

**Keeping Children on the
Path to School Success:
How is Connecticut Doing?**

September 2004

A REPORT ON THE STATE OF THE YOUNG CHILD

Acknowledgements



KEEPING CHILDREN ON THE PATH TO SCHOOL SUCCESS: HOW IS CONNECTICUT DOING?

A Report on the State of the Young Child: September 2004

Authored by: Frances Duran* and Susan Wilson*

Early Childhood DataCONNECTIONS

An initiative of the Child Health and Development Institute of Connecticut and the Connecticut Department of Social Services

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CT Commission on Children

Thomas Brooks*
Elizabeth Brown
Patricia Estill
Sharon Williams
Elaine Zimmerman

CT Association for Human Services

Jude Carroll*
Stephanie Mastrobuono

CT Voices for Children

Penny Canny*
Mary Alice Lee
Peg Oliveira*

Department of Children and Families

Jay Anderson
Mary Ann Dayton-Fitzgerald*
Celeste George
Lester Horvath
Steve Roe

Department of Education

Richard Cloud
Paul Flinter
Janet Foster
Diane Murphy
Joyce Staples*
Maria Synodi
Alison Zhou

Department of Public Health

Federico Amadeo
Eileen Boulay
Nancy Caruk
Marcie Cavacas*
Karen Frost
Donna Maselli
Lloyd Mueller
Ardell Wilson

Department of Mental Retardation

Alice Ridgway

Department of Social Services

Don Beltram
Steve Colangelo
Jan Miller
Peter Palermino*
Hilary Silver
Grace Whitney*

Words & Numbers Research

David Carroll*

Wheeler Clinic

Anna Figueroa*

Other Partners

Jim Farnam, Holt, Wexler & Farnam
Pamela Langer, United Way of CT
Stan McMillan, University of CT
Sam Stephens, Center for Assessment
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Sherri Sutera, United Way of CT

*Members of the Connecticut Early Childhood Indicators Team

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The Connecticut Early Childhood Indicators Team is staffed by the Early Childhood DataCONNECTIONS project, a public-private partnership between the Connecticut Department of Social Services and the Child Health and Development Institute of Connecticut. DataCONNECTIONS is working to promote well-informed decisions on policies and programs for young children by improving state agencies’ research capability. As part of this effort, DataCONNECTIONS is bringing together state agency staff, researchers, community advocates, service providers and legislators to identify and address some of the needs for better information on key early childhood issues. To learn more about this initiative, visit www.chdi.org



OVERVIEW

How are young children (birth to age 5) progressing toward success in school? It is a question that is piquing the interest of parents as well as policy makers and business leaders across the country because of the strong association between school success and lifetime achievement. Early learning and development set the stage for academic performance and help predict whether children will go on to drop out of high school, be dependent upon welfare, or commit crimes versus becoming healthier, more productive members of society. By highlighting trends and key findings at the state and local level in five critical areas affecting child development, this publication will help reveal how Connecticut's young children are faring and where action is needed to promote better outcomes.

This indicator report is unique in its focus on early childhood. Although there is much work that has been done on indicators in Connecticut, this publication is the first to specifically examine the well-being of young children. Taken together and tracked over time, this set of early childhood indicators can help policy makers and others take early steps toward preventing an achievement gap – in the first few years of a child's life.

EARLY CHILDHOOD AND SCHOOL SUCCESS

Preparing children for school success requires a multi-dimensional approach. Although learning ABCs and 123s is important, without good physical health and a strong foundation of social and emotional well-being, children are at risk for school failure. After all, barriers to learning come in all shapes and sizes, from delays in development to malnourishment to chronic fear of abuse. All must be considered and addressed if Connecticut is earnest in its desire to help all children succeed in kindergarten and beyond.

The emphasis on the first five years of life is critical in preparing children for school success. Research strongly supports this assertion. The Institute of Medicine's groundbreaking report, *From Neurons to Neighborhoods*, explains "[f]rom the time of conception to the first day of kindergarten, development proceeds at a pace exceeding that of any subsequent stage of life...What happens during the first months and years of life matters a lot...because it sets either a sturdy or fragile stage for what follows."

Fortunately, research has also shown that during this period of rapid development, children are responsive to well-designed and implemented interventions that address setbacks caused by poverty, physical and behavioral health problems and other threats to healthy development. The challenge for policy makers and program administrators is identifying the children in need of services and targeting funds efficiently so that these children are helped and put back on a trajectory for success.

ABOUT CONNECTICUT'S YOUNG CHILDREN

Of Connecticut's 3.4 million residents, approximately 270,000 (8%) are children under the age of 6. Half of the state's young children are concentrated in eight towns: Bridgeport, Hartford, Waterbury, Stamford, New Haven, Norwalk, Danbury and New Britain.

