Our Children
Our Future

A Report on Child Well-Being in
Northwest Connecticut

50 Years 1969–2019
NORTHWEST CONNECTICUT COMMUNITY FOUNDATION

Produced for:

NORTHWEST CONNECTICUT COMMUNITY FOUNDATION
50 Years 1969-2019

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Introduction

Our country was founded on the ideal that all of its children are born equal, and that they begin life with the same potential to achieve the American dream of a happy and successful life. However, we now know that children born into families marked by food insecurity and poverty, mental illness, parental separation, and neglect, and who live in home environments with mold and lead paint, or in neighborhoods characterized by drug abuse and violence, are destined to begin life's journey with developmental challenges that will follow them for the rest of their lives.

Decades of research on child development, coupled with a worldwide COVID 19 pandemic, have brought us to a watershed moment by clearly illuminating the structural inequities facing young children and their families, while simultaneously reinforcing the causes of and correlations between lifelong negative outcomes and children who grow up facing adversity.

We have long acknowledged the critical importance of the early years of a child's life. These years set the stage for a lifetime of outcomes in educational attainment, economic security, health, and social/emotional well-being. Unfortunately, a significant percentage of our Northwest Corner children are faced with developmental obstacles that have long-term, adverse consequences for them. Further, many of our parents and other family members, as primary caregivers, struggle with challenges that can also affect their children's optimal development.

Recognizing an opportunity to seize this moment, the Foundation's Board of Directors has embraced a more robust early childhood agenda for our region. This work is intended to improve life outcomes for our community's children and families and to create a level of regional cooperation that will maximize our individual efforts through collective action and advocacy.

Developing an Early Childhood Agenda

We commissioned this report to better understand the "cause and effect" of various developmental obstacles that may prevent some local children from reaching their potential.

It is intended to provide insight into how many of our region's youngest residents may not have access to the things that we know are necessary for optimal development, even when they are supported by loving parents and a caring network of state and local service providers, health professionals, educators and neighbors devoted to their well-being.

The indicators selected can serve as a report card on the status of child well-being in our region. We hope that all community stakeholders with an interest in the welfare of local children will use these indicators to take steps to address these findings, develop partnerships with others to create new strategies for supporting our children and families, and to advocate for policy changes that will improve child and family outcomes. We will work to build a measurement system for tracking the overall progress of our collective efforts.

For its part, the Community Foundation's donors and fundholders are committed to making strategic local investments that encourage systemic solutions to chronic family and community issues that cause inequities among our region's children and families.

The investments we collectively make in early childhood development have significant implications for an entire generation of Northwest Corner children by ensuring positive outcomes while minimizing the costs of future social service supports and health care. According to national studies, modest investments directed at our region's most vulnerable children can change the trajectory of their young lives.

The Foundation acknowledges that to be truly impactful, these investments have to go beyond simply awarding grants to local child service organizations. They must bring together families, community resources and collaborative partners regionally and statewide, with the shared goal of building and strengthening an early childhood system in our Northwest Corner.

continued

Building a Regional Early Childhood Alliance

Through its resolve to make our work more intentional, one that nurtures a common agenda around an inclusive regional approach to early childhood development, the Foundation envisions building a Northwest Connecticut Early Childhood Alliance.

This Alliance will be collaboratively developed and will engage individuals from across our region who represent the diversity of perspectives and approaches that make our community vibrant and rich.

If successful, the Alliance will foster a sense of regional ownership and accountability for our children and their families as part of a peer-learning and information-sharing network designed to align, improve, and expand high-quality early childhood programs and services.

The Foundation has pledged backbone support for this multidisciplinary Alliance, with dedicated Foundation staff facilitating work that is designed to champion a shared vision and set of strategies, build public will and thought leadership, advance policy, mobilize and leverage funding and create a best-practice and information-sharing network.

By placing a region-wide lens on this initiative, the Foundation will be better positioned to identify the individual and community needs of parents and caregivers so as to ensure social equity and equal opportunity for them and their children. The extraordinary challenges of the current health crisis serve to underscore the urgency and importance of this work.

Moving forward, we see ourselves engaged with you—our families, community stakeholders, providers of human and health services, educators, government leaders, and our donor community—to help create a stronger network of coordinated support that builds on and improves existing pathways from early childhood to adulthood. Because these pathways embody many diverse and distinctive contributions designed to deliver long-term positive outcomes, we are confident that, with the help of your input and guidance, a comprehensive set of meaningful collaborative strategies will emerge.

We all want the best possible future for our children. Working together, that future is within our grasp.

Guy Rovezzi
President
Northwest Connecticut Community Foundation

To learn more about our work and how you can be a part of it –

Email us: alliance@northwestcf.org

Call our NW CT Early Childhood Alliance Coordinator at 860-626-1245 X110

Or write us at:
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Torrington, CT 06790

I don't know what the future will hold,
but I know who holds the future"

(Reverend) Ralph David Abernathy, Sr.

The Fundamentals of Early Childhood Development

Early Childhood development is a process that refers to the growth of children as they become physically healthy, mentally alert, emotionally sound, socially competent and ready to learn.

The most critical period in early childhood development is birth to age five. During these years, children move from bonding with parents to interacting with others. They learn basic skills such as picking up objects, sitting up, walking and understanding self-control. These developmental milestones generally occur during identifiable time periods and by the ages of 5 to 8, all children should be well on their way to possessing the skills necessary to become self-sufficient individuals with their own distinct personalities.

Young children develop in five main areas:

1. **Gross Motor Skill Development** – a child's ability to use large muscles for crawling, sitting up, running and climbing.
2. **Fine Motor Skill Development** – a child's ability to use small muscles, specifically their hands and fingers, to pick up small objects, turn pages in a book, hold a spoon to feed, and use a crayon to draw.
3. **Speech and Language Development** – a child's ability to both understand and use language, from uttering sounds and saying single words to using full sentences.
4. **Social and Emotional Development** – a child's ability to interact with others, including helping themselves, practicing self-control, waving hello and goodbye and knowing how to take turns.
5. **Cognitive Development** – a child's ability to learn and solve problems, including playing, exploring, understanding pre-reading language, vocabulary and numeracy, and doing simple math problems.

The early development phase in children is a time of highly interactive experiences. From infancy, the child's physical and social-emotional environment constitute powerful influences which chemically affect brain activity and shape brain architecture. These influences either help or impair the development of a wide range of abilities that children will use throughout their lifetimes, including their ability to:

- learn,
- have positive social skills,
- have positive life management skills
- be self-confident and have high self-esteem,
- develop a sense of empathy, and
- have successful relationships at later ages.

As doctors, scientists and researchers have discovered, what happens during the early years of a child's life has far-reaching effects on their well-being over a lifetime.

The Fundamentals of Early Childhood Development

The Critical Importance of the Early Years

The Center on the Developing Child at Harvard University has stated that brains are built over time, but the building blocks of brain activity are constructed very early in life. It is during these years that children develop linguistic, cognitive, social, self-regulatory and decision-making skills that set the stage for long-term outcomes, including their ability to function effectively in school, make sound health choices, have a successful career, and achieve a satisfying and fulfilling life.

The primary reason for this phenomenon is the rapid growth of the brain's architecture during the first five years of life (especially the first three years). Brain architecture is composed of billions of connections between individual neurons across different areas of the brain. These connections enable lightning-fast communication among neurons that specialize in executing different kinds of brain functions.

Starting from birth, children make neural connections – over one million per second – that influence their developing brains. The early years are the most active period, as neural connections are formed by a child's everyday experiences. A child's brain grows as she or he sees, feels, tastes, smells and hears. Each time a child uses one of these senses, a neural connection is made. New experiences repeated many times help to strengthen new connections, which shape the way a child thinks, feels, behaves and learns – now and in the future.

Accordingly, the early years are the best opportunity for a child's brain to develop the neural connections needed to be healthy, capable and successful adults. The connections required for many important, higher-level abilities like motivation, self-regulation, problem solving and communication are formed in these early years. If not formed in the early years, it is much harder for these essential brain connections to be formed later in life.

Early Relationships and the Home Environment as Significant Factors in Child Development

The exceptionally strong effect of early experiences on brain architecture makes the early years a period of great opportunity ***and*** great vulnerability. Sensory interactions that are consistently recurring will influence how a child's brain grows.

The concept used to explain the interrelationships between a child and his/her caregivers is called "***serve and return,***" and it is central to the developmental process. Essentially it means that a child's babbling, gesturing and crying are calls for their caregiver to respond with nurturing eye contact, words or touch.

When the "serve and return" that a child has with parents and caregivers is characterized by consistently healthy and positive interactions, appropriate development is greatly enhanced. If the "serve and return" response either lacks nurturing and affection, or is threatening or absent, a child's physical, mental and emotional health may subsequently be impaired.

So, too, does a child's home environment play an important part in his/her development. Children whose early life experiences take place in a safe, stable, and non-threatening environment are more likely to develop strong communication and social skills and have positive self-awareness.

Each of these assets has long-term implications for positive outcomes related to learning, behavior, self-esteem and problem solving.

A problematic home environment can negatively impact how a child's brain responds to stressful interactions. Disruptive, unstable or neglectful surroundings can raise fear and anxiety in young children. Witnessing or experiencing events that undermine a child's sense of safety, stability and bonding are considered to be ***Adverse Childhood Experiences*** (ACEs).

ACEs can trigger "***fight or flight***" stress hormones into a child's brain. Fight or flight is the body's physiological and psychological reaction to over-whelming fear or acute stress. The Early Childhood Center for Mental Health Consultation at Georgetown University states that the release of hormones in response to frequently occurring fear or anxiety can affect a child's ability to deal with such situations. The Center maintains that ongoing fight or flight responses can affect a child's brain development with regard to its higher-level functions.

Since a child has a very limited capacity to deal with such negative situations, supportive caregiver relationships are critical for buffering the stress. When those nurturing relationships are absent, a child's stress management system is continually overloaded, overproducing neural connections. This overload negatively impacts the brain's capacity and a child's ability to control their emotions and actions and to solve problems, which can lead to increased risks of stress-related physical and mental illness later in life.

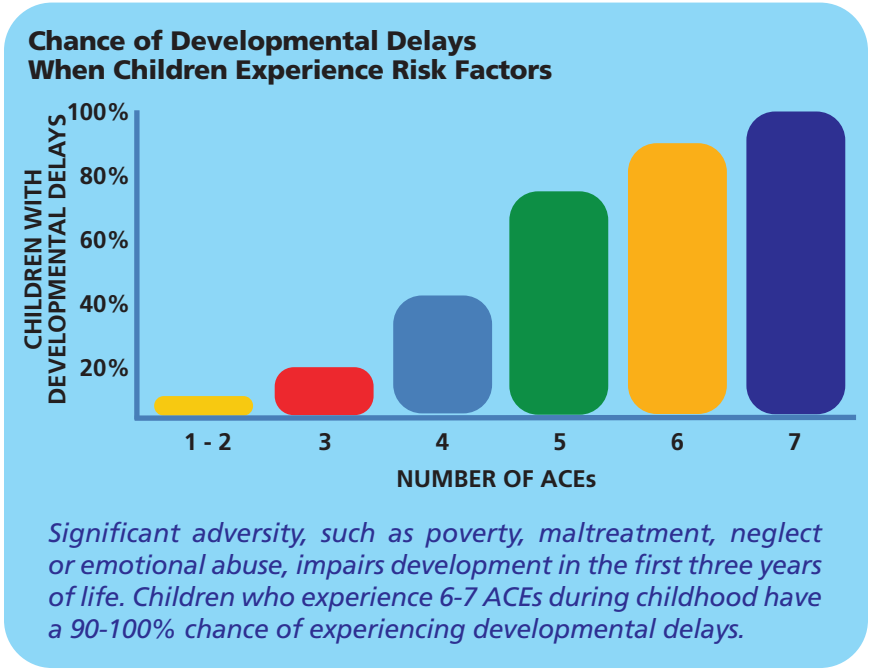
Given both the long- and short-term impact that caregiver relationships and the home environment have on a child's developing brain architecture, and how vulnerable it is to stressful interactions, researchers and child advocates have been intensely studying a troubling occurrence they identify as "***toxic stress***."

Toxic Stress and its Impact

Within the context of child development, the concept of toxic stress represents a child's intense, frequent and/or continued interaction with hardship and/or difficulty. Toxic stress can be the result of physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or a family's economic instability.

The negative effects of continued toxic stress on the child's brain are staggering. Prolonged activation of stress response systems in the early years can disrupt the development of brain architecture and lead to poor language development, behavioral problems, deficits in school readiness, aggression, anxiety, depression, and impaired cognitive development.

These adverse childhood outcomes can have a cumulative impact over time, increasing the risk for cognitive impairment, the absence of life management skills, and an increase in stress-related diseases that extend well into the adult years. A child experiencing toxic stress has a greater likelihood of being unable to fully develop the executive function skills[1] needed to regulate behavior and impulse control, thought to be essential for focusing and following directions. Ultimately, this has a detrimental effect on how the child functions in school, employment and personal relationships. Furthermore, studies indicate that the more ACEs that occur in childhood, the greater the likelihood of health problems emerging later in life, including heart disease, diabetes, substance abuse and depression.



Source: Barth et al. (2008)
Credit: Center on Developing Child

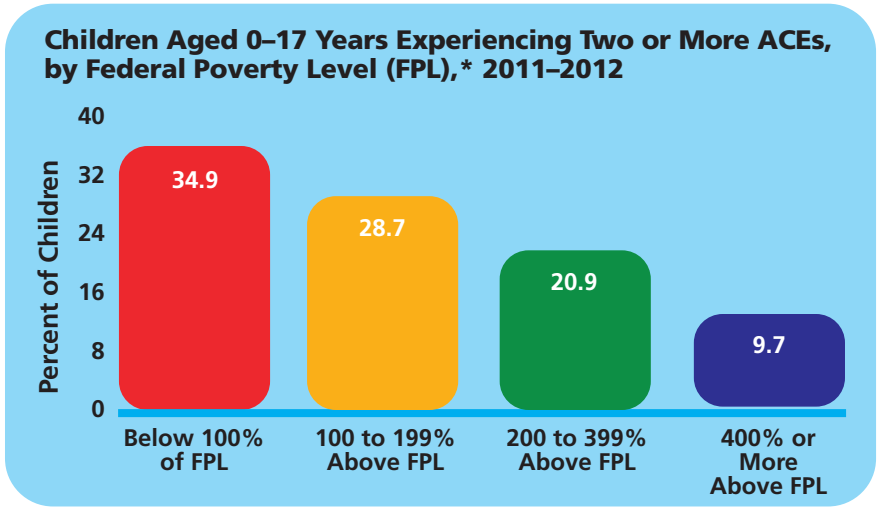
On an optimistic note, research has also found that supportive, responsive relationships with caring adults as early in life as possible can help reverse the damaging effects of toxic stress response.

[1] *The Center on the Developing Child at Harvard University defines executive function and self-regulation skills as the mental process that individuals use to plan, focus attention, work toward goals, work with others, make decisions and problem solve.*

Challenges Associated with Early Childhood Development

Economic Instability and its Impact

Children who live in poverty are much more likely than their peers to be exposed to multiple ACEs. Dr. Vonnie McLoyd, a renowned developmental psychologist, contends that "the stress of poverty is not simply worries about money — poverty creates a 'context of stress', in which conflict, family violence, food insecurity and residential mobility (to name a few) are also commonplace." Impoverished children often live in chaotic and anxiety-ridden conditions that include violence, parental incarceration, household substance abuse, substandard housing, transience/mobility and food insecurity. Researchers have linked these harmful conditions to what they term "poverty-related stress."

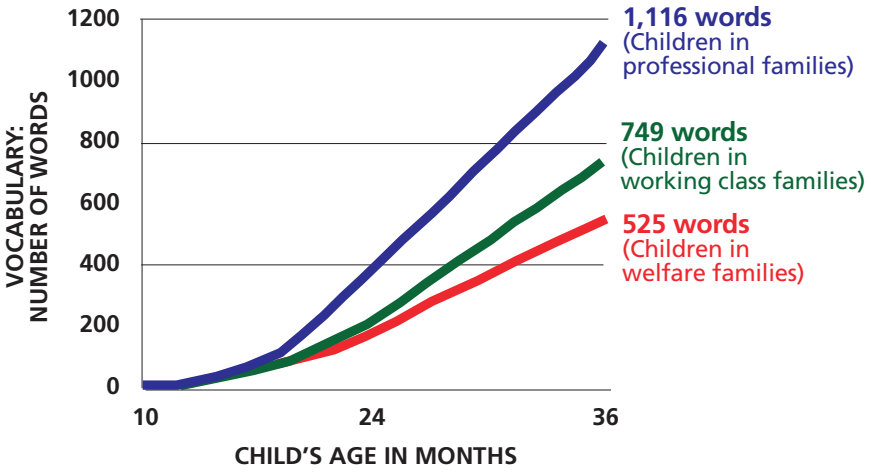


*Based on the U.S. Department of Health and Human Services poverty guidelines, poverty was $23,050 for a family of four in 2012.

Source: Health Resources and Services Administration, Maternal and Child Health Bureau, and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health. Analyzed by the Health Resources and Services Administration's Maternal and Child Health Bureau.

Researchers believe that poverty contributes to family breakdown and dysfunction, reinforcing an environment conducive to toxic stress. Furthermore, the correlation between childhood poverty and lifelong negative outcomes for impoverished children suggests that poverty itself may be considered an ACE. This phenomenon is most clearly illustrated by the data on the acqusition of words by young children linked to economic status.

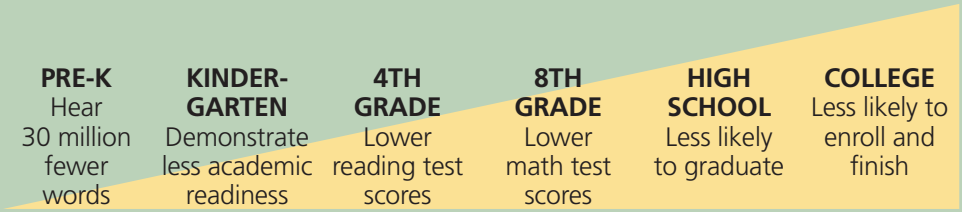
Early Vocabulary Gaps



Source: The Early Catastrophe, Hart & Risley 1995

Achievement Gaps Start Early and Persist

Children of color or low-income status are more likely to lag behind.



Source: Barth et al. (2008)
Credit: Center on Developing Child

- **Poverty and unequal opportunity are a heavy burden for families** with young children to overcome. Experiences that compromise early development disproportionately affect low-income families.
- Failure to address the needs of young children has **dire consequences.** By age four, children living in poverty are already missing out on key opportunities to learn, show empathy, and grow healthy habits for life.
- One-third of all kindergarten students are judged by their teachers to be **"not ready" for school.**
- Because of the lack of adequate developmental supports and toxic stress, **poor children spend their lives behind their better off peers** in cognitive function and educational achievements.

There are three characteristics of early childhood poverty that have the greatest potential for producing long-term negative consequences:

- **Chronic Poverty-Related Stress**
- **Poor Nutritional Status**
- **Unhealthy Physical Environment**.

• Chronic Poverty-Related Stress

The persistent fear and chronic anxiety emanating from poverty-related stress are linked to observable changes in the brain development of young children, particularly those areas of the brain associated with emotion regulation and cognitive development. Consequently, as they develop, young children living in poverty have been found to be more likely than non-poor children to display emotional or behavioral problems.

