviors and how to manage them or even how to teach skills to these individuals. Many insurances don't cover autism specific treatment supports.
Affordable housing and specialized housing for both low-income people and people with Serious MI who need housing that will meet their long-term needs. We need more subsidized units with the Housing Authority and a lower minimum income requirement than the one currently used which effectively rules out people on SSI/SSDI. We need more supported housing units, 24/7 Non-MRO residential programs that can treat clients meeting diagnostic eligibility but not the income/insurance requirements. We need more 'Forever Homes' for those folks with SMI that will always need some level of staff oversight in their housing. As much as I don't like the idea of shelters and want to see everyone in stable long-term housing, we definitely have a problem with homelessness in our client population that I have not seen in my 20 years with CHR. We are struggling every day to try to figure something out for a handful of clients in my programs that are homeless and on the street. We are utilizing our Respite program as Transitional shelter program for homeless clients with MH/SU issues more than we are using it as a Crisis Stabilization program (which is it's contracted purpose). Just last night, we had one of our ACTT clients who has come up through our YA programs and has been served by CHR for many years, in our lobby with nowhere to go. It was raining and cold; he had been 'kicked out' of the warming shelter the night before due to a behavioral outburst and therefore had no option for the night but the streets. We scrambled and got him a motel bed for one night to keep him safe and off the street. This is a very common scenario that we manage. This particular client needs subsidized and supported housing in order to try to be successful. He has failed in milieu settings due to his attachment (trauma-based issues) which led to behavioral/aggressive outbursts.
Drastic increase in homelessness and connection to mental health.
Increasing behavioral health concerns among teenagers and young adults. Lack of insight about the danger of racism, sexism, antisemitism and hate towards LGBTQ+ individuals. shallow mindedness and lack of perspectives on various topics, especially the importance of having plural thinking, identities, and values.
Education around vaping and the legalization of marijuana, particularly with youth should be a strong focus of prevention work.
The continued changes in designer drugs that are leading to overdoses and health issues.
The negative effects of social media on young people's mental health should be on the radar.
Methamphetamine use (pill form).
Lack of communication with larger systems such as DDS, DSS and social security. We get very focused on one problem and put a lot of resources into this area and then other areas although important get passed over.
Xylazine / Fentanyl use.
Really focusing on the whole person. Keeping the patient at the center and working to minimize barriers and keep the process simple. With the changes in healthcare, often times a patient cannot get two services on the same day, often resulting in multiple visits and duplicative work. We really need to figure out a way to keep the patient at the fore front, adapt modalities to meet the patient where they are, and use more innovative technology and tactics to support improvement, and reach those who are not reaching out for help.
The drug supply is becoming increasingly dangerous and toxic; harm reduction interventions should be incorporated into treatment settings so that a continuum of services is available; treatment options for PTSD, treatment-refractory depression and substance use disorders that are likely to be FDA-approved in the next 1-3 years include MDMA and psilocybin; agencies need to be prepared to offer these treatment alternatives as the population otherwise may seek to use them in unregulated/unmonitored settings.
Ineffectiveness of clinical treatment for the majority of folks, and the learned helplessness experienced by folks who engage in publicly funded mental health treatment.
What recommendations or suggestions do you have to improve mental health and substance use issues in the community?

Reliable (not through insurance) transportation services and/or in-home services to rural individuals in need of help. If they don't have a license or are not allowed or okay to drive, then they cannot access services.
Increase the numbers.
Start earlier education in the schools, elementary. More intervention services with the hospital emergency rooms and first responders, police and EMS.
I feel agencies need to advertise their services in the community or even on tv like 'back in the day.' There needs to be a better approach to providing services to those that overuse the EDs.
Higher pay rates for those doing the work, higher more services providers to prevent burn out, community outreach, change the approach from come see me in the office but get out in the community and talk to those who need the services. boots on the ground, less wait times, Better first experience at a clinic (easy to understand process, no long wait) easy access to MAT.
Increases funding for community mental health to provide sustainable services.
After-hours care continues to be important.
Open a shelter and a substance use Tx facility in the town.
Community education. Education in Primary Care offices and hospitals. Advocacy for proper funding at the state level.
Grassroots outreach and community engagement.
I have been asking for an entitlement specialist to be hired at CHR for years, my idea is to have access to the DSS system so that we can utilize our specialist to begin insurance or reinstate insurance to remove the barriers of working with DSS.
I believe we have to address root and/or associated issues that lead to and/or worsen MH/SU issues. Trauma being a root issue. We need to have more of a Trauma informed practice in all of our programs and educate our staff and clients on the effect of past trauma on their current behaviors/symptoms. We need an array of housing options that will meet the needs of the population and create a stable foundation in which to then work on assisting the person to address and stabilize their MH/SU issues. We need to be able to offer more competitive salaries so that we can build our workforce back up and compensate a more skilled and educated workforce. We urgently need an Outreach LOC for at risk Substance users so that we can more aggressively and proactively provide support and counseling around SU and decrease deaths from accidental overdoses.
A greater understanding on why issues are diseases and willingness to allow programming into the town that could support clients and reduce significant basic need barriers (housing, insurance, etc.).
Be willing to learn from states that are doing well in addressing community behavioral health issues and attempt to emulate some of their best practices. E.g. MA implemented community based behavioral health centers to address immediate mental health and substance use treatment needs for both children and adults by significant numbers.
Many of the state or locally funded programs primarily serve clients with Medicaid insurance or no insurance; clients with private insurance have less access and likely know less about the service array. Clients with private insurance tend to stay in the private sector vs coming to a community health center for services.
Making harm reduction more readily available including safe injection sites.
There is a great need for more investment in prevention programs and community mental health centers.
I don't think there is ever going to be a solution but as long as there can be a variety or means and ways for someone to seek help that is comfortable for them is an improvement.
Have bilingual workers who know the community, not fearful of reaching out and answering questions.
Follow up!!!!
Appropriately staff the Danielson CHR location for in person services. Long wait times and lack of facilitators negatively impacts services.
Working on developing foundational supports such as housing supports, food supports, budgeting and obtaining a phone.

Increased follow up.
More public service announcements with messaging on TV with info on evidence-based approaches to treatment; more dissemination of information on cognitive behavioral therapy and coping skills; incentives for providers to go into the mental health/substance use treatment workforce; changes in reimbursement rates so that time spent providing the care is adequately reimbursed and to decrease reliance on state and federal funding; have increased case management services embedded.
Stop funding clinical treatment Fund peer recovery resources Invest directly into communities Stop gatekeeping resources Dismantle systems of oppression within organizational operations.
CHR and its partners will use the information gathered through this survey in guiding their community health improvement activities Please share any other feedback you may have for them below:
Many areas of redundancy in these questions (particularly the questions asking to prioritize most significant issues) that may limit the usefulness of the results.
CHR is an incredible organization. I am grateful for all that they do!
I feel that people hear CHR and think strictly mental health. They don't realize the multiple services we offer for a wide array of concerns.
I truly believe we are on the right frequency for providing adequate care, only it's our responsibility to adjust to the times. We are post-COVID and there are lives to save. It's time to bring the therapy and the professionals into the community at a higher volume, establish efficient wrap around services that include (off business) hour services like weekends and evenings.
The needs of those served are significantly greater with no increase in resources.
Feedback individuals have given as provider options are limited, it is hard to walk into the walk-in hours and be told that CHR cannot meet with them or the wait is so long.