Approximately 70% of these young children live in married two-parent families. One in 5 young children lives in a single-parent family and nearly 1 in 10 lives with other relatives or non-relative caregivers.

Over two-thirds (68%) of young children in Connecticut (under age 5) are white, non-Hispanic. Hispanic and black children account for 15% and 12% of this population, respectively.

42,565 INFANTS
(under age 1)

86,090 TODDLERS
(ages 1 and 2)

139,729 PRESCHOOLERS
(ages 3, 4 and 5)

Source: US Census 2000



ABOUT THE EARLY CHILDHOOD INDICATORS


Using data that concentrate on young children in Connecticut helps to determine who is at risk, how effective state services are, and where opportunities for improvement within this population exist. To develop these data, Connecticut teamed up with the national “School Readiness Indicators Initiative” over the past two years through funding from the David and Lucile Packard Foundation.


Guided by research on what helps and hinders children’s preparedness for school, the Connecticut Early Childhood Indicators Team developed a set of over 20 critical indicators of progress, each touching on a key component of school readiness and helping to measure movement toward desired outcomes.


The indicators in this report are designed to measure trends over time. Since this is the first year of publication, in many instances the data will serve as a benchmark against which future progress can be measured. Where possible, Connecticut data is compared to national goals such as those set forth in the Healthy People 2010 initiative. Hopefully, the findings will initiate a dialogue about how to improve outcomes through policy and programmatic changes, and will inspire additional early childhood research to help answer lingering questions.


The indicators are grouped into five domains, which parallel five policy goals (outcomes) that are important stepping stones to school success:

Health and Child Development:  All children are healthy

Safety and Child Welfare:  All children grow up in safe, stable and nurturing homes

Economic Stability:  All children live in economically self-sufficient families

Early Care and Education:  All children have access to quality early care and education

Ready Schools:  All children attend schools that continue to support their learning and development

This is the first indicator publication to specifically examine the well-being of young children in Connecticut. Hopefully, the findings and recommendations will inspire policy and programmatic changes targeted at improving outcomes, as well as additional early childhood research designed to answer lingering questions.



SUMMARY OF FINDINGS: How is Connecticut Doing?

Many Successes to Build Upon Exist

- Connecticut's immunization rate is #1 among all the states.
- The percent of children born to teens is declining.
- The child poverty rate is one of the lowest in the country.
- The supply of accredited early care and education programs is greater than in most states.
- The School Readiness program¹ has increased preschool attendance 5-24% in 15 of the 18 targeted School Readiness districts.

Young Children are Vulnerable

- They make up 42% of the children on welfare.
- They represent $\frac{1}{4}$ of the children in foster care.
- They suffer the highest rate of child deaths.
- They have higher child poverty rates than older children.

Racial and Ethnic Disparities Persist

- Black and Hispanic children have higher poverty rates than white children.
- Black and Hispanic mothers are less likely than white mothers to receive timely prenatal care.
- Black children are more than twice as likely as white children to die before their first birthday.
- Black and Hispanic teens are approximately 4 times more likely to give birth than white teens.
- Black women are twice as likely as white women to deliver low birthweight infants, despite recent improvements.

Many At-Risk Children are Concentrated in Low-Income Communities

- Over 178,000 (66%) children under age 6 live in Connecticut's most impoverished communities (Bridgeport, Hartford, New Britain, New Haven, New London, Waterbury and Windham).
- In these seven low-income municipalities:
 - half of all the state's teen births occur
 - one-third of all the state's infant deaths occur
 - nearly one-third of all the state's low birthweight babies are born
 - 30 to 50% of children do not benefit from a preschool experience
 - children score far below their more affluent peers on state mastery tests

At-Risk Children Also Reside in Small Towns and Affluent Communities

- Although the numbers of young children in poverty are low in small towns, a closer look reveals that in some of these communities the percent of young children in poverty is quite high: Sharon (30%), Morris (16%) and Eastford (14%).
- Despite the fact that impoverished young children represent a small share of the population in more affluent communities, pockets of poverty do exist in communities like Greenwich (205 children) and West Hartford (226 children).
- Over a three year time period (1999 to 2001²):
 - More than 400 mothers in Fairfield, Glastonbury, Greenwich and West Hartford gave birth without receiving timely prenatal care.
 - Roughly 430 babies (6%) were born at low birthweight in these same wealthy communities.

How can we do better for Connecticut's children? Within each indicator section, policy and practice recommendations are highlighted that identify key strategies and service components needed for improvement.