Research published in the Journal of Child Psychology (2019) found that preschoolers tended to have higher levels of stress hormones than their peers when their family suffered from economic instability and household chaos. Co-author Dr. Eleanor Brown has stated that "economic instability can make it difficult for families to maintain predictable family routines and processes. Instability and chaos are inherently stressful for children, and predict elevations in stress hormones that could, over time, pose problems for children's learning and emotions."

Very young children—birth to five years—experiencing chronic stress can become fearful from feeling helpless, powerless, and unable to protect themselves. Children of this age group often fear being separated from a parent or other important care-giving relationships. They tend to cry, whimper, scream, tremble, or are excessively clingier than usual (NIMH, 2001). The older ages in this category may even revert back to earlier behaviors by thumb sucking, bedwetting, and fear of darkness. Over time, these children are more likely to display problematic behaviors including anxiety, withdrawal, depression, aggression, or fighting and acting out.

Challenges Associated with Early Childhood Development

• Poor Nutritional Status

According to the National Institute of Health, nutritional status is the state of a person's health in terms of the nutrients in his or her diet. A proper balance of nutrients is critical for development, growth, health maintenance and reproduction. Nutritional status is especially important for young children. One of the most important risk factors of growth failure is poor nutritional status, especially at an early age. Adequate nutrition during childhood also strongly promotes cognitive achievement and prevents onset of chronic diseases later in life.

Children who live in economically unstable homes are most likely to live in food insecure homes.

The Community Foundation reported that three out of twenty children living in Litchfield County in 2012 were food insecure. The hunger and poor nutrition that usually accompany food insecurity represent ACEs that have short and long-term consequences including child's risk for asthma, iron deficiency, developmental and behavioral problems such as aggression, anxiety, depression and attention deficit disorder. These concerns early in life increase children's risk of poor school readiness, poor school performance and subsequent health disparities.

Generally, food-insecure households lack the financial means and the knowledge associated with healthy eating to provide a good nutritional environment for their children. As a result, children in food-insecure homes are prone to eating low-cost, high caloric foods. This outcome is associated with under-nutrition and obesity.

• Unhealthy Physical Environment

An unhealthy physical environment is one in which the environmental conditions that can contribute to good health and well-being are absent, such as safe neighborhoods, clean air, play areas and access to healthy food. A growing body of research has documented significant effects of the physical environment on children's cognitive and socio-emotional development. Researchers believe that the accumulation of multiple physical environmental factors rather than a single one may be an especially harmful aspect of childhood poverty.

Unfortunately, the neighborhoods that many low-income young children live in are characterized by substandard housing, noise, crime, drug use, a lack of recreational areas and few if any supermarkets. The home itself may be overcrowded, contain toxins (such as asbestos, lead and mold) and be polluted with tobacco smoke. Low-income households can also experience a high degree of housing instability and residential mobility, making it difficult to find and afford an adequate and safe place to live. These facets termed "housing insecurity" all have negative consequences for the development of young children.

Exposure to toxins such as lead has been found to cause health problems and cognitive deficits in children. Substandard housing and exposure to mold and tobacco smoke are related to respiratory illness. Exposure to violence and excessive noise elevate psychological distress in children. The cumulative impact of these risk factors accelerates the negative consequences they engender.

The Importance of High-Quality Early Care and Education in Healthy Child Development

Early childhood education is a term that generally refers to the learning that takes place during ***the period of time from a child's birth to when they enter kindergarten***. For a child it is a time of rapid and significant learning. During this period the primary goal for parents and caregivers is to provide the appropriate physical, emotional and learning environment for a child to reach the milestones associated with their healthy development.

Naturally, a child's primary attachment to his/her parents is an irreplaceable factor in accomplishing this goal. However, child development experts believe that children benefit from close nurturing relationships with other responsive caregivers both within and outside of the family. In addition, multiple caregivers can actually advance a child's development. In early learning settings, for example, an important emphasis is placed on forming a partnership between a child, their parents and the child's teachers.

Early care and education (ECE), whether provided by caring and informed parents, a network of care-giving relatives and friends, or staff in a high-quality early learning center, is more than providing day care and building basic school readiness skills. It contributes to a child's overall development and has its greatest impact when caregivers take a holistic approach to addressing a child's entire range of developmental needs. Effective early childhood education is concerned with cognitive, physical and "character" skills such as attentiveness, impulse control, persistence and teamwork. When this focus on the "whole child" is done successfully, it establishes a foundation for learning, personality and temperament formation and emotional well-being for years to come.

The Importance of High-Quality Early Care and Education in Healthy Child Development

Evidence-based Research on the Long-Term Outcomes of Early Care and Education

Several seminal longitudinal research studies have validated the long-term positive outcomes that young children reap from being in high-quality, early learning settings.

Abecedarian Project

The Abecedarian Project (ABC) was a carefully controlled scientific study of the potential benefits of early childhood education from **birth to age 5** for low-income children. Four cohorts of individuals (approximately 100 children), born between 1972 and 1977, were randomly assigned as infants either to the Early Educational Treatment Group or the Control Group. Multiple follow-up assessments were conducted as the Abecedarian children aged from childhood to adulthood.

Summary of outcomes:

In the early years, the Abecedarian children had higher IQ scores, scored higher on achievement tests in math and reading, and had lower levels of grade retention and fewer placements in special education classes.

Entering adulthood, Abecedarian participants were more likely to attend a 4-year college or university, more likely either to be in school or to have a skilled job, or both. They also were less likely to be teen parents, less likely to smoke marijuana, and less likely to report depressive symptoms, when compared to individuals in the Control Group.

As adults, Abecedarians were more likely to hold a bachelor's degree, hold a job, and delay parenthood. They enjoyed better physical health had lower rates of high blood pressure, coronary heart disease and obesity, and higher levels of good cholesterol.

High/Scope Perry Preschool Project

The Perry Preschool Project, carried out from 1962 to 1967 in Michigan, provided high-quality preschool education to 123 African-American children who were 3-4 years old, living in poverty and assessed to be at high risk of school failure. About 75 percent of the children participated for two school years (at ages 3 and 4); the remainder participated for one year (at age 4).
Data were collected annually from the Perry children and a control group from ages 3 to 11 and multiple times thereafter until age 40.

Summary of outcomes:

The longitudinal study found that at age 40, the participants who experienced the Perry Preschool program were more likely to have graduated from high school and were more likely to hold a job and have higher earnings. In addition, they were more likely to own their own home and car, have fewer teenage pregnancies, and commit fewer crimes.

The major conclusion of this midlife phase of the Perry Preschool research study is that high-quality preschool programs for young children living in poverty contribute to their intellectual and social development in childhood and into their school years. It also confirms that the long-term effects are lifetime effects.

Chicago Child-Parent Center (CPC)

The Child-Parent Center (CPC) Program has provided comprehensive educational and family-support services to economically disadvantaged children from preschool to third grade since 1967. The overall goals of the program were to advance children's basic knowledge and skills in language arts and math, and to facilitate parents' involvement in their children's education.

Summary of outcomes:

CPC research studies conducted over the years have documented that the program improves cognitive skills, socio-emotional development, kindergarten readiness, and reading and math skills, while reducing grade retention and special education usage. CPC was found to increase parental engagement, which has been linked to increased student motivation and school achievement as well as reduced adolescent problem behaviors and substance use.

The CPC preschool group had significantly higher educational outcomes in the long term. These outcomes included a higher rate of 4-year high school graduation, college attendance, associate's degree or higher, and master's degree or higher. Additional CPC research has shown that higher levels of education are associated with greater economic well-being, reduced depression, fewer instances of child abuse/neglect and less involvement in the criminal justice system.

The Opportunity Project – Early Learning Centers (TOP)

The first TOP center opened in Kansas in 2003. Today three centers serve over 700 children from birth to kindergarten, in all-day, year-round preschool. Over 90% of the children are eligible for free or reduced-price meals. TOP has conducted a longitudinal study of the program's impact by annually collecting outcome data on children from kindergarten through 9th grade.

Summary of outcomes:

Compared to a Control Group of children from similar backgrounds who had not attended TOP programs, the TOP students did better at nearly every grade level in every category—academics, social skills and attendance. For all grades, teachers rated TOP students as having greater emotional maturity, greater ability to behave appropriately and greater social competence than their classmates. Teacher estimations of TOP participants' social-emotional skills were statistically higher than average.

By 6th grade, 83% of TOP students met or exceeded state standards in math, compared to 50% for the Control Group. In reading, 94% of TOP 6th graders met or exceeded state standards, compared to 76% for the Control Group. By 8th grade, TOP students were 107% more likely than their Control Group peers to read at grade level.

TOP graduates attended school with more frequency than their Control Group peers, had lower special education placement rates, and experienced fewer discipline problems.

Chicago School Readiness Project

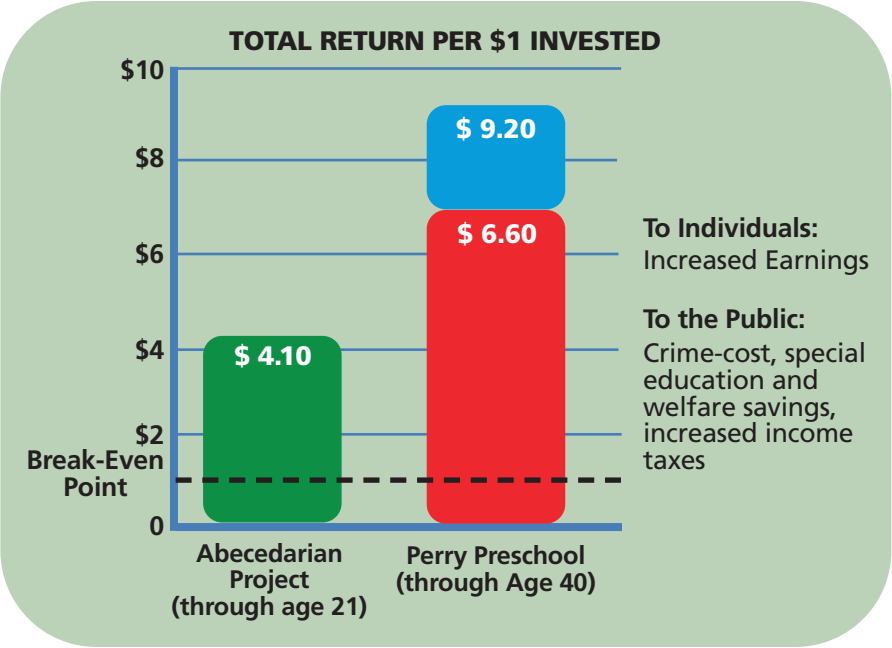
Launched in 2003, the Chicago School Readiness Project (CSRP) was a longitudinal evaluation of a preschool program in Head Start centers designed to improve children's school readiness by increasing self-regulation. Self-regulation describes a child's ability to focus and maintain attention, regulate behavior in order to positively interact with peers and adults, and regulate emotion in the face of stress and anxiety.

Participants included low-income, pre-school children drawn from high-poverty, high-crime neighborhoods. Data were collected when children were in Head Start, kindergarten, and 3rd and 5th grades.

Summary of outcomes:

Findings indicated that CSRP students had higher levels of attention, were less impulsive and performed better on tasks that measure executive function than children who were not in the program. The children also demonstrated better early verbal and math skills resulting in positive long-term effects on grades.

The Importance of High-Quality Early Care and Education in Healthy Child Development



At a minimum, there is a $4 – $9 return on investment for every dollar spent on early childhood interventions

Source: The Center for the Developing Child, Harvard University. Masse, L. and Barnett, W.S., A Benefit Cost Analysis of the Abecedarian Early Childhood Intervention (2002); Karoly et al., Early Childhood Interventions: Proven Results, Future Promise (2005); Heckman et al., The Effect of the Perry Preschool Progam on the Cognitive and Non-Cognitive Skills of its Participants (2009).

Child Well-Being: Working Toward Common Ground

The general concept of ***child well-being*** is one that is embraced by virtually every individual who is responsible for ensuring that children are born healthy, develop optimally and function to their highest potential. From parents, to health care professionals, to child care providers, to teachers and paraprofessionals, and children's policy advocates, each is a champion of *child well-being*. Yet when it comes to a common definition of child well-being, and a standard for measuring it, there is no widely held consensus.

Unfortunately, much of the research on children takes place within silos, where researchers consider a single area of development. For example, educators might focus on cognitive development and academic attainment, while health professionals typically focus on physical health attributes. Social workers might look at economic factors, such as affordable and safe housing.

Fortunately, there is universal agreement that early childhood experiences have an irreparable, profound impact on the ***adult*** that the child becomes. Therefore, the overarching goal of well-being might be to provide our children with any and all opportunities they need to realize their potential and to provide young children with the early foundation necessary to support their continued development and growth. From a holistic perspective, ***well children*** can be thought of as physically and emotionally healthy, prepared to do their best in school, able to engage positively with both adults and other children, live in nurturing and safe environments, eat nutritious food and have a positive self-image. Importantly, they and their families have access to all of the personal, social and material resources needed to make these conditions a reality.

Leaders in our local communities are increasingly concerned about the well-being of our children. They are becoming more aware that some benchmarks by which they can assess how well we are doing in this regard need to be developed and then tracked. Although this is a daunting challenge, the key may be in building regional agreement around a set of values that represents what quality of life means for Northwest Connecticut's children.

Toward this end, the following values are offered as aspects of a child's holistic well-being. Every child in Northwest Connecticut will:

- Develop optimally with regard to cognition, social behavior and emotional expression
- Have ready access to health care services
- Be raised in a safe, stable and nurturing family environment
- Be raised in an economically secure household
- Have access to affordable, high-quality early care and education
- Have access to an adequate supply of nutritious food
- Have access to an adequate supply of safe and affordable housing
- Be provided with optimal learning opportunities throughout his or her school years
- Have access to recreational facilities and programs
- Be provided with the education needed to develop healthy behaviors and lifestyles
- Have access to equal opportunities regardless of individual differences and challenges.

Using Indicators to Measure Child Well-Being in Northwest Connecticut

A major objective of this report is to present a baseline assessment of child well-being in Northwest Connecticut and to use it as a benchmark to track changes over time.

To construct an assessment of this nature, this report highlights six essential components of a child's life that are necessary for healthy and appropriate development.

They include:

- Economically Secure and Stable Home Environment
- Safe and Nurturing Emotional Environment
- Access to Quality Health Services
- Access to Early Care and Education
- Educational Attainment
- Positive Social Behavior

Indicators:

Indicators are used to measure **outcomes** (e.g., educational achievement gap, disciplinary problems) and **conditions that influence outcomes** such as social conditions (e.g., poverty/low income), family conditions (e.g., child abuse/ neglect) and community processes (e.g., availability of affordable, high-quality child care). A critical function of an indicator is its capacity to measure change over time. Indicators are constructed from a variety of data sources, including census data, vital statistics, administrative data sets from federal, state and local agencies, databases of healthcare and educational institutions and surveys.

A complete assessment of child well-being from cognitive and social-emotional perspectives is limited to the data available, and in some instances the data needed to construct an indicator for use in group comparison is lacking, particularly at the regional or local levels. Additionally, some indicators did not easily lend themselves to quantification and comparison, or are not consistently collected on a regular basis.

Criteria for inclusion:

Criteria were established to ensure that the right indicators were selected for their intended purpose. These criteria were applied to the many indicators that could potentially have been included in this core set.

- **Availability.** Data for the indicator are readily available and accessible from a reliable source.
- **Macro Level Applicability.** Data can be used for large group comparisons and are not limited to a micro level examination of individuals.
- **Reliability.** Data for the indicator are consistently collected, compiled and calculated in the same way, from year to year.
- **Validity.** The indicator measures what it is designed to measure and contributes to a greater understanding of the dimension being assessed.
- **Measurability.** The indicator can be quantified.
- **Relevance/action-oriented.** The indicator measures a factor or condition over which community decision-makers can achieve positive change.
- **Sensitivity.** The indicator is able to capture changes in conditions over time.
- **Compelling/interesting.** The indicator lends itself to understanding and has the capability to inform the public, media and decision-makers.

The report includes 20+ indicators organized by six dimensions of child well-being. Each indicator includes the following components: a description of the indicator and its importance, and findings for Northwest Connecticut, including a data table and its source.

Geographic Scope:

The Northwest Connecticut Community Foundation serves the following 20 towns: Barkhamsted, Bethlehem, Canaan/Falls Village, Colebrook, Cornwall, Goshen, Hartland, Harwinton, Kent, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Salisbury, Sharon, Torrington, Warren, Washington and Winchester/Winsted.

In this report, the Community Foundation's 20 towns will be referred to individually, and collectively as NWCT. Other data may be reported for Litchfield County (LC) as a whole, if town data are not available.

Local Early Childhood Well-Being Indicators
Organized by Six Components of a Child's Life

NWCT Births by Selected Social Determinants of Health and Risk Factors
(Marital Status, Education and Income) 2016

What this Indicator is:

A range of personal, socioeconomic and environmental conditions have been linked with short- and long-term health outcomes. Because of this relationship, these conditions have been called **social determinants of health**. They include but are not limited to race and ethnicity, socioeconomic factors, such as income level and educational attainment, health insurance coverage, access to medical care, housing conditions and neighborhood safety.

This indicator illustrates the number and percentage of 2016 births to NWCT residents that were recorded under one or more conditions that can be characterized as an *at-risk social determinant of health:* single marital status, low educational attainment and low income (as indicated by the payment of delivery costs by Medicaid).

Why this Indicator is Important:

Research studies have correlated poor health outcomes in life expectancy, morbidity and health status with adverse conditions in one or more of the social determinants of health. Being born into at-risk socioeconomic circumstances as characterized by the three selected conditions increases the potential that young children will encounter poor health outcomes throughout their lives. These children are in great need of intervention services that can mitigate the negative impact of these at-risk social determinants.

Town	Live Births	Births to Single Mothers		Mothers with Less than a High School Diploma		Payment for Delivery by Medicaid	
		Number	Percent	Number	Percent	Number	Percent
Barkhamsted	27	8	30%	0	0	s	s
Bethlehem	30	4	13%	1	3%	11	39%
Canaan	13	6	46%	1	8%	5	39%
Colebrook	6	s	s	1	17%	s	s
Cornwall	4	s	s	s	s	s	s
Goshen	14	7	50%	0	0	6	43%
Hartland	12	1	8%	0	0	0	0
Harwinton	33	12	36%	1	3%	9	27%
Kent	18	4	22%	0	0	s	s
Litchfield	56	12	21%	0	0	14	27%
Morris	22	52	3%	1	5%	8	38%
New Hartford	59	11	19%	0	0	9	16%
Norfolk	7	s	s	2	29%	s	s
North Canaan	26	15	58%	3	12%	14	54%
Salisbury	26	9	35%	2	8%	14	56%
Sharon	11	4	36%	0	0	8	80%
Torrington	330	153	46%	45	14%	162	50%
Warren	16	3	19%	0	0	6	40%
Washington	16	4	25%	1	6%	s	s
Winchester	89	48	54%	6	7%	56	64%
Total	**815**	**306**	**38%**	**64**	**8%**	**322**	**40%**

s = information suppressed *In geographies under 100,000 people, counts and rates for indicators with 1 to 4 events are suppressed.*

Connecticut Department of Public Health Vital Statistics and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. Nearly forty percent (38%) of the 2016 births to NWCT residents were to single mothers. The towns with the largest number of single mother births were Torrington (153 or 46%) and Winchester (48 or 54%).