NEXT STEPS: Clearing the Path to Success

The indicators presented in this report show many bright spots, but with children's best interest in mind, we must take aim at the deficiencies highlighted. Thankfully, young children are resilient and with well-designed and implemented interventions, policy makers, program administrators and practitioners can help those children who are falling behind catch up to their peers.

Some critical areas for intervention include:

- **Foster care** – 1,600 young children are in the system and need permanent placement in safe, stable and nurturing homes.
- **Poverty** – Nearly 30,000 young children live in poverty and require comprehensive services to help counteract the many negative consequences of growing up poor.
- **Births to teens** – Over 3,000 babies are born each year to teen mothers, highlighting the need to expand proven teen pregnancy prevention programs and support teens in their parenting role so their children can thrive.
- **Comprehensive screenings and treatment** – To prevent unnecessary setbacks in a child's development, all children should receive comprehensive screenings that monitor health, social/emotional well-being and developmental progress and have access to appropriate treatment when problems are detected.
- **Quality early care and education** – Ensuring access to quality child care programs would help over 40,000 children each year reach kindergarten ready to learn.
- **Racial and ethnic disparities** – Black and Hispanic children fare worse than white children on multiple measures, heightening the need for culturally competent intervention strategies.
- **Family supports** – Strong, healthy families are a critical component of a child's success, underscoring the need to help families achieve economic self-sufficiency and to educate parents about ways to give their children a good start in life.

How can we achieve successful interventions? How can we do better for Connecticut's children? Within each indicator section, policy and practice recommendations are highlighted that identify key strategies and service components needed to move toward effective solutions. Taken together, these recommendations seek to promote a systemic approach to addressing the early childhood issues raised in this report – an approach that factors in all aspects of child development, from health to safety to family economic security.

Luckily, the timing couldn't be better for pursuing systems change in the early childhood field. Connecticut has some significant efforts³ in the works that offer meaningful opportunities. Promising among these efforts is the collaborative initiative called Early Childhood Partners that is led by the Department of Public Health and funded by the federal government under a State Early Childhood Comprehensive System planning grant. It envisions a system of systems that holistically and comprehensively supports children, families and communities. It has the potential to recommend the changes in funding, service delivery, practice and infrastructure that will significantly impact the issues raised by this report.

In addition, two recently created state-level bodies provide opportunities to integrate public efforts and address the long-time fragmentation of early childhood services caused by categorical funding and a patchwork of service systems. Commissioners and heads of eight state agencies comprise the State Prevention Council⁴ whose mission is to develop an overall state prevention plan and budget and set goals to promote the health and well-being of children and families. Also, executive and legislative members of the newly-formed Child Poverty Council are charged to “develop a ten-year plan to reduce the number of children living in poverty in the state by fifty percent.”⁵ Both of these bodies are addressing early childhood issues in their planning.

It will surely take leadership and hard work of many stakeholders to reform the early childhood systems. Marking the progress of that journey through indicators will be essential to keeping all of us, especially our children, on the path to success.



INFORMATION GAPS

The indicators selected for this report represent a good starting point for tracking progress, but additional data is needed to deepen our understanding of how young children in Connecticut are doing. Throughout the development of this publication, critical gaps in data availability have surfaced which undermine the ability to examine children's early development more holistically.

One of the most pervasive data issues is the absence of reliable data on key factors that contribute to a young child's development. Some critical information gaps include:

- the status of young children's social and emotional health
- the prevalence of young children receiving developmental assessments and adequate follow-up services when problems are detected
- the length of stay in foster care for young children and the number of different placements experienced while in the foster care system
- the staff turnover rate and provider wages in early care and education centers
- the supply of kindergarten teachers with certification in early childhood education

In other instances, only aggregated data on all children (under age 18) is available preventing analysis of the specific impact on young children. Such barriers exist when trying to examine income for families with young children and (un)insurance rates among children under age 6. Other data problems are evident when trying to obtain a holistic view of how all young children are doing, not just those receiving services through publicly-funded programs (like Medicaid). Throughout the publication, information gaps are highlighted. The list is not exhaustive, but the intent is to raise awareness of additional data needs and help further data collection and analysis, as well as development of an early childhood research agenda.

Accessing available data can also be a challenge. While tools like the Annie E. Casey Foundation's *KIDS COUNT Census Data Online* interactive data site (<http://www.aecf.org/kidscount/census/>) provide relatively easy access to demographic, income and other data from the Census, not all data retrieval is so user-friendly. State agencies do publish some standardized reports online, but they are often not available in a format that one can manipulate for further analysis (e.g. electronic spreadsheets, which enable the user to sort the data in a different way). Furthermore, the timeliness of the data varies from agency to agency. In some cases, the most current data is three years old.