2. Overall, the number of births to mothers who had less than a high school diploma was small. Torrington had 45 births or 14% to mothers with less than a high school diploma.

3. Two of every five births (322) in 2016 had their delivery expenses paid for by Medicaid. The largest number occurred in Torrington, with 162 (50%), and Winchester, with 56 (64%).

Several towns with smaller overall numbers had notable percentages of Medicaid-paid births, including Sharon (80%), Salisbury (56%) and North Canaan (54%).

Food Insecurity among Litchfield County's Children
2017

What this Indicator is:

(1) **Child Food Insecurity** is defined as the household-level economic and social condition of limited or uncertain access to adequate food, as reported for households with children under age 18. It is assessed in the Current Population Survey (CPS) and represented in U.S. Department of Agriculture (USDA) food security reports.

As part of their methodology, Map the Meal Gap uses publicly available state and local data from the U.S. Census Bureau and Bureau of Labor Statistics on factors that contribute to food insecurity. These factors include unemployment and poverty, as well as other demographic and household characteristics.

(2) **Child Food Insecurity Rate** is defined as the percentage of children living in households that experienced food insecurity at some point during the year.

(3) Child food-insecurity estimates are sorted by the income categories used to identify **eligibility for federal child nutrition programs**, generally at or below 185% of the federal poverty line - such as the National School Lunch Program (NSLP), the School Breakfast Program (SBP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Children whose household incomes are above 185% of the federal poverty line are considered *"likely"* ***ineligible*** for nutrition programs by Feeding America.

Why this Indicator is Important:

Research has shown a correlation between food insecurity and poor child health and behavioral outcomes at every age. Among the adverse health consequences of prolonged hunger for children are developmental delays, anemia, asthma and oral health problems. Overall, food insecurity is linked with poorer physical quality of life, which may prevent children from fully engaging in daily activities.

At school, food-insecure children are at increased risk of falling behind their food-secure peers both academically and socially. Food insecurity is linked to lower reading and mathematics test scores, and children may be more likely to exhibit behavioral problems, including hyperactivity, aggression and anxiety. (*Child Food Insecurity* in Map the Meal Gap 2019, Feeding America)

Food Insecurity among Litchfield County's Children 2017	
Total Child Population of Litchfield County (under 18 years of age)	**35,214**
Number of Food Insecure Children	**4,770**
Food Insecurity Rate	**13.6%**
Food Insecure Income Eligible for Nutrition Programs (incomes at or below 185% of poverty)	**2,051 / 43%**
Food Insecure Likely Ineligible for Nutrition Programs (incomes above 185% of poverty)	**2,719 / 57%**

Feeding America; U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. Approximately one in seven children in Litchfield County may not have consistent access to enough food for an active, healthy life. Of the county's 35,214 children under 18 years of age, 4,770 were determined to be food insecure. This results in a Food Insecurity Rate of 13.6%.

2. Only four in ten of these food insecure children are income eligible for nutrition programs such as Supplemental Nutrition Assistance Program (SNAP), School Lunch and Breakfast programs and Women, Infant and Children program (WIC). Of the remaining children, 57% (2,719) are above the Federal Poverty Level threshold and therefore do not qualify for federal child nutrition programs.

Impoverished and Low-Income Children in NW CT Ages 5 and Under
2013 - 2017 U.S. Census Bureau

What this Indicator is:

Poverty is measured in the United States by comparing a person's or family's income to a set poverty threshold or minimum amount of income needed to cover basic needs. The **Census Bureau** issues the poverty thresholds, which are generally used for statistical purposes to estimate the number of people in poverty nationwide, and classify them by type of residence, race, and other social, economic, and demographic characteristics. The **Department of Health and Human Services** issues the poverty guidelines for administrative purposes—for instance, to determine whether a person or family is eligible for assistance through various federal programs. Both the poverty thresholds and poverty guidelines are updated yearly.

2017 Federal Health and Human Services Department Poverty Guidelines

To get the poverty level for larger families, add $4,480 for each additional person in the household.

Number of People in Household	Federal Poverty Level (FPL)	185% of FPL
One	$12,060	$22,311
Two	$16,240	$30,044
Three	$20,420	$37,777
Four	$24,600	$45,510
Five	$28,780	$53,243

Why this Indicator is Important:

Poverty and low-income environments have a detrimental impact on children, mentally and physically, in both the short-term and long-term. Compared with their peers, children living in poverty and low-income, especially young children, are more likely to have cognitive, behavioral, social and emotional difficulties. Throughout their lifetimes, they are more likely to encounter poor academic and health outcomes.

Town	Total Population Ages 5 and Under	Children in Poverty		Children at 185% of Poverty (Low Income)		Total Children in Poverty and Low Income	
		Number	Percent	Number	Percent	Number	Percent
Barkhamsted	93	0	0	0	0	0	0
Bethlehem	125	31	25%	17	14%	48	38%
Canaan	65	0	0	12	19%	12	19%
Colebrook	68	0	0	6	9%	6	9%
Cornwall	40	6	15%	6	15%	12	30%
Goshen	126	0	0	0	0	0	0
Hartland	101	3	3%	0	0	3	3%
Harwinton	237	30	13%	0	0	30	13%
Kent	144	0	0	9	6%	9	6%
Litchfield	381	55	14%	26	7%	81	21%
Morris	147	5	3%	42	29%	47	32%
New Hartford	312	0	0	0	0	0	0
Norfolk	44	3	7%	3	7%	6	14%
North Canaan	203	0	0	34	17%	34	17%
Salisbury	137	0	0	0	0	0	0
Sharon	81	30	37%	0	0	30	37%
Torrington	2,023	224	11%	266	13%	490	24%
Warren	51	4	8%	8	16%	12	24%
Washington	143	0	0	21	15%	21	15%
Winchester	500	117	23%	26	5%	143	29%
Total	**5,021**	**508**	**10%**	**476**	**10%**	**984**	**20%**

U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates and Words & Numbers Research, Inc.

Findings for Northwest Connecticut next page

Students Eligible for Free and Reduced-Price Meals
(grades PK–8) School Year 2017-2018

Impoverished and Low-Income Children in NW CT Ages 5 and Under

Findings for Northwest Connecticut:

1. Ten percent or 508 of the region's children age 5 and under live in households with incomes below the Federal Poverty Level (FPL).

2. An additional ten percent or 476 children live in households with incomes between the Federal Poverty Level and 185% of FPL *which is typically considered as a threshold of* ***low income*** *for eligibility for many federal and state assistance programs.*

3. In total, one of every five children (984) in NWCT aged five and under lives in a household with an income under 185% of the Federal Poverty Level.

What this Indicator is:

Children eligible for **free** lunch live in a family with income less than 130% of the federal poverty level, while children eligible for **reduced** price lunch live in a family with income between 130% and 185% of the federal poverty level. For a household of four persons this equates to an income of $31,980 at 130% FPL and $45,510 at 185% FPL.

Why this Indicator is Important:

Student eligibility for Free and Reduced-Price Meals (FRPM) serves as a useful measurement of family poverty, economic instability and food insecurity in a given area. All three conditions are linked to developmental risks, poor academic performance and adverse health outcomes.

Recent research by Thurston Domina, Professor of Education at the University of North Carolina at Chapel Hill, found that FRPM data capture the negative impact that family income instability has on students' academic performance. He also stated that emerging research suggests that income volatility can have powerful negative consequences for youth development.

Students Eligible for Free and Reduced-Price Meals (grades PK–8) School Year 2017-2018

School	Grades	Number Eligible	Percent of School	Percent of District
Barkhamsted Elementary	PK - 6	26	12%	11%
Lee H. Kellogg (Canaan)	K - 8	11	16%	16%
Colebrook Consolidated	K - 6	16	18%	18%
Cornwall Consolidated	K - 8	7	10%	10%
Hartland	PK - 8	14	8%	9%
Kent Center	PK - 8	32	14%	14%
Litchfield Center	PK - 3	41	14%	11%
Litchfield Intermediate	4 - 6	17	9%	11%
Litchfield Middle	6 - 8	18	12%	11%
Ann Antolini (New Hartford)	3 - 6	34	13%	11%
Bakerville Consolidated (New Hartford)	K - 2	8	7%	11%
New Hartford Elementary	PK - 2	9	10%	11%
Botelle Elementary (Norfolk)	PK - 6	26	27%	27%
North Canaan Elementary	PK - 8	66	24%	24%
Goshen Center (Reg. 6)	PK - 6	16	8%	10%
James Morris (Reg. 6)	PK - 6	19	14%	10%
Warren Elementary (Reg. 6)	PK - 6	*	*	10%
Wamogo Regional (Reg. 6)	7 & 8	10 est.	10%	10%
Northwest Regional Middle (Reg. 7)	6 - 8	30	10%	10%
Harwinton Consolidated (Reg. 10)	PK - 4	29	8%	6%
Lake Garda Elementary (Reg. 10)	PK - 6	23	5%	6%
Har-Bur Middle (Reg. 10)	5 - 8	45	6%	12%
Washington Primary (Reg. 12)	PK - 5	21	14%	8%
Shepaug Valley (Reg. 12)	6 - 8	12 est.	7%	8%
Bethlehem Elementary (Reg. 14)	PK - 5	39	15%	9%
Mitchell Elementary (Reg. 14)	PK - 5	29	8%	9%
Woodbury Middle (Reg. 14)	6 - 8	27	8%	9%
Salisbury Central	PK - 8	48	16%	16%
Sharon Center	PK - 8	43	31%	31%
East (Torrington)	PK - 5	141	39%	54%
Forbes (Torrington)	PK - 5	234	69%	54%
Southwest (Torrington)	PK - 5	207	65%	54%
Torringford (Torrington)	PK - 5	221	41%	54%
Vogel-Wetmore (Torrington)	PK - 5	357	81%	54%
Torrington Middle	6 - 8	563	54%	54%
Batcheller Early Ed Ctr (Winchester)	PK - 2	126	55%	56%
Pearson (Winchester)	3 - 6	172	58%	56%
Gilbert (Winsted)	6 - 8	63 est.	38%	38%
Total		**2,800**		

Findings for Northwest Connecticut:

1. A total of 2,800 PK to 8th grade students from NWCT's elementary and middle schools were eligible for free and reduced-price meals during the 2017-18 school year. This signifies that they lived in households with incomes either at or below 185% of the Federal Poverty Level (FPL).

2. Torrington schools by far comprised the majority of the PK to 8th grade FRPM-eligible population with 1,723 students or 62% of the total. Winchester had approximately 361 students for 13% of the total. Six schools in these two towns had FRPM-eligible students that exceeded one-half of their school population.

3. Although the numbers were considerably lower than those in Torrington and Winchester, several of the region's elementary schools had a large proportion of FRPM-eligible students. They included Sharon Center (31%), Botelle Elementary (27%), and North Canaan Elementary (24%).

CT State Department of Education EdSight and Words & Numbers Research, Inc.

** The data are suppressed to ensure confidentiality.*

Geographic Mobility by Town and Age
(1–4 Years of Age) 2017

What this Indicator is:

Geographic mobility is assessed through the American Community Survey (ACS) for persons one year and older by documenting the respondent's answer to a question concerning the household's residence one year previously. If the residence was different from the current one, it is determined whether the respondent moved within the county, from a different county or from another state. The ACS also assesses the extent to which individuals of ***all*** ages who moved in a given year are considered to be low-income. In this instance, low-income is defined as being at or below 149% of the Federal Poverty Level.

Moving frequently is considered an aspect of **housing instability.** For low-income households, moving frequently is associated with difficulty paying rent, spending more than 50% of household income on housing, living in overcrowded conditions, or doubling up with friends and relatives.

NOTE:
The limitation of this indicator is that there is no way of knowing whether the move was precipitated by positive (upward mobility) or negative (housing instability) factors.

Why this Indicator is Important:

Stable and familiar surroundings enhance a child's potential to develop optimally and to develop secure and nurturing relationships. Research has shown that changes to a child's environment, especially frequent changes, may place the child at risk for academic, behavioral, emotional and health problems.

A 2016 Urban Institute study showed that families are more likely to be evicted—and possibly become homeless—when their income is unstable. This can lead to children having to change their child care providers and schools. Author Heather Sandstrom states that "changes in schools and child care arrangements are common, particularly as families move or change jobs, but school mobility and child care instability are most prevalent among low income families."

The report discusses the impact that housing instability has on infants, pre-schoolers and school-age children.

For infants, changes in child care arrangements can lead to poor attachment with providers and problem behaviors. For preschoolers, early care and education settings support children's development of foundational school readiness skills; changes in care settings can disrupt the continuity of learning.

For school-age children, changes in schools impede children's academic progress and decrease social competence. School mobility has the strongest effect during early elementary and high school, with multiple school transfers increasing negative effects.

Town	Total Population, 1 to 4 Years of Age	Moved within the Last Year 1 to 4 Years of Age		Low-Income Movers within the Last Year (All Ages)	
	Number	Number	Percent	Number	Percent
Barkhamsted	53	10	19%	10	6%
Bethlehem	59	0	0	20	13%
Canaan	49	12	24%	29	27%
Colebrook	51	21	41%	40	21%
Cornwall	26	8	31%	3	6%
Goshen	86	0	0	13	17%
Hartland	74	20	27%	1	3%
Harwinton	155	0	0	10	5%
Kent	135	0	0	47	27%
Litchfield	229	63	28%	78	13%
Morris	122	14	15%	29	12%
New Hartford	230	30	13%	62	18%
Norfolk	27	7	26%	12	17%
North Canaan	136	0	0	21	8%
Salisbury	108	7	7%	20	14%
Sharon	59	30	51%	225	48%
Torrington	1,462	325	22%	1,105	27%
Warren	28	6	21%	0	0
Washington	85	26	31%	21	13%
Winchester	340	98	27%	870	47%
Total	**3,514**	**677**	**19%**	**2,616**	**27%**

U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. Approximately 20% of NWCT children between the ages of one and five moved in the year previous to 2017, totaling 677 children.

2. Towns with the largest number of young children who moved were Torrington, 325 (22%), Winchester, 98 (27%) and Litchfield, 63 (28%).

3. Two towns with smaller overall numbers had notable percentages of young children who moved. These were Sharon, 30 (51%) and Colebrook, 21 (41%).

4. One-quarter (27%) of all movers in NWCT were low-income.

5. The towns with the largest number of low-income movers were Torrington, 1,105 (27%), Winchester 870 (47%) and Sharon, 225 (48%).

6. Litchfield, 78 (13%) and New Hartford, 62 (18%) had a notable number of movers but a low percentage of low-income movers.

7. The majority (15) of NWCT's 20 towns had a percentage of low-income movers that was below the regional average.

Adverse Childhood Experiences Reported by NWCT Home Visitation Caregivers
2018

What this Indicator is:

Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional or sexual abuse to economic hardship, substance abuse, parental divorce or the incarceration of a parent or guardian.

A growing body of research has sought to quantify the prevalence of adverse childhood experiences and further document their harmful impact on health, behavior and opportunities later in life. [Child Trends Research brief, July, 2014]

As discussed in the introduction, ACEs have been linked to the creation of environments that cause "toxic stress" in children. ACEs can detrimentally affect childrens' brain development and negatively influence their attention, decision-making, learning, and how they respond to stress.

An ACEs Study was conducted between 1995 and 1997 by the Centers for Disease Control and Prevention and Kaiser Permanente. The first research results were published in 1998. The following were among the key findings:

- childhood trauma was very common, even in employed white middle-class, college-educated people with excellent health insurance;
- there was a direct link between childhood trauma and adult onset of chronic disease, as well as depression, suicide, being violent and being a victim of violence;
- more types of trauma increased the risk of health, social and emotional problems; and,
- people usually experience more than one type of trauma – rarely is it only sex abuse or only verbal abuse. [ACEs Too High Blog]

This report was followed by more than 70 other publications through 2015.

Based on this study, a Parental ACEs Screening Tool was developed to determine the extent of these harmful incidences in the lives of children's caregivers. The belief is that asking parents about their own childhood adversity is the first step in helping them to prevent their children from experiencing the same childhood trauma.

The Parental ACEs Screening Tool consists of ten questions which measure ten types of traumatic experiences that may have occurred in parents' own childhood. These include:

- Abuse: physical; emotional; or sexual;
- Family member who is: depressed or diagnosed with other mental illness; or addicted to alcohol or another substance;
- Witnessing a mother being abused;
- Poverty or economic hardship (e.g., lacking adequate food, shelter or clothing); and
- Separation from a parent (e.g., divorce, incarceration or abandonment).

Each type of trauma counts as one. For example, a caregiver who had been physically abused as a child, had an alcoholic parent, and lived in a household with insufficient food has an ACEs score of three.

According to the ACEs study, the more ACEs a caregiver has, the greater the risk for chronic disease, mental illness, violence and being a victim of violence. Caregivers with an ACEs score of 4 are twice as likely to be smokers and seven times more likely to be alcoholic. Having an ACEs score of 4 increases the risk of emphysema or chronic bronchitis by nearly 400 percent, and attempted suicide by 1200 percent.

People with high ACEs scores are more likely to be violent, to have more marriages, more broken bones, more drug prescriptions, more depression, and more autoimmune diseases. People with an ACEs score of 6 or higher are at risk of their lifespan being shortened by 20 years. [ACEs Too High Blog]

EdAdvance's Nurturing Families Network (NFN) provides home visiting services to Torrington and Winchester women and their families, beginning in pregnancy and continuing until their children are 5 years old. NFN uses a "Parents as Teachers" model that has four goals:

- Increase parent knowledge of early childhood development and improve parent practices;
- Provide early detection of developmental delays and health issues;
- Prevent child abuse and neglect;
- Increase children's school readiness and success.

NFN uses an ACEs Parental Screening Tool to assess the extent to which the caregiver has experienced childhood trauma and to establish individualized education and support services.

For purposes of constructing this indicator, the ACEs scores of 44 families that were on NFN's caseload as of August 2018 were compiled and analyzed.

Why this Indicator is Important:

Preventing emergent ACEs and undoing the harm of existing ones has far-ranging consequences for the healthy development of young children and the enhancement of positive outcomes for their health, behaviors and life opportunities as they age. Home visitation services provide an important approach for addressing ACEs and their harmful effects.

This indicator provides a snapshot of how prevalent and acute ACEs are among those young families and their need of home visitation services.

ACES for Nurturing Families Network Caregivers 2018

Number of Caregivers Reporting	Number of ACES	Abuse – Physical, Emotional or Sexual	Mental Health or Substance Abuse	Witness	Poverty	Separation
1	0	-	-	-	-	-
7	1	0	0	0	6	1
7	2	4	5	0	2	3
11	3	10	9	1	6	7
6	4	5	8	2	3	6
9	5	16	13	4	3	9
1	6	2	1	1	1	1
0	7	-	-	-	-	-
2	8	6	5	1	2	2
44	-	43	42	9	23	29

EdAdvance Nurturing Families Network and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. Virtually every caregiver (98%) with whom Nurturing Families Network (NFN) conducted a home visit had at least one adverse childhood experience.

2. Two-thirds (29) of the NFN caregivers had 3 or more ACEs.

3. Two-of-five NFN caregivers (18) had 4 or more ACEs.

4. The predominant ACEs were parental abuse, physical, emotional or sexual (43) and parental mental health issues or substance abuse (42).