The indicators selected for this report represent a good starting point for tracking progress, but additional data is needed to deepen our understanding of how young children in Connecticut are doing.



Developing several of the indicators presented in this report required special requests from numerous state agencies to obtain unpublished data. Significant effort went into analyzing a special extract of early care and education provider data from Child Care Infoline, an administrative database containing information on child care facilities in the state. In addition to producing data on key indicators, this process illustrated the unrealized potential that many administrative databases possess for informing key policy issues.

State administrative databases house a wealth of information that, if effectively harnessed, analyzed and shared, could provide valuable insights for policy makers and others making decisions affecting young children. The DataCONNECTIONS project is working with state agencies toward this end. For more information and a listing of data-enhancement recommendations, see the 2003 report *Reshaping Administrative Databases for Policy-Relevant Research* available at www.chdi.org.

In addition to modifying existing state agency databases, additional data collection and analysis is needed. Policy makers can have a significant impact on data improvement by promoting data collection that addresses many of the information gaps outlined in this publication and encouraging coordinated data collection in legislation. More and better data collection will help provide a deeper look at how children are doing and support efforts to improve and coordinate service systems.

Beyond the specific data recommendations suggested above and throughout this report, the state should consider building the infrastructure, processes and analytic capacity to make better use of administrative data. Connecticut could improve its research and data analysis capacity and its public policy planning with the following initiatives:

- 1. Build a foundation of commitment** from state agencies and other key stakeholders (e.g. legislators, who mandate data collection) for developing databases that support policy-relevant research
- 2. Adopt a set of core indicators on early childhood** that will inform policy development and tract state service systems and child outcomes and report on those indicators consistently
- 3. Invest in data analysis and research** within state agencies and across service systems.

It will surely take the leadership and hard work of many stakeholders to improve outcomes for Connecticut's young children. Marking the progress of that journey through indicators will be essential to keeping all of us, especially our children, on the path to success.

NOTES AND REFERENCES

1 Connecticut's School Readiness program was created in 1997 to provide high-quality preschool services in accredited or approved programs for three- and four-year old children in urban and high poverty districts or in high-need schools within other districts.

2 2001 is the most recent year for which data is available.

3 Notable public and private planning initiatives are addressing universal access to preschool, infant and toddler care and development, infant mental health, child care provider career ladders in addition to ongoing efforts to improve current services.

4 Public Acts 01-121 and 03-145

5 Public Act No. 04-238





STEPPING STONE 1: HEALTH AND CHILD DEVELOPMENT

Goal: All children are healthy





INDICATOR: Maternal Health

DEFINITION: The *Maternal Health* indicator includes two data measures. *Late or No Prenatal Care* examines births to women that do not initiate prenatal care until the 2nd or 3rd trimester of pregnancy or at all. *Smoking During Pregnancy* measures births to mothers who reported that they smoked during pregnancy.

SIGNIFICANCE: Maternal health, particularly during pregnancy, has strong implications for children's health, development and chances for success. Before children are born, mothers can increase the chances of a healthy birth by following medically recommended diet and exercise guidelines, receiving timely prenatal care check-ups and refraining from risky behaviors, such as smoking.

Initiating prenatal care in the first trimester and adhering to the recommended schedule of check-ups is an effective way for mothers to reduce the risk of infant mortality and a host of other negative child health and development outcomes. Prenatal care visits offer an opportunity for health professionals to screen for complications and intervene when necessary to improve the health of both mother and child. Mothers who do not receive any prenatal care are three times more likely than mothers receiving adequate prenatal care to deliver low birthweight infants.¹ Children born at low birthweight are more likely to experience physical and developmental problems that can inhibit performance in many areas, including academics.

Babies born to mothers who smoke during pregnancy are also at a disadvantage. Compared to children of non-smokers, they are much more likely to suffer negative consequences such as low birthweight and Sudden Infant Death Syndrome (SIDS). In addition, smoking during pregnancy has been linked to increased learning and behavioral problems in children.²

HOW ARE WE DOING?