5. Separation from a parent (29) and the hardships associated with poverty (23) also accounted for considerable ACEs for caregivers. There were fewer incidences (9) of a caregiver witnessing abuse being committed against a mother or stepmother.

Child Abuse and Neglect
Allegations Made and Substantiated, 2018

What this Indicator is:

The State of Connecticut Judicial Branch defines Child Abuse and Neglect as:

Abused: "A child may be found 'abused' who (A) has been inflicted with physical injury or injuries other than by accidental means, (B) has injuries that are at variance with the history given of them, or (C) is in a condition that is the result of maltreatment, including, but not limited to, malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment;" Conn. Gen. Stats. § 46b120(5) (2019).

Neglected: "A child may be found 'neglected' who, for reasons other than being impoverished, (A) has been abandoned, (B) is being denied proper care and attention, physically, educationally, emotionally or morally, or (C) is being permitted to live under conditions, circumstances or associations injurious to the well-being of the child;" Conn. Gen. Stats. § 46b-120(4) (2019).

Why this Indicator is Important:

According to the Center on the Developing Child at Harvard University, toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support.

Prolonged exposure to toxic stress can inhibit a child's brain development. Over time, this can change the architecture of a child's rapidly developing brain. Altered brain architecture can result in long-term problems in learning, behavior, and physical and mental health. These consequences can include poor academic achievement, juvenile delinquency, maladaptive coping and stress management skills, increased risk for unhealthy lifestyles and poor health outcomes.

Town	Total Number of Allegations (a)	Total Number of Allegations Substantiated (b)	Substantiation Rate (d)	Number of Unique Children (e)
Barkhamsted	32	<= 10 (c)	No Data	<= 10
Bethlehem	59	35	59%	<= 10
Canaan	96	33	34%	11
Colebrook	17	<= 10	No Data	<= 10
Cornwall	<= 10	0	0	0
Goshen	48	15	31%	<= 10
Hartland	47	16	34%	<= 10
Harwinton	74	32	43%	<= 10
Kent	52	19	37%	<= 10
Litchfield	120	23	19%	<= 10
Morris	30	<= 10	No Data	<= 10
New Hartford	61	14	23%	<= 10
Norfolk	15	<= 10	No Data	<= 10
North Canaan	18	<= 10	No Data	<= 10
Salisbury	13	<= 10	No Data	<= 10
Sharon	50	20	40%	<= 10
Torrington	1,109	298	27%	113
Warren	16	<= 10	No Data	<= 10
Washington	13	<= 10	No Data	<= 10
Winchester	328	97	30%	37
Total	**2,198**	**>602**	**>27%**	**–**

CT Department Child and Family Services and Words & Numbers Research, Inc. 2018

Findings for Northwest Connecticut:

1. Over two thousand (2,198) child abuse and neglect allegations were made in NWCT in 2018. At least 602 of those allegations were substantiated. This equated to a substantiation rate of approximately one-in-four cases, greater if suppressed data were to be factored in.

2. Torrington accounted for one-half (1,109) of the allegations and substantiated allegations (298). However, the city's substantiation rate was in line with the overall average.

3. Winchester (328), Litchfield (120) and Canaan (96) also had a notable number of abuse and neglect allegations. Both Winchester (30%) and Canaan (34%) had substantiation rates that were somewhat higher than the average while Litchfield's was lower (19%).

4. Several towns had lower allegation numbers but higher substantiation rates. These towns included Bethlehem (59%), Harwinton (43%), Sharon (40%) and Kent (37%).

Notes:

(a) Allegation types include: At Risk, Educational Neglect, Emotional Neglect, High Risk Newborn, Medical Neglect, Physical Abuse, Physical Neglect, and Sexual Abuse. A single report may contain many allegations of abuse/neglect.

(b) Each allegation is independently evaluated during the course of an investigation's response, and a determination of whether or not there is reasonable cause to believe it occurred. If reasonable cause is found to exist then that allegation is **'Substantiated,'** and if not, it is considered 'Unsubstantiated.'

(c) Towns with fewer than 10 substantiated cases in any category have their values suppressed to minimize the risk of revealing protected information that could lead to personal identification of individual children.

(d) Substantiation rate is calculated as a percentage of total allegations that are considered 'substantiated' based on independent evaluations.

(e) The number of **Unique Children** is an unduplicated count of children with at least one Substantiated Allegation during the reporting period.

Estimated Births
and the Need for Home Visitation Services, 2018

What this Indicator is:

According to the Child and Family Research Partnership, home visitation services provide structured visits by trained professionals to parents (particularly high-risk parents) who are pregnant or have young children. These programs support families by providing health check-ups, screenings, referrals, parenting advice, and guidance with navigating other programs and services in their community. The programs also monitor progress on children's developmental milestones. Quality home visiting programs help parents provide safe and supportive environments for their children, and over time, families and home visitors build strong relationships that lead to lasting benefits for the entire family. *

Estimating the number of births for NWCT provides an indication of the region's potential need for home visiting services. When compared to the number of slots available to NWCT for reimbursement, it is possible to estimate the region's potential shortfall of home visiting services.

Why this Indicator is Important:

Scientific research has shown that home visits by a nurse, social worker, early childhood educator, or other trained professional during pregnancy and in the first years of a child's life help prevent child abuse and neglect, support positive parenting, improve maternal and child health, and promote child development and school readiness.

** "States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line." Pew Center on the States Washington, D.C. (2011)*

Estimated Northwest Connecticut Births by Town 2018

Town	Estimated 2016 Population	2016 Births Estimated	2018 Birth Rate *(a)*	Estimated 2018 Population	Estimated 2018 Births
Barkhamsted	3,664	27	6.8	3,671	25
Bethlehem	3,447	30	7.5	3,452	26
Canaan	1,177	13	7.6	1,196	9
Colebrook	1,430	6	4.9	1,518	7
Cornwall	1,380	4	2.4	1,302	3
Goshen	2,891	14	4.8	2,903	14
Hartland	2,117	12	6.3	2,041	13
Harwinton	5,466	33	5.7	5,469	31
Kent	2,819	18	5.7	2,824	16
Litchfield	8,175	56	6.6	8,198	54
Morris	2,279	22	6.9	2,288	16
New Hartford	6,733	59	7.1	6,755	48
Norfolk	1,632	7	4.3	1,503	6
North Canaan	3,186	26	7.8	3,302	26
Salisbury	3,618	26	6.5	3,631	24
Sharon	2,714	11	3.7	2,721	10
Torrington	34,646	330	10.1	34,737	351
Warren	1,408	16	6.6	1,432	9
Washington	3,452	16	5.5	3,472	19
Winchester	10,754	89	8.2	10,798	88
Total	**102,988**	**815**	**7.7**	**103,213**	**795**

Connecticut Department of Public Health Vital Statistics, U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates and Words & Numbers Research, Inc.

(a) Birth rate is the number of live births per 1,000 persons in a given geography. Estimated 2018 birth rates were determined by averaging a town's birth rates for 2014, 2015 and 2016. These birth rates were applied to an estimated 2018 population for each town. Population estimates were obtained from the U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Availability of Home Visiting Services in NWCT 2018

Home Visiting Programs	Provider	Number of Slots	Service Area	Number of Estimated 2018 Births
Nurturing Families	EdAdvance	45	Torrington/ Winchester	439
Child First	Charlotte Hungerford Hospital	66	Torrington/ Winchester	439
Early Head Start	EdAdvance	32	Torrington/ Winchester	439
Home Visiting	Family Strides	42	Litchfield County	795*
Total		**185**		

Connecticut Department of Public Health Vital Statistics, EdAdvance and Words & Numbers Research, Inc.

**Northwest Connecticut births only*

Findings for Northwest Connecticut:

1. The number of 2018 estimated births in NWCT is expected to decline slightly from 2016 by 20 births or -2.5%.

2. Contrary to the downward trend, Torrington births will increase slightly by 21 births for a gain of 6.4%.

3. As of January 2020, a total of 143 reimbursable slots are available to provide home visiting services to families of young children in Torrington and Winchester. In 2018 there were an estimated 439 births to mothers in these two towns. Based on these two data points, it can be assumed there is a considerable unmet need for home visitation services in Torrington and Winchester alone.

4. There is a maximum of 42 home visitation slots available from Family Strides to serve all of Litchfield County. For 2018, an estimated 356 births occurred in NWCT towns other than Torrington and Winchester. Given the number of births and the very limited availability of slots, the need for home visitation services in NWCT's outlying towns appears to be overwhelming.

CT Department of Children and Families (DCF)
Foster Care System by Placement Type, 2018, Litchfield County

What this Indicator is:

Foster care is intended to provide temporary, safe living arrangements and therapeutic services for children who cannot remain safely at home because of risk of maltreatment or inadequate care. The U.S. foster care system aims to safely reunite children with their parents or secure another permanent home, (e.g., through adoption). However, too often this goal is not achieved, especially for older youth and children with disabilities. Instead, many children spend years in foster homes or group homes, often moving many times.

Title IV-E of the Social Security Act requires that states "consider giving preference to an adult relative over a nonrelated caregiver when determining placement for a child, provided that the relative caregiver meets all relevant State child protection standards." The American Bar Association has supported relative placement as the first and best option for child placement, stating that "The various detriments of foster care placements on a child are severely mitigated in cases where a family member can take in a child…"*

The number of Litchfield County children from birth to age 3, ages 4 to 6, and ages 7 to 12 either entering into or already in the DCF foster care system are categorized by placement type. These cases are the responsibility of the Torrington regional DCF office, which serves Litchfield County.

PLACEMENT TYPES:

Foster parent: A person licensed by DCF or approved by a DCF-licensed child-placing agency to provide care for a child in a private family home.

Relative or kin: The person who provides foster care is doing so for a specific child related to the person by blood, marriage or adoption descended from a common ancestor not more than three generations removed.

Other Placement: This includes special study, therapeutic foster care, permanency diagnostic center safe home, shelter, group home and residential treatment center.

Why this Indicator is Important:

Children in foster care are at increased risk for a variety of emotional, physical, behavioral, and academic problems, with outcomes generally worse for children in group homes. Recognizing this, advocates and policymakers make efforts to prevent children from entering the system and to safely reduce the number of children living in foster care, particularly in group homes. (kidsdata.org)

**Why Relative Placement is Best for a Child in Need of Care; Avery Alexson Guidry; American Bar Association website (Children's Rights Litigation article); October, 2019.*

Total Number of Litchfield County Children Entering DCF Placement, 2018

This table reports aggregate data concerning the number of children who entered DCF placement during a given state fiscal year (SFY).

Age	Total Entry	Foster Care	Relative Care	Other Placement
Birth to 3	27	14	12	1
4 to 6	11	6	2	3
7 to 12	17	8	4	5
Total	**55**	**28**	**18**	**9**

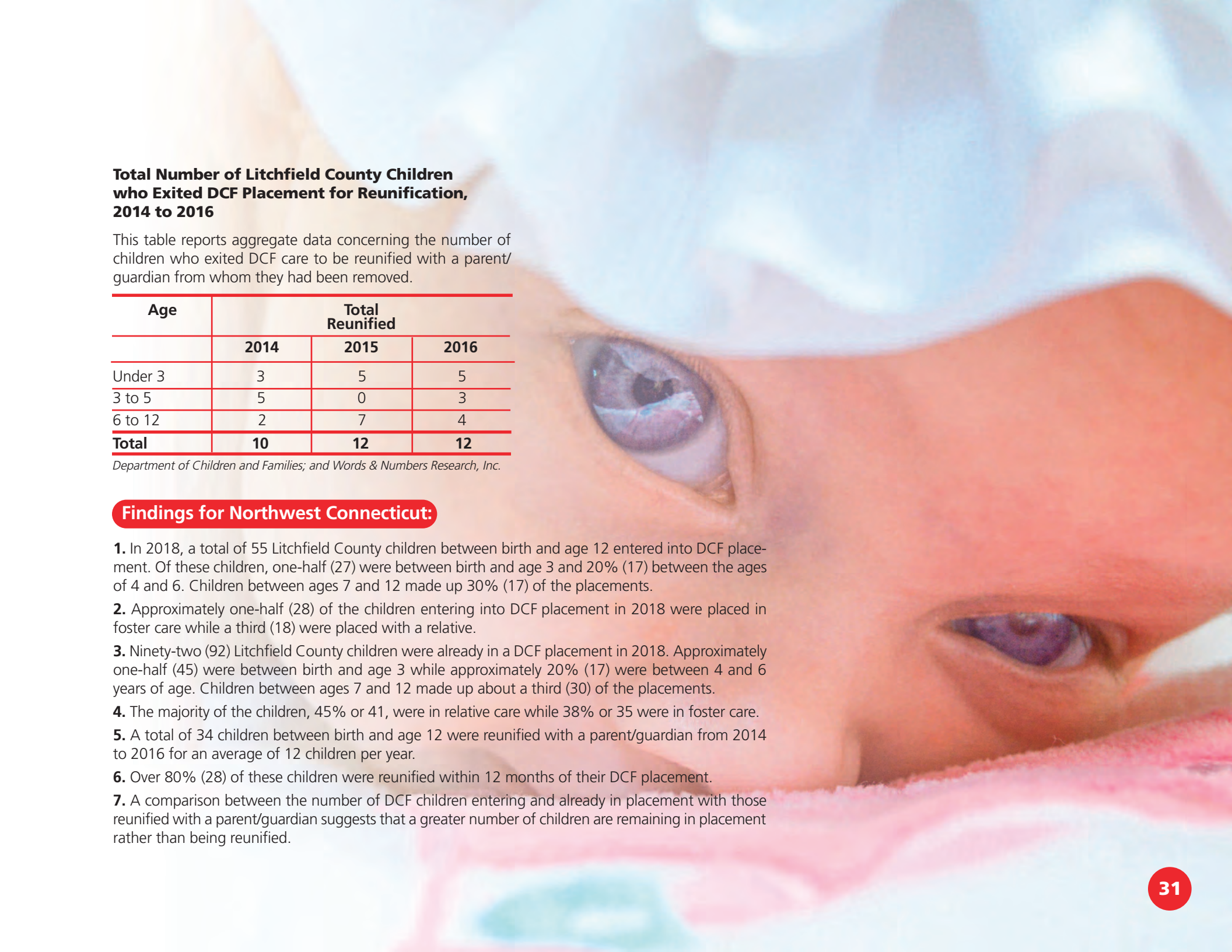
Department of Children and Families; and Words & Numbers Research, Inc.

Total Number of Litchfield County Children in DCF Placement, 2018

This table reports aggregate data concerning the number of unique children placed in open DCF placements on the observation date (July 1st each year).

Age	Total in Placement	Foster Care	Relative Care	Other Placement
Birth to 3	45	21	20	4
4 to 6	17	4	10	3
7 to 12	30	10	11	9
Total	**92**	**35**	**41**	**16**

Department of Children and Families; and Words & Numbers Research, Inc.



Total Number of Litchfield County Children who Exited DCF Placement for Reunification, 2014 to 2016

This table reports aggregate data concerning the number of children who exited DCF care to be reunified with a parent/guardian from whom they had been removed.

Age	Total Reunified		
	2014	2015	2016
Under 3	3	5	5
3 to 5	5	0	3
6 to 12	2	7	4
Total	**10**	**12**	**12**

Department of Children and Families; and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. In 2018, a total of 55 Litchfield County children between birth and age 12 entered into DCF placement. Of these children, one-half (27) were between birth and age 3 and 20% (17) between the ages of 4 and 6. Children between ages 7 and 12 made up 30% (17) of the placements.

2. Approximately one-half (28) of the children entering into DCF placement in 2018 were placed in foster care while a third (18) were placed with a relative.

3. Ninety-two (92) Litchfield County children were already in a DCF placement in 2018. Approximately one-half (45) were between birth and age 3 while approximately 20% (17) were between 4 and 6 years of age. Children between ages 7 and 12 made up about a third (30) of the placements.

4. The majority of the children, 45% or 41, were in relative care while 38% or 35 were in foster care.

5. A total of 34 children between birth and age 12 were reunified with a parent/guardian from 2014 to 2016 for an average of 12 children per year.

6. Over 80% (28) of these children were reunified within 12 months of their DCF placement.

7. A comparison between the number of DCF children entering and already in placement with those reunified with a parent/guardian suggests that a greater number of children are remaining in placement rather than being reunified.

Litchfield County School Immunization Survey Data
2017-2018 School Year

What this Indicator is:

Immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Today, children in the United States routinely get vaccines that protect them from more than a dozen diseases, including measles, polio, tetanus, diphtheria, and pertussis (whooping cough). Most of these diseases are now at their lowest levels in history, thanks to years of immunization. Children must get at least some vaccines before attending school.

Why this Indicator is Important:

States and local areas put school vaccination requirements in place to minimize the risk of vaccine-preventable diseases. School vaccination requirements help safeguard children and adolescents by making sure they are protected when they get to school, where the potential for vaccine-preventable disease transmission is higher.

School vaccination assessments identify pockets of under-vaccinated students. The local school-and classroom-level data can be used by schools and health departments to ensure high vaccination coverage and, in response to an epidemic, help them identify those students most at risk of disease, allowing them to be vaccinated and protected. (Centers for Disease Control and Prevention)

	Percent Vaccinated Litchfield County	Percent Vaccinated Connecticut
Seventh Grade		
Polio	98%	98%
Diphtheria, tetanus, and acellular pertussis	98%	98%
Measles, mumps, and rubella	98%	98%
Hepatitis B	97%	98%
Varicella	97%	98%
Meningococcal conjugate vaccine	88%	95%
Diphtheria, tetanus, and acellular pertussis	89%	96%
Exemptions	**52 (3%)**	**623 (1%)**
Religious	41	491
Medical	11	132
Kindergarten		
Polio	96%	97%
Diphtheria, tetanus, and acellular pertussis	97%	97%
Measles, mumps, and rubella	96%	97%
Hepatitis B	96%	97%
Varicella	96%	96%
Hepatitis A	96%	97%
Exemptions	**49 (3%)**	**890 (2%)**
Religious	40	764
Medical	9	126
Preschool		
Influenza	84%	86%
Exemptions	**52 (6%)**	**1,778 (8%)**
Religious	45	1,607
Medical	7	171

CT Department of Public Health and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. At the 7th grade level, Litchfield County is considerably under the state immunization average for two vaccines: meningococcal disease; and diphtheria, tetanus, and acellular pertussis.

Meningococcal is a serious infection that can lead to bacterial meningitis and infection of the bloodstream. Diphtheria, tetanus, and acellular pertussis vaccine (also known as DTaP) protects against infections caused by **diphtheria, tetanus (lockjaw)**, and **pertussis (whooping cough)**.

2. Litchfield County 7th graders have a somewhat higher percentage of vaccination exemptions than students statewide.

3. Immunization percentages and exemptions for Litchfield County's kindergartners are comparable to their peers, statewide.

4. A slightly lower percentage of the county's preschoolers are vaccinated for influenza when compared to the statewide average. On the other hand, the County has fewer influenza exemptions than at the State level.

Lead Screening and Lead Poisoning

Lead Screening for Children between 9 Months and 2 Years of Age
Lead Poisoning for Children Ages 5 Years and Under

What this Indicator is:

All healthcare providers in Connecticut are required to conduct annual blood lead testing for children between 9 and 35 months of age. According to the CT Department of Public Health, most doctors test at 12 months and 24 months of age to meet this requirement.