- There has been an unsteady decrease in mothers receiving late or no prenatal care over the last decade (11% decline overall from 1992 to 2001).
- Considerable racial and ethnic disparities exist. White mothers are twice as likely as black mothers and nearly three times as likely as Hispanic mothers to receive timely prenatal care. Percentages may be higher for minorities due to greater uninsurance and teen pregnancy rates.
- The percentage of pregnant women receiving late or no prenatal care has decreased across race and ethnicity, with the most noticeable improvement among black mothers.
- There has been a steady decline in mothers reporting smoking during pregnancy since data collection began in 1995. Racial disparities have greatly decreased and Hispanic women consistently report less smoking than do white or black women. However, mothers enrolled in Medicaid are more than four times as likely as other mothers to report smoking during pregnancy.³
- According to the state's most recent data, 93% of children are born to mothers who abstained from smoking during pregnancy. This is still below the national Healthy People 2010 goal of 99%. Approximately 3,000 Connecticut children are born each year to smokers.
- From 1999 to 2003, the number of children born to mothers with HIV declined 27% (from 70 to 51). Of those children, approximately 3% were confirmed as having contracted the disease through perinatal exposure.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Support efforts to promote access to and utilization of preventive health care, particularly for pregnant women. This would include reducing the number of uninsured families and improving health education so that women are more aware of the early signs of pregnancy.
- Increase the Medicaid eligibility level for pregnant women from 185% of the federal poverty level to at least 200%. Other New England states have already done this, including Massachusetts, Maine, Vermont (all 200%) and Rhode Island (250%).
- Fully implement presumptive eligibility for pregnant women so that expectant mothers seeking health care through Medicaid can access services immediately with minimal documentation rather than encountering long waiting periods while the formal eligibility process takes place.
- Develop and/or expand upon successful strategies to improve the timing and frequency of prenatal care visits among Hispanic women.
- Encourage health care professionals to use proven prenatal smoking cessation models in their practices, such as the “5 A’s” counseling approach.⁴
- Ensure that smoking cessation services for pregnant women are covered through private and public health insurance.

**Children Born to Mothers with HIV and Current HIV Status
Connecticut, 1999-2003**

Year	# Born	# Confirmed with HIV	# with Unknown HIV Status	% Confirmed with HIV
1999	70	5	2	7.4%
2000	76	2	3	2.7%
2001	65	2	9	3.6%
2002	63	0	19	0%
2003	51	0	28	0%

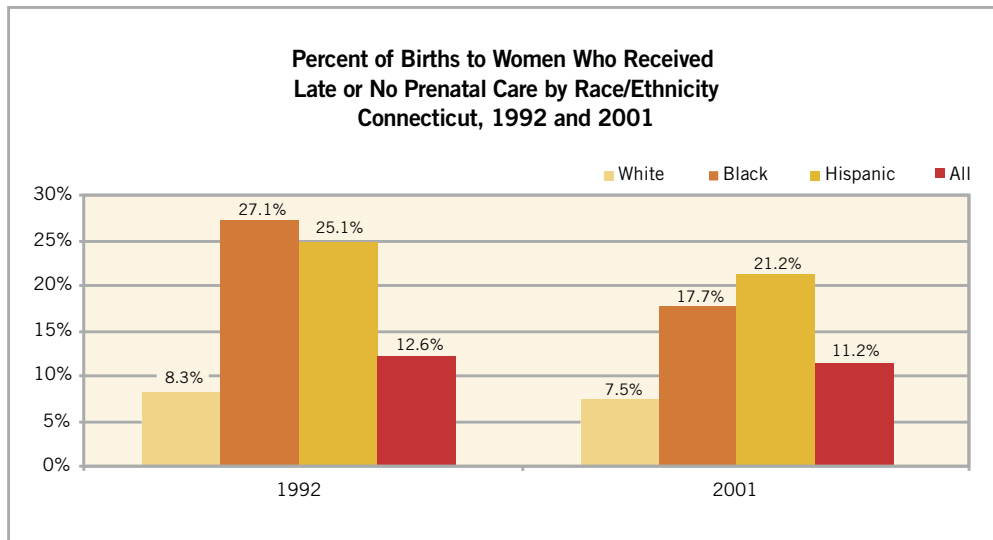
Source: Connecticut Department of Public Health, data collection through June 30, 2004.