The Centers for Disease Control uses a blood lead reference value of 5 micro-grams per deciliter to identify children ages 1-5 years with blood lead levels that may require case management.

Why this Indicator is Important:

Lead is a toxin that is particularly dangerous to young children because of their small size and rapid growth and development. It can cause behavioral and learning difficulties, anemia, seizures and other medical problems. The Centers for Disease Control has stated that "protecting children from exposure to lead is important to lifelong good health. No safe blood lead level in children has been identified. Even low levels of lead in blood have been shown to affect IQ, the ability to pay attention and academic achievement. And effects of lead exposure cannot be corrected."

Lead Screening for Children in Northwest Connecticut Between 9 Months and 2 Years of Age 2016

Town	Population, Age 9 Months to 2 Years	Number and Percent of Children Age 9 Months to 2 Years Screened #	%	Number of Children Without 1 Lead Screening Test #	%
Barkhamsted	43	40	93%	3	7%
Bethlehem	56	45	80%	11	20%
Canaan (a)	49	39	80%	10	20%
Colebrook	14	4	29%	10	71%
Cornwall	10	10	100%	0	0
Goshen	29	27	93%	2	7%
Hartland	27	13	48%	14	52%
Harwinton	67	54	81%	13	19%
Kent	33	24	73%	9	27%
Litchfield	107	96	90%	11	10%
Morris	28	21	75%	7	25%
New Hartford	95	72	76%	23	24%
Norfolk	18	15	83%	3	17%
North Canaan (a)	0	–	–	–	–
Salisbury	35	28	80%	7	20%
Sharon	24	18	75%	6	25%
Torrington	729	614	84%	115	16%
Warren	12	3	25%	9	75%
Washington	37	29	78%	8	22%
Winchester	193	155	80%	38	20%
Total	**1,606**	**1,309**	**81.5% (b)**	**299**	**18.5%**

CT Department of Public Health, Childhood Lead Poisoning Surveillance, 2016, and Words & Numbers Research, Inc.

(a) DPH combines Canaan and North Canaan for the number and percentage of children tested.
(b) CT State Average - among children born in 2014, 86.1% were tested once by age 2 (defined as under 24 months)

Findings for Northwest Connecticut:

SCREENING:

1. NWCT lags behind the State with regard to lead screening tests for children between 9 months and 2 years of age. Statewide, 86.1% of this birth cohort received at least one lead screening during this age span, while regionally 81.5% were tested.

2. Approximately 300 (or nearly one in five) NWCT children in the 2014 birth cohort did not receive a lead screening test by the time they reached two years of age.

3. The largest numbers are in Torrington (115), Winchester (38) and New Hartford (23).

4. The largest proportions (although small in number) were found in Warren (75%), Colebrook (71%), Hartland (52%), Kent (27%), Sharon (25%), Morris (25%) and New Hartford (24%).

Findings for Northwest Connecticut:

POISONING:

1. The prevalence of lead poisoning among NWCT's children ages one to five (5.5%) is twice the statewide average of 2.7%.

2. Eighty-five (85) children had elevated blood levels equal to or greater than 5 micrograms per deciliter. Torrington accounted for 40 (47%) and Winchester, 24 (28%).

Children with Lead Poisoning in Northwest Connecticut, Ages Five Years and Under

Town	Number of Children with Confirmed Test	0-4 Micrograms per Deciliter		Equal to or greater than 5 Micrograms per Deciliter		Equal to or greater than 10 Micrograms per Deciliter	
		#	%	#	%	#	%
Barkhamsted	42	41	98%	1	2%	0	0
Bethlehem	51	50	98%	1	2%	0	0
Canaan	8	6	75%	2	25%	0	0
Colebrook	5	5	100%	0	0	0	0
Cornwall	13	13	100%	0	0	0	0
Goshen	29	29	100%	0	0	0	0
Hartland	14	13	93%	1	7%	0	0
Harwinton	64	61	95%	3	0	0	0
Kent	28	28	100%	0	0	0	0
Litchfield	107	104	97%	3	3%	0	0
Morris	23	23	100%	0	0	0	0
New Hartford	82	80	99%	1	1%	1	1%
Norfolk	15	14	93%	1	7%	0	0
North Canaan	36	34	94%	2	6%	0	0
Salisbury	31	30	97%	1	3%	0	0
Sharon	22	21	95%	1	5%	0	0
Torrington	729	689	95%	36	5%	4	<1%
Warren	4	4	100%	0	0	0	0
Washington	37	34	94%	2	6%	1	3%
Winchester	198	174	89%	21	11%	3	2%
Total	**1,538**	**1,453**	**94.5%** *	**76**	**4.9%**	**9**	**.6%**

CT Department of Public Health, Childhood Lead Poisoning Surveillance, 2016 and Words & Numbers Research, Inc.
** CT State Avergae = 97.3%*

Notes:

Children who are diagnosed with a blood lead level of greater than or equal to 5 micrograms per deciliter are considered to be lead poisoned.

According to Connecticut General Statue, local health departments are required to respond to reported blood lead levels of 10 g/dLμ or more. They must provide the parent or guardian with information describing the dangers of lead poisoning, precautions to reduce the risk of lead poisoning, information about potential eligibility for services under the Birth-to-Three Program, and laws and regulations pertaining to lead abatement.

HUSKY A Utilization for Well-Child Care and Developmental Screening

Birth to 8 Years of Age
1/1/18 TO 12/31/18

What this Indicator is:

HUSKY A is a health insurance program for Connecticut's low-income children (from birth to age 19), their families, and pregnant women. The program offers comprehensive health care services, including well-child preventive care and treatment, dental care, emergency care and developmental screenings.

Since HUSKY A is part of Connecticut's Medicaid program, which is an entitlement program, the State must make HUSKY coverage available to all eligible applicants. Connecticut's Department of Social Services (DSS) is the lead agency for HUSKY health services.

To be eligible for HUSKY A, household income must be at or below 201% of the Federal Policy Level (FPL). For a household of 4 this equates to an annual income equal to or less than $51,758.*

Parents/caregivers with children from birth to 19 are eligible if their household income is at or below 160% of the Federal Policy Level (FPL). For a household of 4, annual income must be equal to or less than $41,200.*

Pregnant women are eligible if their household income is at or below 263% of the Federal Policy Level (FPL). For a household of 4, annual income must be equal to or less than $67,723.*

HUSKY A children are entitled to receive a comprehensive set of health services under the **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** guidelines. EPSDT's goal is to ensure that children and teens receive regular, preventive health care by following a set schedule of "well-child" doctor visits, and all medically necessary care.

EPSDT services include periodic comprehensive health screenings, immunizations, inter-periodic encounters, vision services, dental services *(see page 40 for HUSKY A Oral Health),* hearing services and other diagnostic services and treatment services. Children can receive emergency care services as needed.

Eligible children are also entitled to receive developmental screenings. Preventive Pediatric Health Care Bright Futures/American Academy of Pediatrics recommends that all children be screened for developmental delays and disabilities during regular well-child visits at 9, 18 and 24 (or 30) months.

** According to the 2019 Federal Poverty Guidelines*

Why this Indicator is Important:

EPSDT's goal is to assure that children receive early detection and care, so that physical, mental and developmental problems are either prevented or diagnosed and treated as early as possible. Through the EPSDT benefit, children are entitled to receive timely and appropriate health care to treat any problem that may arise so they can experience good health and optimal development.

Early identification of developmental disorders is critical to the well-being of children and their families. It is an essential function and the responsibility of all pediatric healthcare professionals to provide this screening and to assure that any concerns noted during the assessment are promptly addressed. Early identification of developmental issues along with timely referrals to specialists and services can improve the developmental outcomes across the lifespan of a child.

The numbers contained in the following table represent children who were **continuously enrolled** in HUSKY A for all 12 months of 2018. Children who were enrolled in HUSKY A then determined to be ineligible and re-enrolled at a later date were not included.

HUSKY A Utilization for Well-Child Care (EPSDT) and Developmental Screening
Birth to 8 Years of Age
1/1/18 to 12/31/18

Town	Age Group	Total HUSKY A Enrolled (0-8)	Enrollees with a Well-Child Visit	Percent having Well-Child Visits	Enrollees with a Developmental Screening	Percent having Developmental Screenings
Barkhamsted	Total	45	39	87%	32	71%
	0-2	11	10	91%	8	73%
	3-5	15	14	93%	9	60%
	6-8	19	15	79%	15	79%
Bethlehem	Total	69	47	68%	25	36%
	0-2	23	18	78%	14	61%
	3-5	24	22	83%	7	29%
	6-8	22	9	41%	5 or fewer	18%
Canaan	Total	71	59	83%	52	73%
	0-2	20	16	80%	15	75%
	3-5	19	15	79%	10	53%
	6-8	32	28	88%	27	84%
Colebrook	Total	21	20	95%	18	86%
	0-2	5 or fewer	5 or fewer	100%	5 or fewer	100%
	3-5	8	7	88%	5 or fewer	63%
	6-8	9	9	100%	9	100%
Cornwall	Total	19	14	74%	13	68%
	0-2	5 or fewer	5 or fewer	100%	5 or fewer	100%
	3-5	6	5 or fewer	67%	5 or fewer	50%
	6-8	10	7	70%	7	70%
Goshen	Total	40	37	93%	30	75%
	0-2	9	9	100%	9	100%
	3-5	22	20	91%	14	64%
	6-8	9	8	89%	7	78%
Hartland	Total	25	20	80%	8	32%
	0-2	5 or fewer	5 or fewer	100%	5 or fewer	100%
	3-5	9	8	89%	5 or fewer	22%
	6-8	12	8	67%	5 or fewer	33%

Town	Age Group	Total HUSKY A Enrolled (0-8)	Enrollees with a Well-Child Visit	Percent having Well-Child Visits	Enrollees with a Developmental Screening	Percent having Developmental Screenings
Harwinton	Total	66	56	85%	45	68%
	0-2	17	17	100%	15	88%
	3-5	20	17	85%	10	50%
	6-8	29	22	76%	20	69%
Kent	Total	43	33	77%	9	21%
	0-2	12	11	92%	7	58%
	3-5	18	13	72%	5 or fewer	6%
	6-8	13	9	69%	5 or fewer	8%
Litchfield	Total	74	58	78%	50	68%
	0-2	12	11	92%	10	83%
	3-5	27	22	81%	17	63%
	6-8	35	25	71%	23	66%
Morris	Total	42	34	81%	20	48%
	0-2	14	13	93%	11	79%
	3-5	12	11	92%	5 or fewer	33%
	6-8	16	10	63%	5 or fewer	31%
New Hartford	Total	96	75	78%	47	49%
	0-2	23	20	87%	11	48%
	3-5	35	27	77%	13	37%
	6-8	38	28	74%	23	61%
Norfolk	Total	27	23	85%	20	74%
	0-2	5 or fewer	5 or fewer	100%	5 or fewer	100%
	3-5	9	9	100%	7	78%
	6-8	15	11	73%	10	67%
North Canaan	Total	12	12	100%	11	92%
	0-2	6	6	100%	6	100%
	3-5	5 or fewer	5 or fewer	100%	5 or fewer	67%
	6-8	5 or fewer	5 or fewer	100%	5 or fewer	100%
Salisbury	Total	15	13	87%	12	80%
	0-2	6	5 or fewer	83%	5 or fewer	83%
	3-5	7	7	100%	6	86%
	6-8	5 or fewer	5 or fewer	50%	5 or fewer	50%
Sharon	Total	34	31	91%	29	85%
	0-2	9	9	100%	8	89%
	3-5	9	9	100%	9	100%
	6-8	16	13	81%	12	75%

Town	Age Group	Total HUSKY A Enrolled (0-8)	Enrollees with a Well-Child Visit	Percent having Well-Child Visits	Enrollees with a Developmental Screening	Percent having Developmental Screenings
Torrington	Total	1,571	1,300	83%	1,008	64%
	0-2	377	360	95%	282	75%
	3-5	611	523	86%	366	60%
	6-8	583	417	72%	360	62%
Warren	Total	21	18	86%	5 or fewer	24%
	0-2	5 or fewer	5 or fewer	100%	5 or fewer	75%
	3-5	11	10	91%	5 or fewer	9%
	6-8	6	5 or fewer	67%	5 or fewer	17%
Washington	Total	13	11	85%	5 or fewer	38%
	0-2	5 or fewer	5 or fewer	100%	5 or fewer	100%
	3-5	5 or fewer	5 or fewer	100%	5 or fewer	33%
	6-8	6	5 or fewer	67%	0	0%
Winchester	Total	397	332	84%	240	60%
	0-2	124	118	95%	89	72%
	3-5	132	111	84%	75	57%
	6-8	141	103	73%	76	54%
NWCT	**Total**	**2,709**	**2,235**	**83%**	**1,687**	**62%**
	0-2	**685**	**645**	**94%**	**510**	**74%**
	3-5	**1,003**	**853**	**85%**	**565**	**56%**
	6-8	**1,021**	**737**	**72%**	**612**	**60%**

Connecticut Department of Social Services and Words & Numbers Research, Inc.

Note: The Connecticut Department of Social Services reports fewer than five children as **"5 or fewer"** to protect confidentiality.

Findings for Northwest Connecticut:

1. Overall, four-of-five (2,235 or 83%) NWCT HUSKY A children from ages birth to eight had a well-child visit in 2018.

2. As children age, however, the incidence of a well-child visit perceptibly declines. Ninety-four percent (94%) of children birth to 2 had a well-child visit, equating to only 40 children who did not receive one. The percent of 3 to 5 year-olds fell to 85% resulting in 150 children without a well-child visit. For 6 to 8 year-olds, the percent further dropped to 72% with 284 children not receiving a well-child visit. It is very important for 3 to 8 year-olds to receive an annual well-child visit since it includes screening for vision, hearing and lead.

3. Overall, nearly two-thirds (1,687 or 62%) of NWCT HUSKY A children from ages birth to eight had a developmental screening in 2018.

4. Three-of-four (74% or 1,687) NWCT children ages 0 to 2 had a developmental screening in 2018. On the other hand, 175 very young children did not receive a developmental screening during this important time span.

5. However, as children age the percentage of those receiving a developmental screening noticeably drops. Just over one-half (56%) of children ages 3 to 5 had a developmental screening resulting in 438 children who were not screened. Only 60% of 6 to 8 year-olds were screened leaving 409 children who were not. It is critical that developmental surveillance continue as children grow older so those who have developmental delay or are at risk for developmental delay can be identified and given timely and appropriate treatment.

HUSKY A Utilization for Oral Health Care Services
Birth to 8 Years of Age
Federal Fiscal Year 7/1/17 to 6/30/18

What this Indicator is:

HUSKY A is a health insurance program for Connecticut's low-income children (from birth to age 19), their families and pregnant women.The program offers comprehensive health care services, including well-child preventive care and treatment, dental care, emergency care and developmental screenings. *(See previous indicator.)*

In 2008, DSS combined its HUSKY oral care programs into one dental plan called the **Connecticut Dental Health Partnership (CTDHP)**.

Among CTDHP's goals are improving access to care, educating HUSKY caregivers about oral health and reducing the barriers to receiving regular dental exams and treatment. CTDHP is also intended to promote and foster the concept of a primary care dentist and the importance of each child having a dental home.

According to the American Academy of Pediatric Dentistry (AAPD), a dental home is:

> "the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health."

CTDHP provides the following oral health services at no charge to HUSKY A recipients when they see a participating dentist:

- Oral exams
- Cleanings
- X-Rays
- Fillings
- Extractions
- Partial and full dentures
- Root canals
- Crowns
- Oral surgery
- Orthodontic Services (Under 21 only/ Prior Authorization Required – must qualify)

Why this Indicator is Important:

The condition of a person's mouth impacts the health of their whole body. Cavities and gum disease can lead to serious medical problems including some types of heart disease. Poor oral health has been linked to low birth-weight babies and oral cancer, and makes some diseases such as diabetes difficult to control. Teeth that are not properly cared for cause pain and discomfort and make eating more difficult.

Tooth decay is the most common chronic disease among children in the United States. The Centers for Disease Control and Prevention (CDC) reports that more than 40 percent of children have decay by the time they reach kindergarten. (Center for Pediatric Dentistry at the University of Washington)

The sooner children begin getting regular dental checkups, the healthier their mouths will stay throughout their lives. Early checkups help prevent cavities and tooth decay, which can lead to pain, trouble concentrating and other medical issues. Children with healthy teeth chew food easily, learn to speak clearly and smile with confidence.

The American Dental Association (ADA) and the American Academy of Pediatrics say that every child should visit a dentist by age 1 – or as soon as the first tooth appears. This "well baby visit" teaches parents and caregivers how to care for their children's teeth and help them remain cavity-free.

The numbers contained in the following table represent children who were **continuously enrolled** in HUSKY A for all 12 months of 2018. Children who were determined to be ineligible for HUSKY A and re-enrolled at a later time are not included.