ADDITIONAL MATERNAL HEALTH ISSUES

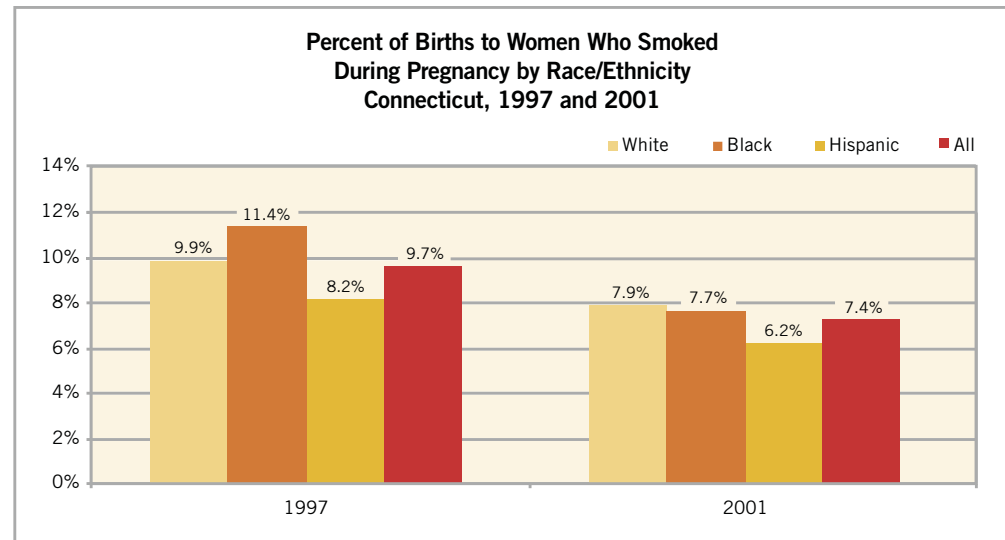
Other maternal health factors, like mental health and oral health, are also important to child development. Children whose mothers are depressed are more likely to have behavioral, academic and health problems than children whose mothers do not suffer from depression.⁵ With respect to oral health, mothers with dental problems can transmit the bacteria that causes tooth decay to their babies. In addition, research suggests that mothers have a strong impact on their young children’s dental health, given parental influence on children’s oral hygiene and diet.⁶



INDICATOR: Maternal Health (continued)



Source: Connecticut Department of Public Health, Registration Reports, 1992 and 2001. (Data for 2001 are provisional).



Source: Connecticut Department of Public Health, Registration Reports, 1997 and 2001. (Data for 2001 are provisional).
Note: Data collection began in 1995, therefore a five-year comparison rather than a ten-year comparison is provided.

The percentage of pregnant women receiving late or no prenatal care has decreased across race and ethnicity, with the most noticeable improvement among black mothers.

Births to Women Receiving Late or No Prenatal Care
 (Towns/cities with percentages that rank in the top quartile of the state are displayed)
Connecticut, 1999-2001

Town/City	Total Number of Births with Late or No Prenatal Care	% of Births with Late or No Prenatal Care (three-year average)
Lebanon	55	25.7%
New London*	239	21.3%
New Britain*	630	21.3%
Cornwall	6	20.0%
Waterbury*	940	19.9%
Bridgeport*	1,229	19.7%
Hartford*	1,243	19.6%
Meriden	429	18.9%
New Haven*	954	18.2%
Windham*	167	17.5%
Salisbury	16	17.2%
Norwich	223	15.6%
Bozrah	12	15.2%
East Hartford	287	15.0%
Killingly	98	15.0%
Middletown	233	14.2%
Sharon	8	14.0%
Groton	270	13.9%
Sterling	15	13.0%
West Haven	246	12.8%
Franklin	7	12.7%
Thompson	30	12.7%
Putnam	40	12.5%
Ledyard	54	12.3%
Berlin	67	12.2%
Kent	11	11.7%
North Canaan	11	11.6%
Norwalk	425	11.6%
Hampton	6	11.5%
Stamford	599	11.4%
Cromwell	44	11.0%
Ashford	14	10.9%
Connecticut	13,519	10.9%
Bloomfield	62	10.8%
Wilton	67	10.6%
Marlborough	22	10.3%
Pomfret	13	10.2%
Lyme	6	10.2%
Vernon	102	10.2%
Plainfield	57	10.2%
Newington	81	10.2%
Rocky Hill	55	10.1%
Chester	12	10.1%

For a full listing of towns/cities, see page 72.

Source: Connecticut Department of Public Health, unpublished data and Provisional Registration Reports, 1999-2001.

Note: Towns/cities with less than 5 births to women receiving late or no prenatal care over the three-year period are excluded due to the high degree of variability associated with small numbers.

*Denotes a town/city with over 15% of the population in poverty.

Indicator Notes and References

- 1 State of Connecticut Department of Public Health. (1999). *Looking Toward 2000: An Assessment of Health Status and Health Services*. Hartford, CT: Office of Policy, Planning, and Evaluation.
- 2 March of Dimes Birth Defects Foundation. (2004). *Fact Sheet: Smoking During Pregnancy*.
- 3 *Births to Mothers in HUSKY A: 2001*. (August 2003). Hartford, CT: Children's Health Council.
- 4 For more information on this approach, visit the National Partnership to Help Pregnant Smokers Quit at www.helpregnantsmokersquit.org/care/methods.asp
- 5 Ahluwalia, S.K., McGroder, S.M., Zaslow, M., & Hair, E.C. (2001). Symptoms of depression among welfare recipients: A concern for two generations. *Child Trends Research Brief, December 2001*. Washington, D.C.: Child Trends.
- 6 Sanchez, O. & Childers, N. (2000). *Anticipatory Guidance in Infant Oral Health: Rationale and Recommendations*. American Academy of Family Physicians. <http://www.aafp.org/afp/20000101/115.html>



INDICATOR: Infant Mortality

DEFINITION: *Infant Mortality* measures the number of children who die before their first birthday. This indicator is expressed as a rate – the number of infant deaths per 1,000 live births.

SIGNIFICANCE: Preventable infant mortality is one of the most basic indicators of a society's overall health and well-being. It is closely associated with factors such as maternal health, quality and access to health care, socioeconomic status and general public health conditions.

The majority of infant deaths in Connecticut (75%) occur during the neonatal period, when the infant is less than 28 days old¹. Neonatal infant deaths are most likely due to conditions of pregnancy and delivery, whereas post neonatal deaths (29 to 365 days old) are likely to stem from environmental conditions and inadequate access to health care.

HOW ARE WE DOING?

- Statewide, infant mortality rates have declined over the past decade to 6.1 deaths per 1,000 live births and Connecticut's rates are slightly better than the national average.
- Connecticut still needs to reduce infant mortality significantly in order to reach the national Healthy People 2010 goal - 4.5 deaths per 1,000 live births.
- Racial disparities are escalating. The most recent data (2001) show that black children are more than three times as likely as white children to die before their first birthday. Further, infant mortality rates between 1999 and 2001 increased 56% for black children, while rates declined 19% among white and Hispanic children.
- Infant mortality rates are particularly high in low-income communities. Over one-third of infant deaths between 1999 and 2001 occurred in Connecticut's most impoverished municipalities (Bridgeport, Hartford, New Britain, New Haven, New London, Waterbury and Windham).

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Promote initiatives that focus on reducing infant mortality, particularly those using culturally-sensitive strategies that target racial and ethnic minorities.
- Improve access to adequate prenatal care, particularly in low-income communities, as research has shown a strong association between prenatal care and birth outcomes. Examine barriers to access such as lack of insurance and inconvenient provider locations and office hours.
- Implement community-specific interventions recommended by the local Fetal and Infant Mortality Review committees.²
- Support programs that work to modify risky behaviors known to contribute to infant mortality, such as smoking, alcoholism or other substance abuse.

Infant Mortality Rate, 2001
(infant deaths per 1,000 live births)

United States	6.8
Connecticut	6.1

Source: *Kids Count Data Book: State Profiles in Child Well-Being 2004*. (2004). Baltimore, MD: The Annie E. Casey Foundation.

Infant Deaths

(Towns/cities with infant mortality rates that rank in the top quartile of the state are displayed)
Connecticut, 1997-2001

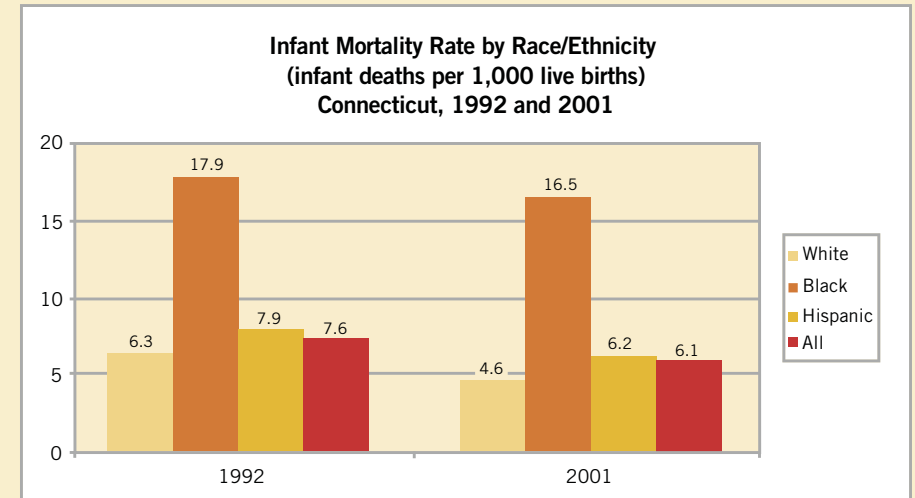
Town/City	Total Number of Infant Deaths	Infant Deaths per 1,000 Live Births (five-year average)
Middlefield	5	23.8
Windsor Locks	10	14.8
Old Lyme	5	14.5
Ledyard	10	13.1
Hartford*	144	13.0
Plainville	11	12.7
Bridgeport*	141	12.2
New London*	23	12.0
Coventry	9	11.8
Windsor	19	11.6
Bloomfield	11	11.2
East Hartford	37	11.2
Putnam	6	11.2
Plainfield	10	10.7
Stafford	7	10.6
New Britain*	52	10.4
Vernon	17	10.1
Killingly	11	9.9
Waterbury*	78	9.5
Griswold	5	9.3
Granby	6	9.2
New Haven*	84	9.0
Ansonia	11	8.9
Tolland	7	8.3
Milford	25	8.0
Norwich	19	8.0
East Haven	13	7.8
Suffield	5	7.7
Farmington	9	7.5
Madison	7	7.5
Windham*	11	6.9
West Haven	24	6.9
Stratford	19	6.6
Connecticut	1,422	6.6
Rocky Hill	6	6.4
Trumbull	13	6.4
Simsbury	7	6.4
East Windsor	5	6.4
Middletown	18	6.4
Torrington	13	6.4
Avon	5	6.0
Groton	20	6.0