HUSKY A Utilization for Oral Health Care Services
Birth to 8 Years of Age
1/1/18 to 12/31/18

Town	Age Group	Total HUSKY A Enrolled (0-8)	Total HUSKY A Receiving Any Dental Service	Percent Having Any Dental Services	Prevention Services (Number/Percent Having Any Dental Service)		Treatment Services (Number/Percent Having Any Dental Service)	
Barkhamsted	Total	45	36	80%	35	97%	8	23%
	0-2	4	4	100%	3	75%	0	0
	3-5	17	14	82%	14	100%	2	14%
	6-8	24	18	75%	18	100%	6	33%
Bethlehem	Total	58	40	69%	39	98%	8	21%
	0-2	14	8	57%	7	88%	0	0
	3-5	24	16	66%	16	100%	2	13%
	6-8	20	16	80%	16	100%	6	38%
Canaan Includes North Canaan	Total	75	58	77%	56	97%	16	28%
	0-2	16	10	63%	10	100%	1	10%
	3-5	25	21	84%	21	100%	2	10%
	6-8	6	6	100%	6	100%	1	17%
Colebrook	Total	13	13	100%	13	100%	2	15%
	0-2	1	1	100%	1	100%	0	0
	3-5	6	6	100%	6	100%	1	17%
	6-8	6	6	100%	6	100%	1	17%
Cornwall Includes 06753 only	Total	2	1	50%	1	100%	0	0
	0-2	-	-	-	-	-	-	-
	3-5	-	-	-	-	-	-	-
	6-8	2	1	50%	1	100%	0	0
Goshen	Total	33	26	79%	26	100%	5	19%
	0-2	7	5	71%	5	100%	0	0
	3-5	19	15	79%	15	100%	3	20%
	6-8	7	6	86%	6	100%	2	33%
Hartland No data								

Town	Age Group	Total HUSKY A Enrolled (0-8)	Total HUSKY A Receiving Any Dental Service	Percent of Any Dental Services	Prevention Services (Number/Percent of Any Dental Service)		Treatment Services (Number/Percent of Any Dental Service)	
Harwinton	Total	67	54	81%	53	98%	11	20%
	0-2	10	5	50%	5	100%	0	0
	3-5	25	20	80%	20	100%	2	10%
	6-8	32	29	91%	28	97%	9	31%
Kent	Total	31	16	52%	16	100%	8	50%
	0-2	5	1	20%	1	100%	1	100%
	3-5	15	7	47%	7	100%	4	57%
	6-8	11	8	73%	8	100%	3	38%
Litchfield	Total	65	49	75%	48	98%	10	20%
	0-2	10	6	60%	6	100%	0	0
	3-5	26	21	81%	21	100%	3	14%
	6-8	29	22	76%	21	95%	7	32%
Morris	Total	44	31	70%	31	100%	6	19%
	0-2	9	6	66%	6	100%	0	0
	3-5	17	14	82%	14	100%	3	21%
	6-8	18	11	61%	11	100%	3	27%
New Hartford	Total	79	56	71%	52	93%	15	27%
	0-2	17	7	41%	7	100%	1	14%
	3-5	28	22	79%	20	91%	2	9%
	6-8	34	27	79%	25	93%	12	44%
Norfolk	Total	26	19	73%	18	95%	9	47%
	0-2	3	0	0	0	0	0	0
	3-5	9	6	66%	6	100%	3	50%
	6-8	14	13	93%	12	92%	6	46%
North Canaan Included in Canaan								
Salisbury	Total	19	12	63%	12	100%	4	33%
	0-2	7	1	14%	1	100%	0	0
	3-5	9	8	89%	8	100%	3	38%
	6-8	3	3	100%	3	100%	1	33%
Sharon	Total	30	23	77%	23	100%	10	43%
	0-2	7	2	29%	2	100%	0	0
	3-5	7	6	86%	6	100%	1	17%
	6-8	16	15	94%	15	100%	9	60%

Town	Age Group	Total HUSKY A Enrolled (0-8)	Total HUSKY A Receiving Any Dental Service	Percent Having Any Dental Services	Prevention Services (Number/Percent Having Any Dental Service)		Treatment Services (Number/Percent Having Any Dental Service)	
Torrington	Total	1,266	1,014	80%	998	98%	309	30%
	0-2	178	119	67%	119	100%	10	8%
	3-5	561	452	81%	445	98%	107	24%
	6-8	527	443	84%	434	98%	192	43%
Warren No data								
Washington Includes 06793 only	Total	4	3	75%	3	100%	0	0
	0-2	1	0	0	0	0	0	0
	3-5	1	1	100%	1	100%	0	0
	6-8	2	2	100%	2	100%	0	0
Winchester Includes 06098 only	Total	304	223	73%	218	98%	58	27%
	0-2	66	42	64%	40	95%	1	2%
	3-5	113	88	78%	86	98%	21	24%
	6-8	125	93	74%	92	99%	36	39%
NWCT	**Total**	**2,161**	**1,674**	**77%**	**1,642**	**98%**	**479**	**29%**
	0-2	**355**	**217**	**61%**	**213**	**98%**	**14**	**6%**
	3-5	**902**	**717**	**80%**	**706**	**98%**	**159**	**22%**
	6-8	**904**	**740**	**82%**	**723**	**98%**	**306**	**41%**

Connecticut Department of Social Services and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. Three-of-four (1,674 or 77%) NWCT HUSKY A children from ages birth to eight received either preventive dental care or a treatment service in 2018.

2. Although this percentage is consequential, it also reflects the fact that approximately one-quarter (487) of HUSKY A children did not receive any dental care in 2018.

3. Sixty-one percent (217 or 61%) of children birth to two, received dental care leaving two-of-five children (138) in this age span who did not see a dentist in 2018. This finding is troublesome given the importance that the AAPD and ADA place on the establishment of a dental home by age one.

4. Dental care climbed to 80% for children, 3 to 5 years of age and increased slightly to 82% for 6 to 8-year-olds.

5. Of the children who received dental care, the vast majority (1,642 or 98%) received preventive care while 479 or 29% received a treatment service (e.g., filling, extraction, root canal).

6. Dental treatment services increased exponentially as children aged. While treatment was naturally very low for children between birth and age two (14 or 6%), it increased noticeably (159 or 22%) for those ages 3 to 5. By the time children were between the ages of 6 and 8, two of every five (306 or 41%) required dental treatment.

Teenage Births and Low Birthweight

What this Indicator is:

A **teenage pregnancy**, as defined by the American Pregnancy Association, is a pregnancy that occurs for a woman under the age of 20. Although technically not a teenager, an adolescent 12 or under who is pregnant falls into this definition of teenage pregnancy as well.

Low birthweight (LBW) is defined by the World Health Organization as a birthweight of an infant of 2,499 grams or less (5 pounds 8 ounces or less), regardless of gestational age.

Subcategories include:

Very low birthweight (VLBW), which is less than 1500 g (3 pounds 5 ounces)

Extremely low birthweight (ELBW), which is less than 1000 g (2 pounds 3 ounces).

Normal weight at term delivery is 2500–4200 g (5 pounds 8 ounces – 9 pounds 4 ounces).

Why this Indicator is Important:

Childbirth to teenage mothers is associated with long-term difficulties for the mother and her child. Compared with babies born to older mothers, babies born to teenage mothers are at higher risk of low birthweight and infant mortality. These babies are also more likely to grow up in homes that offer lower levels of emotional support and cognitive stimulation. Teenage mothers are less likely to earn high school diplomas which, in turn can reduce career opportunities and long-term earnings potential.

Children with a low birthweight (less than 2,500 grams, or 5 lbs. 8 oz.) are at higher risk of early death and long-term health and developmental issues than infants at a higher birthweight. (*America's Children: Key Indicators of Well-Being 2017*, Forum on Child and Family Statistics)

Teenage Births and Birthweight 2015

(a) Low birthweight reflects children with low birthweight, very low birthweight, and extremely low birthweight.

Towns	Total Births	Births to Teenagers		Low Birthweight Births (a)	
		#	%	#	%
Barkhamsted	30	0	x	0	x
Bethlehem	23	0	x	1	*
Canaan	5	0	x	0	x
Colebrook	7	0	x	1	*
Cornwall	4	0	x	0	x
Goshen	5	0	x	1	*
Hartland	10	0	x	0	x
Harwinton	35	1	*	1	*
Kent	13	0	x	0	x
Litchfield	52	1	*	2	*
Morris	10	1	*	1	*
New Hartford	37	1	*	4	*
Norfolk	9	0	x	0	x
North Canaan	30	1	*	1	*
Salisbury	24	0	x	3	*
Sharon	6	0	x	0	x
Torrington	367	9	2%	33	9%
Warren	5	0	x	0	x
Washington	23	1	*	0	x
Winchester	85	1	*	7	8%
Total	**790**	**16**	**2%**	**55**	**7%**

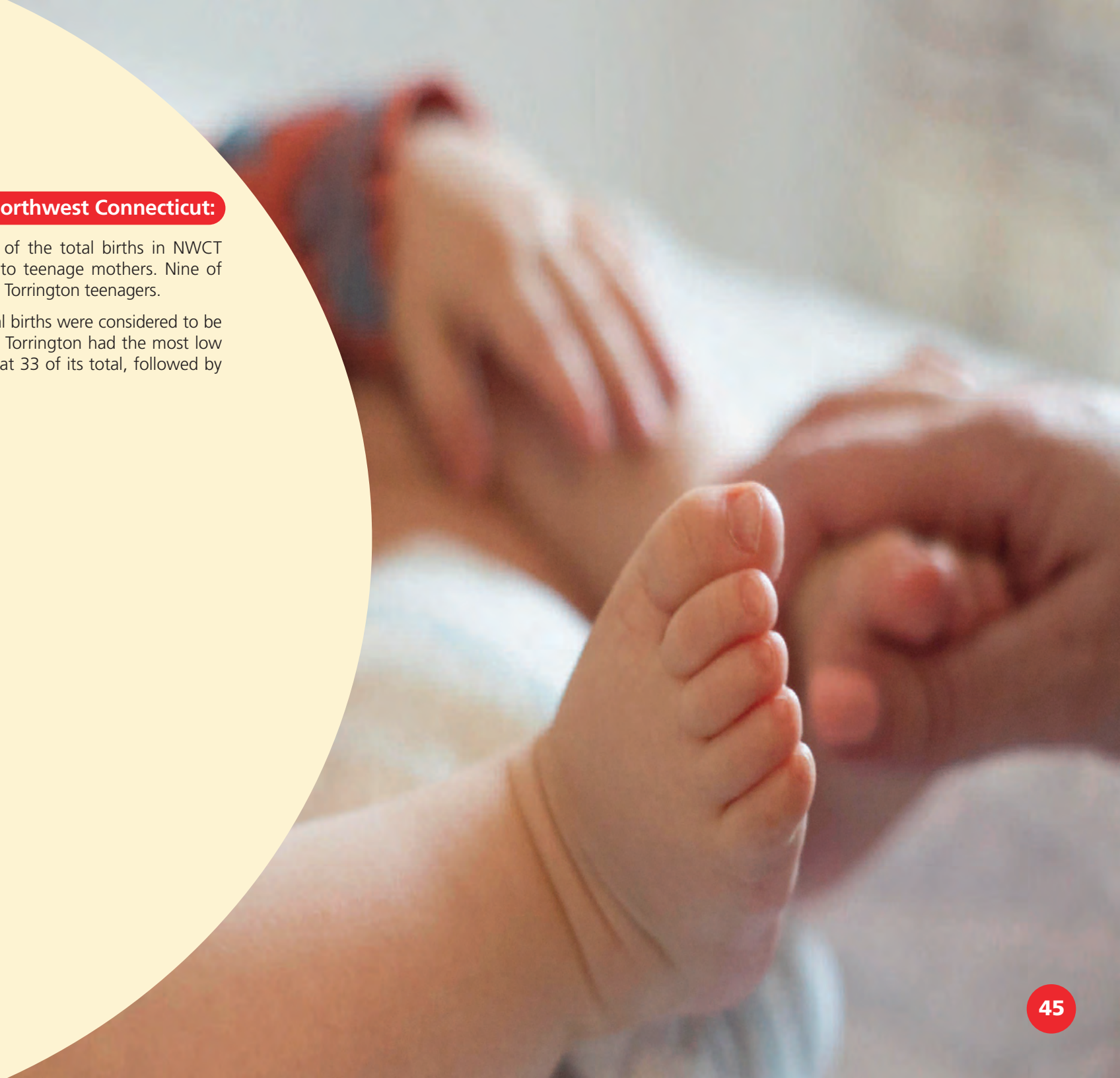
Connecticut Department of Health, Vital Statistics and Words & Numbers Research, Inc.

** Percentages were not calculated for less than five events because of the high degree of variability associated with small numbers.*

Findings for Northwest Connecticut:

1. Only 2% or 16 of the total births in NWCT during 2015 were to teenage mothers. Nine of these births were to Torrington teenagers.

2. 55 or 7% of total births were considered to be of low birthweight. Torrington had the most low birthweight babies at 33 of its total, followed by Winchester at 7.



Prenatal Care, Timing and Adequacy
2015

What this Indicator is:

The US. Department of Health and Human Services defines prenatal care as the health care a woman gets while she is pregnant. Health care during pregnancy is normally provided by an obstetrician or a midwife, and includes dietary and lifestyle advice, weighing to ensure proper weight gain, and examinations for problems of pregnancy such as edema and preeclampsia.

Why this Indicator is Important:

Women who receive early and consistent prenatal care enhance their likelihood of giving birth to a healthy child and reduce the chances of serious problems like preterm birth, anemia and low birth weight. Health care providers recommend that women begin prenatal care in the first trimester of their pregnancy.

Adequacy is based on the Adequacy of Prenatal Care Utilization (APNCU) Index.
The number of expected visits is based on the American College of Obstetricians and Gynecologists standards (one visit per month through 28 weeks, one visit every 2 weeks through 36 weeks, and one visit per week thereafter, adjusted for data of initiation of prenatal care). This is the newly measured dimension of the APNCU-Index.

2015 Towns	Total Births	Timing (late or none)		Non-Adequate (a)		Adequate		Intensive	
		#	%	#	%	#	%	#	%
Barkhamsted	30	4	*	8	27%	11	37%	11	37%
Bethlehem	23	2	*	3	*	8	35%	12	52%
Canaan	5	1	*	0	x	1	*	3	*
Colebrook	7	0	x	0	x	6	86%	1	*
Cornwall	4	0	x	1	*	3	*	0	*
Goshen	15	2	*	3	*	5	33%	7	47%
Hartland	10	2	*	3	*	4	*	3	*
Harwinton	35	2	*	6	17%	19	54%	10	29%
Kent	13	0	x	0	x	5	39%	8	62%
Litchfield	52	3	*	6	12%	33	64%	13	25%
Morris	10	1	*	2	*	5	50%	3	*
New Hartford	37	3	*	9	24%	19	52%	9	24%
Norfolk	9	2	*	4	*	4	*	1	*
North Canaan	30	5	17%	5	17%	15	50%	10	33%
Salisbury	24	1	*	5	23%	9	41%	8	36%
Sharon	6	0	0	1	*	2	*	3	*
Torrington	367	30	8%	65	18%	197	54%	103	28%
Warren	5	0	0	1	*	1	*	3	*
Washington	23	2	*	4	*	12	52%	7	30%
Winchester	85	7	8%	18	21%	46	54%	21	25%
Total	**790**	**67**	**9%**	**144**	**18%**	**405**	**52%**	**236**	**30%**

Connecticut Department of Health, Vital Statistics and Words & Numbers Research, Inc.

(a) Some of the total birth numbers are not represented in the *Adequacy* data. The variability is minor, however, and does not compromise the quality of the data.

* Percentages were not calculated for less than five events because of the high degree of variability associated with small numbers.

Timing:

• **Late or no prenatal care** is calculated as the percentage of births that occur to mothers who, on their child's birth certificate, reported receiving prenatal care only in the third trimester of their pregnancy, or reported receiving no prenatal care.

• **Non-adequate care** is defined as prenatal care (PNC) begun after the 4th month or less than 50% of expected visits, received.

• **Intermediate care** is defined as PNC begun by month 4 and between 50-79% of expected visits, received. **In the table on the facing page, Non-Adequate prenatal care** also includes **Intermediate prenatal care.**

• **Adequate care** is defined as PNC begun by month 4 and of 80-109% of expected visits, received.

• **Intensive care** is defined as PNC begun by month 4 and 110% or more of expected visits, received.

Findings for Northwest Connecticut:

1. Almost one-of-ten (67) NWCT births in 2015 had either late or no prenatal care. The majority of these births occurred in Torrington at 30 or 8% of its total, followed by Winchester at 7 or 8% and North Canaan at 5 or 17% of its total.

2. Nearly one-in-five (18% or 144) NWCT births in 2015 received non-adequate prenatal care.

3. Torrington had the largest number of births (65) with non-adequate prenatal care, followed by Winchester with 18.

4. Although their numbers were smaller, several NWCT towns had relatively high percentages of non-adequate prenatal care births, including Barkhamsted (27%), New Hartford (24%) and Salisbury (23%). This means that for these towns, one-in-four births occurred with non-adequate prenatal care.

Birth to Three Program Services by Town

What this Indicator is:

Birth to Three is an early intervention treatment strategy targeted for children who have been diagnosed with significant development delays.

Connecticut's Birth to Three System (B23) is administered pursuant to Part C of the Individuals with Disabilities Education Act (IDEA). B23 supports (by referral) families with infants and toddlers that have possible developmental delays in order to make recommendations on everyday activities intended to enhance the child's development.

Once families with children below age 3 are referred, the child's development is evaluated for eligibility. If eligible, the family can receive support until the child no longer has delays or until the child turns age 3. Children are determined to be eligible when a diagnosed medical condition with a high likelihood of developmental delay occurs. Parents must accept the evaluation for the child to be eligible. Because an infant can be referred within days of being born, a family may be enrolled for almost three full years.

Why this Indicator is Important:

The first 3 years of life are considered by developmental experts as a necessary foundation for the health and emotional, behavioral, cognitive and social development of all children. Initiating intervention services early on improves a child's ability to develop and learn. Research has shown that Birth to Three services help to close the developmental delay gap for many children.

Birth to Three Program Services by Town

The data reported in the chart below, published annually by Connecticut's Birth to Three System, represents CT Fiscal Year 2017 (July 1, 2016 - June 30, 2017). Some towns will have more children served than were referred because they were referred in a previous calendar or fiscal year. Birth data were drawn from the CT Department of Public Health Office of Vital Records' Annual Registration Report for calendar year 2016. They are provided as a context for analysis. *SPED = Special Education*

Town	2016 Births	Referrals	Evaluations	Total Eligible	Individual Family Service Plan	Total Served	Exited to SPED
Barkhamsted	27	<5	8	<5	7	7	<5
Bethlehem	30	6	<5	<5	6	6	<5
Canaan	10	<5*	<5	<5	8	8	<5
Colebrook	6	0	0	0	0	0	0
Cornwall	4	0	0	0	0	0	0
Goshen	13	7	<5	<5	<5	<5	<5
Hartland	12	6	<5	<5	<5	<5	0
Harwinton	33	6	<5	<5	8	8	<5
Kent	18	<5	<5	<5	<5	<5	<5
Litchfield	56	10	9	6	11	11	<5
Morris	22	<5	<5	0	<5	<5	<5
New Hartford	59	8	7	<5	8	8	<5
Norfolk	7	<5	<5	<5	<5	<5	<5
North Canaan	25	<5	<5	<5	<5	<5	<5
Salisbury	26	<5	<5	<5	<5	<5	0
Sharon	11	<5	<5	<5	<5	<5	<5
Torrington	329	92	87	67	117	116	26
Warren	16	6	<5	0	0	0	0
Washington	16	0	0	0	<5	<5	<5
Winchester	89	17	16	12	18	18	<5
Total*	**809**	**181 (22%)**	**157 (87%)**	**115 (73%)**	**206**	**205**	**61**

Connecticut Office of Early Childhood, Connecticut Birth to Three System and Words & Numbers Research, Inc.

* The Connecticut Office of Early Childhood reports less than five children as "**<5**" to protect confidentiality. Since this is not a real number and cannot be used for statistical computation, the midpoint of 2.5 is used to calculate totals.

Findings for Northwest Connecticut:

1. Approximately one-in-five (181) NWCT children born in 2016 were referred for Birth to Three services during 2017. Of these referrals, 87% (157) were evaluated. Three-quarters (115) were subsequently determined to be eligible for Birth to Three services.

2. During FY17, 61 three-year-old children exited the program to early childhood special education. In these cases, it was determined that continued services were needed to address developmental delays that were likely to impact a child's future academic performance.

3. While many NWCT towns have children who are receiving Birth to Three services, Torrington makes up the majority of the program, comprising 55% of all evaluations, 58% of eligibilities and 57% of the total served. [As noted, Torrington makes up 41% of all 2016 births, but the rates of participation are higher.]

Students Reaching Health Standard (grades 4 and 6)
School Year 2017 – 2018

What this Indicator is:

The Connecticut Physical Fitness Assessment (CPFA) is Connecticut's annual assessment of public school students' physical well-being. Students in Grades 4, 6, and 8 are assessed annually. At the high school level, schools have the flexibility to assess students at any grade, but must assess each student at some point between Grades 9 and 12.

Students taking the CPFA are evaluated using age and gender appropriate standards in four Health Fitness Zone Areas:

- aerobic endurance;
- flexibility;
- upper body strength and endurance; and
- abdominal muscle strength and endurance.

Why this Indicator is Important:

While the assessment goals are informational and evaluative regarding fitness and physical activity in the state's schools, CPFA has considerable value as a measurement of the overall health of young children and as a predictor of future health issues. These can include obesity, diabetes, high blood pressure and muscular-skeletal problems.

School	Grades	Percent - Grade 4	Percent - Grade 6
Barkhamsted Elementary	PK - 6	44%	42%
Lee H. Kellogg (Canaan)	K - 8	NA	NA
Colebrook Consolidated	K - 6	79%	NA
Cornwall Consolidated	K - 8	NA	NA
Hartland	PK - 8	NA	NA
Kent Center	PK - 8	29%	40%
Litchfield Center	PK - 3	NA	NA
Litchfield Intermediate	4 - 6	67%	62%
Litchfield Middle	6 - 8	X	X
Ann Antolini (New Hartford)	3 - 6	60%	46%
Bakerville Consolidated (New Hartford)	K - 2	X	X
New Hartford Elementary	PK - 2	X	X
Botelle Elementary (Norfolk)	PK - 6	NA	NA
North Canaan Elementary	PK - 8	45%	X
Goshen Center (Reg. 6)	PK - 6	NA	67%
James Morris (Reg. 6)	PK - 6	NA	NA
Warren Elementary (Reg. 6)	PK - 6	NA	NA
Wamogo Regional (Reg. 6)	7 - 12	NA	NA
Northwest Regional Middle (Reg. 7)	6 - 8	X	NA
Harwinton Consolidated (Reg. 10)	PK - 4	64%	NA
Lake Garda Elementary (Reg. 10)	PK - 6	45%	NA
Har-Bur Middle (Reg. 10)	5 - 8	NA	67%
Washington Primary (Reg. 12)	PK - 5	59%	NA
Shepaug Valley (Reg. 12)	6 - 8	X	85%
Bethlehem Elementary (Reg. 14)	PK - 5	65%	NA
Mitchell Elementary (Reg. 14)	PK - 5	71%	NA
Woodbury Middle (Reg. 14)	6 - 8	NA	46%
Salisbury Central	PK - 8	24%	NA
Sharon Center	PK - 8	NA	NA
East (Torrington)	PK - 5	47%	NA
Forbes (Torrington)	PK - 5	53%	NA
Southwest (Torrington)	PK - 5	51%	NA
Torringford (Torrington)	PK - 5	56%	NA
Vogel-Wetmore (Torrington)	PK - 5	NA	20%
Torrington Middle	6 - 8	X	20%
Batcheller Early Ed Center (Winchester)	PK - 2	X	X
Pearson (Winchester)	3 - 6	39%	36%
Gilbert (Winsted)	6 - 8	NA	X

State Target = 75%

CT State Department of Education and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. The majority of NWCT's reporting elementary and middle schools have large percentages of third- and sixth-graders who are unable to meet the CT State Department of Education's health standard on the CT Physical Fitness Assessment (CPFA) for the four Health Fitness Zone Areas.

2. Only 1 of 17 reporting NWCT elementary schools (Colebrook) had the requisite percentage of third-graders who were able to meet the goals of all four fitness tests, thus surpassing the state target of 75%.

3. Mitchell Elementary (71%), Litchfield Intermediate (67%), Bethlehem Elementary (65%) and Harwinton Consolidated (64%) were reasonably close to reaching the state target.

4. Only 1 of 11 reporting NWCT elementary and middle schools had the requisite percentage of sixth-graders who were able to meet the CPFA health standard on the four Health Fitness Zone Areas. Eighty-five percent (85%) of Shepaug Valley's sixth graders met the goals of all four fitness tests.

5. Goshen Center (67%), Har-Bur Middle (67%) and Litchfield Intermediate (62%) came reasonably close to reaching the state target.

Child Care Provider Availability by Age and Program Type
Fall, 2018

What this Indicator is:

According to U.S. Code*, the term child care provider means "a provider of non-residential compensated child care services (including center-based, family-based, and in-home child care services) that is legally operating under state law, and complies with applicable state and local requirements for the provision of child care services."
**Title 20 Section 9402 [Early Learning Opportunities]*

Why this Indicator is Important:

Access to high-quality child care relative to its availability, affordability and location is critical for parents who must make decisions involving the relationship between their child's well-being and their own financial livelihood. Often parents are forced to choose between spending a significant portion of their income on quality child care, or finding a cheaper, potentially lower-quality care option, or a more convenient option—or leaving the workforce altogether to become a full-time caregiver.

Access to high-quality care, in addition to keeping children healthy and safe, is critical for its educational component. Considerable research has shown that children are learning from birth and that education during the early years is crucial to their long-term development. From birth to five, high-quality child care can help children to develop their social, emotional and communication skills as well as pre-literacy and basic mathematical skills and concepts. All of these are important building blocks for future learning.

Annual Capacity, Availability and Enrollment Survey

2-1-1 Child Care, a United Way statewide childcare referral and resource agency, conducts an annual survey to provide a "snapshot" of the availability of child care in Connecticut and the number of children served.

Licensed and licensed exempt child care programs are surveyed to verify whether they are currently operating, the ages served, capacity, vacancy and enrollment based on full-time equivalents. The survey results are available each spring.

In order to capture as many children in the survey as possible:

- **Infant/ Toddler, Preschool and School Age** include licensed and license-exempt center-based programs and group homes, and licensed family day care homes;
- **Toddler** counts include Early Head Start slots;
- **Preschool** counts include Head Start slots;
- **Nursery School,** a part-day enrichment program, includes school-based exempt programs.

Age Requirements for Child Care

	Home	Center
Infant/Toddler	0 to 23 months	0 to 35 months
Preschool	2 to 5 years	3 to 5 years
School Age	5 to 12 years	

Child Care Provider Availability by Age and Program Type Fall, 2018

- **Capacity** is the number of licensed slots for specific age groups.
- **Enrollment** is the number of full-time equivalent children enrolled for a specific age group.
- **Vacancy** is the number of vacant slots reported at the time of survey.

NOTE: Enrollments plus vacancies do not always equal capacity, because some programs choose not to operate at full capacity.

	Capacity	Enrollment	Vacancies	NWCT Availability (a)	CT Availability
Infant/Toddler	536	381	72	13%	12%
Preschool	1,040	545	202	19%	11%
School Age	938	414	128	14%	14%
Nursery School	404	260	32	8%	5%

2-1-1 Child Care and Words & Numbers Research, Inc.

(a) The availability of child care is determined by dividing the total vacancies reported by providers at the time of the annual 2-1-1 Child Care survey by the total capacity of their facilities. It can be used as one benchmark for assessing the extent to which parents have access to licensed and license-exempt early care and education in a given area.
(b) This indicator does not consider program quality.

Findings for Northwest Connecticut:

1. Availability of preschool childcare is higher in NWCT (19%) compared to statewide averages (11%). There were 202 vacancies with respect to NWCT's 1,040 preschool capacity.

2. Further consideration should be given to determining why the availability of preschool child care is noticeably higher in the region. Oversupply of preschool slots is a possible factor, as it may relate to demographic changes in the number of NWCT's children aged 2 to 5 years. However, the cost of preschool child care, particularly for those households without a subsidy, also needs to be thoroughly explored.

3. Availability of infant/ toddler, school age and nursery school care in NWCT is in line with the statewide averages.

Child Care Costs and Annual Income Required
Litchfield County, September, 2019

What this Indicator is:

2-1-1 ChildCare conducts an annual statewide fee analysis of child care facilities in Connecticut. Fee Information does not include State or Federally subsidized programs or programs with sliding scale rates.

The **ALICE** (Asset Limited, Income Constrained, Employed) **Project** was initiated by the United Way of Northern New Jersey several years ago to bring into focus the families and individuals who work but whose salaries do not provide sufficient resources to meet basic needs. The ALICE Project developed a methodology using publicly available census, employment, wage, cost of living and other data to help understand the extent of those in our communities who earn above the federal poverty level, but below a sustainable wage. The ALICE Project is now implemented in 18 states.

ALICE provides two model budgets (survival and stability) for various household scenarios based on their composition (i.e., single adult, adult with an infant/toddler, two adults with infant/toddler and school-age child).

Survival budget estimates the bare minimum cost of the five basic household necessities – housing, child care, food, transportation, and health care. It is a better representation of the real cost of household "survival" than the Federal Poverty Level.

Stability budget is a representation of a sustainable family budget in the modern economy, with a few extras and a 10-percent savings commitment every month to deal with unexpected expenses.

Why this Indicator is Important:

Cost is one of the major constraints on a parent's ability to have access to high-quality child care. The annual income required to obtain high-quality child care can be staggering to a household with limited means. Lacking a subsidy oftentimes means parents are forced to choose a lesser quality option because of their inability to pay the cost of child care.

Annual Income Required to Meet Child Care Costs

	Average Annual Cost (a)	Average 1 Adult, 1 Infant on Survival Budget (23%) (b)	1 Adult, 1 Infant on Stability Budget (17%) (c)	2 Adults, 1 Infant, 1 Preschool on Survival Budget (27%) (d)	2 Adults, 1 Infant, 1 Preschool on Stability Budget (20%) (e)
Infant/Toddler Center	$13,260	$57,600	$77,700	$91,920	$120,000
Preschool Center	$11,284	–	–		
School Age Center	$ 5,616	–	–	–	–

2-1-1 Child Care and Words & Numbers Research, Inc.

(a) 2-1-1 ChildCare Fee Analysis of Child Care Facilities, 2019, Connecticut United Way's ALICE Project, 2018 and Words & Numbers Research, Inc.

(b) The 2016 ALICE Project assumes child care costs for this scenario are 23% of this household's survival budget. Using 2-1-1 fee analysis, monthly child care costs are approximately $1,105 or $13,260 annually.

(c) The 2016 ALICE Project assumes child care costs for this scenario are 17% of this household's stability budget. Using 2-1-1 fee analysis, monthly child care costs are approximately $1,105 or $13,260 annually.

(d) The 2016 ALICE Project assumes child care costs for this scenario are 27% of this household's survival budget. Using 2-1-1 fee analysis, monthly child care costs are approximately $2,045 or $24,544 annually.

(e) The 2016 ALICE Project assumes child care costs for this scenario are 20% of this household's stability budget. Using 2-1-1 fee analysis, monthly child care costs are approximately $2,045 or $24,544 annually.

Findings for Northwest Connecticut:

1. For NWCT parents of limited financial means, the annual cost of child care can be overwhelming without a subsidy. It can be assumed that many of the region's parents are being forced to choose lower cost and possibly lower quality child care options for their children, or alternatively, pressed to leave the workforce.

2. A single parent with an infant/toddler in NWCT must have an annual income of $57,600 to pay average child care costs on a "bare minimum survival" budget. If that same parent were to have slightly more economic security offered by a "stability" budget, they would need an annual income of $77,000 to meet child care expenses. As a point of reference, 185% of the Federal Poverty Level for a 2-person household is $31,284 in 2019. People earning above 185% of the Federal Poverty level are often ineligible for many state and federal entitlement programs.

3. Two parents with two children, an infant/toddler and a preschooler, must have an annual income of $91,920 to pay average child care costs on a "bare minimum survival" budget and $120,000 on a "stability" budget. As a point of reference, 185% of the Federal Poverty Level for a 4-person household (considered to be low income for most federal entitlement programs) is $47,638 in 2019.

Child Care Subsidy Program Enrollments (Care4Kids)

All Services (Infant/Toddler, Preschool, School Age) by Town
April, 2019

What this Indicator is:

Care4Kids: Sponsored by the Connecticut Office of Early Childhood, Care4Kids is a funding program designed to make child care affordable for low to moderate income families in Connecticut. To participate in the program, there are certain eligibility requirements for parents, children and child care providers. The income limit for families applying for Care4Kids must be less than 50% of the State Median Income (SMI).

The Connecticut Office of Early Childhood provides the following definitions for early care:

Family child care homes: Family child care homes are private homes that meet the following criteria:

- Provide care for up to six children, including the provider's children, who are not in school full-time
- During the school year, providers may take up to three additional children who are in school full-time
- If the provider has more than three children in school full-time, all of them are permitted
- Care is provided for no less than three and no more than twelve hours within a 24-hour period on a regular basis
- More than twelve hours of care is allowed on an intermittent basis, but may not exceed 72 consecutive hours.

Group child care homes: Group child care homes fall under one of the following definitions:

- Provides regular care for not less than seven or more than twelve related or unrelated children, or
- Meets the definition of a family child care home, but operates in a facility other than a private home.

Child care centers: Child care centers provide regular care to more than twelve related or unrelated children outside of their homes.

Youth camps: Youth camps are programs or organized activities that operate during school vacations or on weekends. Camps may accommodate five or more children who are between the ages of three and sixteen.

Connecticut State Median Income: 2019-2020

Family Size	100% State Median Income	50% State Median Income
1	60,285	30,142
2	78,834	39,417
3	97,383	48,690
4	115,932	57,966
5	134,481	67,241
6	153,030	76,515
7	156,508	78,254
8	159,986	79,993

State Median Income is established by the U.S. Department of Health and Human Services.

SOURCE: Connecticut Department of Social Services
PREPARED BY: 211/tb
CONTENT LAST REVIEWED: September 2019

Why this Indicator is Important:

Child care subsidies are essential for enabling low-income parents to obtain high-quality early care and education opportunities for their children and for themselves to remain in their jobs. Without a child care subsidy many low-income parents would be forced to choose either a lower cost, and potentially lower quality, care option for their children or to leave their jobs and become full-time care givers.

An undersupply of Care4Kids subsidies may have a "dampening effect" on the demand for regulated/licensed preschool child care in NWCT. There is relatively high availability for preschool child care (see page 52) and a considerable cost to obtaining it (see page 54). Households unable to afford the cost and lacking a subsidy will likely search for other lower-cost options, such as care from friends or relatives.

Approximately one-third (73) of all Care4Kids child care subsidies were in infant/ toddler program settings. Preschool child care subsidies accounted for 41% (89) of the total, while school age (54) made up one-quarter.

NWCT Child Care Subsidies (Care4Kids) by Program Type
April, 2019

		Regulated/Licensed			Unregulated	Total
	Center	Group Home	Family Child Care Home	Youth Camp	Relative Care	
Infant/ Toddler	57	1	8	0	7	73
Preschool	75	0	5	0	9	89
School Age	38	0	3	0	13	54
Total	170	1	16	0	29	216

Connecticut Office of Early Childhood, and Words & Numbers Research, Inc.

Child Care Subsidy Program Enrollments (Care4Kids)
All Services (Infant/Toddler, Preschool, School Age) by Town
April, 2019

		Regulated/Licensed			Unregulated	Total
Town	Center	Group Home	Family Child Care Home	Youth Camp	Relative Care	
Barkhamsted	3	0	0	0	0	3
Bethlehem	3	0	0	0	0	3
Canaan	6	0	0	0	0	6
Colebrook	0	0	0	0	0	0
Cornwall	1	0	0	0	1	2
Goshen	0	0	0	0	0	0
Hartland	3	0	0	0	0	3
Harwinton	2	0	0	0	0	2
Kent	1	0	0	0	0	1
Litchfield	3	0	0	0	0	3
Morris	1	0	0	0	3	4
New Hartford	2	0	0	0	0	2
Norfolk	2	0	0	0	0	2
North Canaan	0	0	0	0	0	0
Salisbury	3	0	0	0	0	3
Sharon	3	1	0	0	0	4
Torrington	107	0	14	0	21	142
Warren	2	0	0	0	0	2
Washington	2	0	1	0	0	3
Winchester	26	0	1	0	4	31
Total	170	1	16	0	29	216

Connecticut Office of Early Childhood, and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. It appears that the number of child care subsidies provided in NWCT are considerably lacking when compared to the number of impoverished and low-income infant/ toddlers and preschoolers in NWCT. As of April 2019 there was a total of 216 subsidized child care enrollments in NWCT, while there were nearly a thousand children aged 5 years and under who were in impoverished or low-income households (see table at left). This total does not take into account low-income school-age children who may be in need of subsidized care options.

2. The majority of the child care subsidies, 187 (87%), were at regulated/ licensed programs, while 29 (13%) were at unregulated Relative Care options.

3. Two-thirds (142) of the child care subsidies were provided in Torrington while 31 (14%) were in Winchester. The remaining 43 (20%) subsidies were scattered throughout the region.

Early Care and Education (ECE) State Subsidies in relation to Number of Impoverished and Low-Income Children in NWCT Birth to 5 Years of Age

What this Indicator is:

Care4Kids: Sponsored by the Connecticut Office of Early Childhood, Care4Kids is a funding program designed to make child care affordable for low to moderate income families in Connecticut. To participate in the program, there are certain eligibility requirements for parents, children and child care providers. **The income limit for families applying for Care4Kids must be less than 50% of the State Median Income (SMI).**

School Readiness: The School Readiness Program is a state grant program providing spaces for eligible 3 & 4 year-old children living in priority school districts and competitive grant municipalities in high-quality preschool programs either accredited by the National Association for the Education of Young Children (NAEYC) or Head Start approved. **At least 60 percent of the children enrolled must be at or below 75% of the State Median Income (SMI).**

Head Start: Head Start is a Federal program that promotes school readiness for children (birth to five) from low-income families (at or below federal poverty guidelines) by enhancing their cognitive, social, and emotional development. Head Start programs provide a learning environment that supports children's growth in areas such as language, literacy, and social and emotional development. Many Head Start programs also provide Early Head Start, which serves infants, toddlers, pregnant women and their families who meet the same guidelines.

Why this Indicator is Important:

For many low-income families, a subsidy is essential to obtaining quality child care for their children. A comparison between the number of subsidies and the number of impoverished and low-income children in a given area can serve as a measurement of the accessibility of Early Care and Education opportunities available to families most in need.

Availability of Subsidized Early Care and Education (ECE) Opportunities in Relationship to Number of Impoverished and Low-Income Children in NWCT, Birth to 5 Years of Age

Town	Impoverished/Low Income Children, B-5	Care4Kids Subsidies	School Readiness Spaces	Early & Head Start Slots	Total Subsidized ECE	Potential Shortfall of Subsidized ECE
Barkhamsted	0	3	-	-	3	3
Bethlehem	48	3	-	-	3	-45
Canaan	12	6	-	-	6	-6
Colebrook	6	0	-	-	0	-6
Cornwall	12	2	-	-	2	-10
Goshen	0	0	-	-	0	0
Hartland	3	3	-	-	3	0
Harwinton	30	2	-	-	2	-28
Kent	9	1	-	-	1	-8
Litchfield	81	3	-	-	3	-78
Morris	47	4	-	-	4	-43
New Hartford	0	2	-	-	2	2
Norfolk	6	2	-	-	2	-4
North Canaan	34	0	15	-	15	-19
Salisbury	0	3	-	-	3	3
Sharon	30	4	-	-	4	-26
Torrington	490	142	45	149	336	-154
Warren	12	2	-	-	2	-10
Washington	21	3	-	-	3	-18
Winchester	143	31	35	27	93	-50
Total	984	216	95	176	487	-497

U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates; Connecticut Office of Early Childhood; EdAdvance; and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. The potential need for subsidized early care and education opportunities in NWCT could approach nearly 500 slots.

2. There are 984 children in NWCT aged birth to five years old who live in households whose annual income is either below the Federal Poverty Level (impoverished) or between the Federal Poverty Level and 185% of it (classified as low-income). There are only 487 subsidized spaces to meet the potential need of these children for quality and affordable early child care and education. This is a deficit of 497 spaces potentially needed but unavailable.

3. The potential need for subsidized ECE is most apparent in Torrington (-154), Winchester (-50), Litchfield (-78), Bethlehem (-45), Morris (-43), Harwinton (-28) and Sharon (-26).

Kindergartners with a Preschool Experience
School Year 2018 – 2019

What this Indicator is:

Preschool experience refers to a child's attendance in an early childhood program at some point between the ages of 3 and 5 prior to enrolling in kindergarten.

Why this Indicator is Important:

A quality preschool experience helps to enhance a child's social, emotional, cognitive and physical development. Research supports that early care and education not only provides children with school readiness skills, but also helps to develop skills that will benefit them throughout their lives.

School	Grades	Kindergartners with a Preschool Experience
Barkhamsted Elementary	PK – 6	100%
Lee H. Kellogg (Canaan)	K – 8	50%*
Colebrook Consolidated	K – 6	50%*
Cornwall Consolidated	K – 8	91%
Hartland	PK – 8	85%
Kent Center	PK – 8	100%
Litchfield Center	PK – 3	90%
Bakerville Consolidated (New Hartford)	K – 2	79%
New Hartford Elementary	PK – 2	71%
Botelle Elementary (Norfolk)	PK – 6	100%*
North Canaan Elementary	PK – 8	94%
Goshen Center (Reg. 6)	PK – 6	96%
James Morris (Reg. 6)	PK – 6	88%
Warren Elementary (Reg. 6)	PK – 6	100%
Harwinton Consolidated (Reg. 10)	PK – 4	100%
Lake Garda Elementary (Reg. 10)	PK – 6	91%
Washington Primary (Reg. 12)	PK – 5	92%
Bethlehem Elementary (Reg. 14)	PK - 5	65%
Mitchell Elementary (Reg. 14)	PK – 5	81%
Salisbury Central	PK – 8	50%
Sharon Center	PK – 8	67%
Torringford (Torrington)	PK – 5	35%
Vogel-Wetmore (Torrington)	PK – 5	49%
Batcheller Early Ed Center (Winchester)	PK – 2	84%

CT State Department of Education EdSight and Words & Numbers Research, Inc.

* Enrollment size is noted as small by CT State Department of Education since the addition or subtraction of additional students can substantially influence the percentage.

Findings for Northwest Connecticut:

1. **Eight** of the 24 elementary schools report that at least one-fourth of their Kindergarten students do not have the benefit of a preschool experience. Small student numbers should be noted when reviewing their percentages.

Achievement Gap based on Socioeconomic Status

(Free and Reduced-Price Meals) Eligible and Non-Eligible Students in English Language Arts (ELA) and in Math (grades 3-8)

What this Indicator is:

The "**achievement gap**" (also referred to as the **equity** or **opportunity gap**) is the difference in educational achievement between groups of students based on socioeconomic status, racial and ethnic difference, primary language spoken in the home (English Language Learners-ELL) and/or special needs students.

Eligibility for Free & Reduced-Price Meals (FRPM) is regularly used as a measure of socio-economic status designating poverty and low-income status.

- Children eligible for **free meals** live in a family with an income less than 130% of the federal poverty level.
- Children eligible for **Reduced-Price Meals** live in a family with an income between 130% and 185% of the federal poverty level.
- For a household of four persons, this equates to an income of $33,475 at 130% FPL and $45,510 at 185% FPL based on 2017 guidelines.

In the following analysis, **Free & Reduced-Price Meals** eligibility is isolated to better determine its role as a socioeconomic factor contributing to academic progress.

Why this Indicator is Important:

Research has shown that over time an achievement gap can grow and have a lasting detrimental impact on a student's ability to graduate from high school, enter and graduate from college, and attain employment that provides for lifelong economic security.

In 2014, a report by the non-partisan Center for American Progress titled *The Economic Benefits of Closing the Achievement Gap* attributed the gap to several factors. They included income and wealth inequality, access to child care and preschool programs, nutrition, physical and emotional health, environmental factors, community and family structures, differences in the quality of instruction and school, and educational attainment.

The Performance Index

The Performance Index is the average performance of students in a subject area (i.e., English Language Arts (ELA), Mathematics, Science, etc.) on the state summative assessments.

The Performance Index ranges from 0-100 and is reported for all students and for students in each individual student group. Connecticut's target for a Performance Index is 75.

School	Grades	ELA Performance Index		ELA Performance Gap	Math Performance Index		Math Performance Gap
		FRPM Eligible	Non-FRPM Eligible		FRPM Eligible	Non-FRPM Eligible	
Barkhamsted Elementary	PK-6	70.1	77	6.9	65.6	72.7	ß7.1
Lee H. Kellogg (Canaan)	K-8	*	78.9	NA	*	70.4	NA
Colebrook Consolidated	K-6	*	84.8	NA	*	76.8	NA
Cornwall Consolidated	K-8	*	76.7	NA	*	72	NA
Hartland	PK-8	76	79.4	3.4	67.7	70.7	3
Kent Center	PK-8	73.8	89.2	15.4	67.8	79.4	11.6
Litchfield Center	PK-3	*	79.2	NA	*	76.2	NA
Litchfield Intermediate	4-6	72.7	80.6	7.9	72.3	80.3	8
Litchfield Middle	6-8	71.8	78	6.2	72.7	75.4	2.7
Ann Antolini (New Hartford)	3-6	68.1	76.3	8.2	62.6	69.9	7.3
Botelle Elementary (Norfolk)	PK-6	*	77.7	NA	*	71.5	NA
North Canaan Elementary	PK-8	70.3	77.9	7.6	58.7	71.3	12.6
Goshen Center (Reg. 6)	PK-6	*	84.6	NA	*	79.8	NA
James Morris (Reg. 6)	PK-6	*	80.5	NA	*	76	NA
Warren Elementary (Reg. 6)	PK-6	*	*	NA	*	*	NA
Northwest Reg. Middle (Reg. 7)	6-8	72	77.3	5.3	56.5	65	8.5
Harwinton Cons. (Reg. 10)	PK-4	*	81.2	NA	*	83.4	NA
Lake Garda Elem. (Reg. 10)	PK-4	*	78.4	NA	*	77.6	NA
Har-Bur Middle (Reg. 10)	5-8	66	77.5	11.5	62.6	74.8	12.2
Washington Primary (Reg. 12)	PK-5	*	87.7	NA	*	86.4	NA
Shepaug Valley (Reg. 12)	6-12	70.1	72.4	2.3	64	68.9	4.9
Bethlehem Elem. (Reg. 14)	PK-5	66.6	75.9	9.3	62.9	74.6	11.7
Mitchell Elem. (Reg. 14)	PK-5	74.7	75.7	1	71.3	70.8	-.5
Woodbury Middle (Reg. 14)	6-8	59.2	71.4	12.2	50.3	62.8	12.5
Salisbury Central	PK-8	72.6	85.2	12.6	60.9	74.5	13.6
Sharon Center	PK-8	72.9	76.4	3.5	65.7	67.4	1.7
Forbes (Torrington)	PK-5	62.2	69.7	7.5	56.4	66	9.6
Southwest (Torrington)	PK-5	63.8	75.9	12.1	59.5	68.6	9.1
Torringford (Torrington)	PK-5	62.4	72.4	10	58.1	65.2	7.1
Vogel Wetmore (Torrington)	PK-5	62.6	74.4	11.8	54.8	68.4	13.6
Torrington Middle	6-8	57.5	67.5	10	49.2	60	10.8
Pearson (Winchester)	3-6	66.6	72.4	5.8	67.5	74.3	6.8

CT Department of Education, EdSight and Words & Numbers Research, Inc.

*The data are suppressed to ensure confidentiality because of small cell sizes.

Findings for Northwest Connecticut:

1. There are notable achievement gaps between NWCT's **Free & Reduced-Price Meals** (FRPM) eligible and FPRM non-eligible elementary school students on both the ELA and Math Performance Indices. The average difference (achievement gap) for the ELA Performance Index is 8.1 (median score is 7.9) and the average gap for Math is 8.3 (median score is 8.5).

2. For all reporting schools (except one) the **Free & Reduced-Price Meals** eligible student population had ELA and Math Performance Index scores that fell below the Connecticut target score of 75 (in red). Of those, ten (10) schools had ELA scores that were between 70 and 74.

3. Of the reporting schools, seven (7) **Free & Reduced-Price Meals** non-eligible student populations fell short of the state target for English Language Arts performance. Of those, four (4) schools had scores between 70 and 74.

4. Twenty-one (21) schools reported **Free & Reduced-Price Meals** non-eligible student populations falling below the state target in Math. Of those, (3) had Math scores that were between 70 and 74.

School Readiness Spaces
2018-19

What this Indicator is:

The School Readiness Program provides low-income children in eligible communities with an avenue to early care and educational opportunities, otherwise unaffordable.

The program was established by CT legislation in 1997 to provide quality preschool access for eligible children in priority school districts and Competitive Grant Municipalities. These high-quality programs are accredited by the National Association for the Education of Young Children (NAEYC) or Head Start-approved. Eligibility is for children who are ages 3 and 4, and children 5 years of age who are not eligible to enroll in kindergarten.

No NWCT community is a designated priority school district. Torrington, Winchester and North Canaan are considered to be Competitive Grant Municipalities because they are ranked in the fifty CT communities with the lowest per capita income and therefore eligible to apply for a grant for School Readiness spaces.

Why this Indicator is Important:

The U.S. Department of Education defines the elements of school readiness as follows:

1. Language and literacy development
2. Cognition and general knowledge (including early mathematics and early scientific development)
3. Approaches to learning
4. Physical well-being and motor development
5. Social and emotional development

School readiness programs are intended to address these five elements, with the goal of preparing children to enter kindergarten ready to learn and succeed academically, in both the short- and long-term.

Many programs also provide supportive services, including family literacy, well-child screenings, developmental assessments, referrals for additional educational services, parent education/ support programs, referrals to educational opportunities and family counseling.

Town	Total School Readiness Preschool Spaces	Full Day 10 hours	School Day 6 hours	Part Day 2.5 hours
North Canaan	15	15	0	0
Torrington	45	17	4	24
Winchester	35	18	17	0
Total	**95**	**50**	**21**	**24**

Connecticut Office of Early Childhood and Words & Numbers Research, Inc.

Findings for Northwest Connecticut:

1. There are only 95 school readiness spaces provided for preschool children in NWCT. These spaces are designated for three towns: Torrington (45), Winchester (35) and North Canaan (15). Given the large number of impoverished and low-income children in these communities, their school readiness allocation appears to be insufficient in relationship to the need.

2. A small number (50) of the total NWCT school readiness spaces are for full-day programs (10 hours per day). The other 45 are for school-day (6 hours per day) and part-day (2.5 hours per day) programs.

Students' Chronic Absenteeism from School (grades PK – 8)
School Year 2017 – 2018

What this Indicator is:

Chronic absenteeism is defined by CT state statute as "missing ten percent or more of the academic year for any reason, including excused and unexcused absences, suspensions and time missed due to changing schools."

Why this Indicator is Important:

Learning is a daily progression of mastering concepts and information. When a student is consistently missing time from school, the learning process is disrupted. Over time this can negatively impact students' academic performance as well their attitude and behavior at school.

Long-term, a student who has an attendance issue is at greater risk of either dropping out of school or lacking the grades or motivation for pursuing higher levels of education. All of these outcomes can have adverse employment, health and behavioral consequences.

School PK stands for PreKindergarten	Grades	Absent – All Students	Number – High Need Students	Absent – High Need Students
Barkhamsted Elementary	PK - 6	3%	*	3%
Lee H. Kellogg (Canaan)	K - 8	9%	*	10%
Colebrook Consolidated	K - 6	1%	0	0%
Cornwall Consolidated	K - 8	4%	*	*
Hartland	PK - 8	1%	*	2%
Kent Center	PK - 8	4%	*	2%
Litchfield Center	PK - 3	4%	*	7%
Litchfield Intermediate	4 - 6	3%	*	5%
Litchfield Middle	6 - 8	6%	*	8%
Ann Antolini (New Hartford)	3 - 6	2%	*	5%
Bakerville Consolidated (New Hartford)	K - 2	4%	*	*
New Hartford Elementary	PK - 2	7%	*	14%
Botelle Elementary (Norfolk)	PK - 6	9%	*	14%
North Canaan Elementary	PK - 8	10%	*	15%
Goshen Center (Reg. 6)	PK - 6	3%	*	3%
James Morris (Reg. 6)	PK - 6	6%	*	11%
Warren Elementary (Reg. 6)	PK - 6	5%	*	*
Wamogo Regional (Reg. 6)	7 - 12	14%	31	22%
Northwest Regional Middle (Reg. 7)	6 - 8	*	*	*
Harwinton Consolidated (Reg. 10)	PK - 4	6%	8	9%
Lake Garda Elementary (Reg. 10)	PK - 6	2%	*	5%
Har-Bur Middle (Reg. 10)	5 - 8	4%	17	10%
Washington Primary (Reg. 12)	PK - 5	*	*	6%
Shepaug Valley (Reg. 12)	6 - 8	11%	26	18%
Bethlehem Elementary (Reg. 14)	PK - 5	8%	12	14%
Mitchell Elementary (Reg. 14)	PK - 5	3%	*	6%
Woodbury Middle (Reg. 14)	6 - 8	13%	25	22%
Salisbury Central	PK - 8	8%	9	12%
Sharon Center	PK - 8	7%	*	9%
East (Torrington)	PK - 5	9%	19	10%
Forbes (Torrington)	PK - 5	11%	*	13%
Southwest (Torrington)	PK - 5	11%	*	13%
Torringford (Torrington)	PK - 5	5%	22	7%
Vogel-Wetmore (Torrington)	PK - 5	13%	*	14%
Torrington Middle	6 - 8	19%	160	24%
Batcheller Early Ed Center (Winchester)	PK - 2	9%	*	11%
Pearson (Winchester)	3 - 6	5%	15	8%
Gilbert (Winsted)	6 - 8	*	*	*

State Target = <5%

CT State Department of Education EdSight and Words & Numbers Research, Inc.

* The data are suppressed to ensure confidentiality.

Students' Chronic Absenteeism from School (grades PK – 8)

Findings for Northwest Connecticut:

1. A third Of NWCT's elementary and middle schools had rates of absenteeism that were more than double the state's goal of less than 5% during the 2017-18 academic year. The student populations in twelve (12) of the 38 schools experienced absenteeism that averaged from 9% to 19%. Among the schools with the highest rates were Torrington Middle (19%), Wamogo Region 6 (14%), Woodbury Middle (13%) and Vogel-Wetmore (13%).

2. Absenteeism among high-need student populations was even more widespread. High-need students at 19 of the region's 38 elementary and middle schools had absenteeism rates more than double the state's target goal.

3. While high-need students at numerous elementary schools exhibited excessive absenteeism, the data suggest that the problem increases as children age. Absenteeism for elementary school high-need students ranged from 9% to 15%. However the highest rates of absenteeism for high-need students were at Torrington Middle (24%), Woodbury Middle (22%), Wamogo Region 6 (22%) and Shepaug Valley Regional 12 (18%).

Students' Disciplinary Actions (grades PK – 8)
School Year 2017 – 2018

What this Indicator is:

Disciplinary actions are normally tracked as a function of institutional suspensions and expulsions. The **Suspension/Expulsion Rate** is the percentage of students who received at least one in-school suspension, out-of-school suspension or expulsion during a school year.

Why this Indicator is Important:

Poor mental health, emotional immaturity, poor home environment, lack of interest in school activities and learning disabilities are among the common causes of disciplinary problems among children. Typically, disciplinary problems are manifested by disrespect, defiance, bullying and aggression.

Left uncorrected or inadequately addressed, discipline problems can have long-term consequences for young children. These can include low academic achievement levels, failure to graduate from high school, illegal behavior, anti-social attitudes and unstable employment history.

Students Disciplinary Actions (grades PK – 8)

School PK stands for PreKindergarten	Grades	Suspension/ Expulsion Rate	In-School Suspension	Out-of-School Suspension	Expulsions
Barkhamsted Elementary	PK – 6	0	0	0	0
Lee H. Kellogg (Canaan)	K – 8	NA	*	*	0
Colebrook Consolidated	K – 6	NA	*	*	0
Cornwall Consolidated	K – 8	NA	*	*	0
Hartland	PK – 8	NA	*	*	0
Kent Center	PK – 8	NA	*	0	0
Litchfield Center	PK – 3	NA	*	*	0
Litchfield Intermediate	4 – 6	NA	*	0	0
Litchfield Middle	6 – 8	10%	26	7	*
Ann Antolini (New Hartford)	3 – 6	NA	*	0	0
Bakerville Consolidated (New Hartford)	K – 2	0	0	0	0
New Hartford Elementary	PK – 2	NA	*	0	0
Botelle Elementary (Norfolk)	PK – 6	NA	*	0	0
North Canaan Elementary	PK – 8	NA	*	0	0
Goshen Center (Reg. 6)	PK – 6	NA	*	*	0
James Morris (Reg. 6)	PK – 6	NA	*	0	0
Warren Elementary (Reg. 6)	PK – 6	0	0	0	0
Wamogo Regional (Reg. 6)	7 – 12	7%	26	31	*
Northwest Regional Middle (Reg. 7)	6 – 8	3%	16	6	0
Harwinton Consolidated (Reg. 10)	PK – 4	0	0	0	0
Lake Garda Elementary (Reg. 10)	PK – 6	NA	*	0	0
Har-Bur Middle (Reg. 10)	5 – 8	5%	*	11	0
Washington Primary (Reg. 12)	PK – 5	NA	*	0	0
Shepaug Valley (Reg. 12)	6 – 8	5%	22	10	*
Bethlehem Elementary (Reg. 14)	PK – 5	0	0	0	0
Mitchell Elementary (Reg. 14)	PK – 5	3%	15	0	0
Woodbury Middle (Reg. 14)	6 – 8	4%	12	*	0
Salisbury Central	PK – 8	3%	10	*	0
Sharon Center	PK – 8	NA	6	0	0
East (Torrington)	PK – 5	NA	*	*	0
Forbes (Torrington)	PK – 5	2%	8	0	0
Southwest (Torrington)	PK – 5	2%	7	*	0
Torringford (Torrington)	PK – 5	2%	8	16	0
Vogel-Wetmore (Torrington)	PK – 5	0	0	0	0
Torrington Middle	6 – 8	15%	233	177	0
Batcheller Early Ed Center (Winchester)	PK – 2	5%	6	24	0
Pearson (Winchester)	3 – 6	4%	*	*	0
Gilbert (Winsted)	6 – 8	18%	202	44	0

State Target = <5%

CT State Department of Education EdSight and Words & Numbers Research, Inc.

* The data are suppressed to ensure confidentiality.

Findings for Northwest Connecticut:

1. NWCT's elementary schools had few disciplinary situations during 2017-18 that required either in-school or out-of-school suspensions.

2. Beginning in 6th grade however, it appears that more serious disciplinary problems emerge. The majority of the region's middle schools had suspension rates that exceeded the state target of less than five percent. Gilbert School (18%), Torrington Middle (15%), Litchfield Middle (10%) and Wamogo Regional (7%) were among those with high rates of suspensions.

3. During 2017-18, few NWCT schools had problems resulting in student expulsions. Only three schools reported expulsions and each had fewer than five cases.

Child Well-Being Sources

The following data sources were accessed in compiling this report.

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