For a full listing of towns/cities, see page 72.

Source: Connecticut Department of Public Health, Registration Reports, 1997-2001.
(Data for 1999-2001 are provisional).

Note: Towns/cities with less than 5 infant deaths over the five-year period are excluded due to the high degree of variability associated with small numbers.

*Denotes towns/cities with over 15% of the population in poverty.



Source: Connecticut Department of Public Health, Registration Reports, 1992 and 2001.
(Data for 2001 are provisional).

Note: Hispanic children may be included in any race category.

Indicator Notes and References

Due to small cell sizes, the infant mortality rate used here is a five-year average rate, rather than a three-year average, as has been used frequently throughout this publication.

1 Connecticut Department of Public Health, 2001 Provisional Registration Report, Table 7.

2 Fetal Infant Mortality Review committees provide on-going community needs assessment and work to improve the health status of women and infants and reduce health disparities, particularly with respect to infant mortality, at the local level.

Stepping Stone 1: Health and Child Development



INDICATOR: Births to Teen Mothers

DEFINITION: *Births to Teen Mothers* measures how many children are born to mothers between the ages of 15 and 19.

SIGNIFICANCE: Children born to teenage mothers are at a great disadvantage compared to children whose mothers delay childbearing. Children born to teens are at greater risk for poor birth outcomes, particularly low birthweight. In addition, many teen mothers are single parents, which can increase financial burdens and limit the amount of time the mother has to spend with her child(ren). Furthermore, in many cases teen mothers do not finish high school and lack the parenting skills necessary to foster healthy child development. As a result, children of teen mothers are more likely to experience health problems, live in poverty, and perform poorly in school.¹

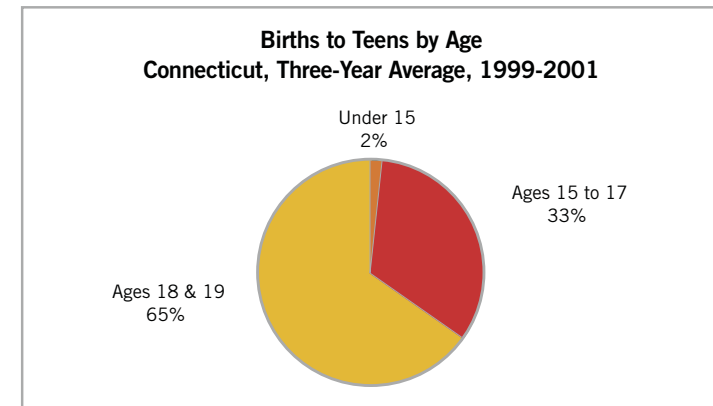
For mothers who bear more than one child during their teenage years, the likelihood of completing high school and moving out of poverty are greatly reduced. Between 1999 and 2001, over 22% of births to Connecticut teens ages 18 and 19 were repeat births. Teen pregnancy is most prevalent in low-income communities and among Hispanic girls.

HOW ARE WE DOING?

- In the past decade, there has been an overall decline in births to teens statewide and among minorities.
- Marked racial and ethnic disparities still exist. The latest data show that 18% of all Hispanic children are born to a teen mother, compared to only 4% of white children. Black teens are nearly four times as likely to give birth as white teens.
- Teen pregnancy remains prevalent in low-income communities. From 1999 to 2001, births to teens accounted for more than 10% of all births in each of Connecticut's seven most impoverished municipalities. In Hartford, more than one in five births was to a teenage mother.
- The number of repeat births to teens, particularly girls ages 18 and 19, is high. Nearly 18% of all births to teens between 1999 and 2001 were to girls who already had one or more children.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Support programs that improve school performance, particularly in communities with high teen pregnancy rates, as research has shown poor academic achievement is one key predictor of teen pregnancy.
- Promote proven abstinence/sex education programs that help delay the onset of sexual activity among male and female adolescents, so that more children will be born to parents who are better prepared to handle the demands of childrearing.²
- Ensure that pregnancy prevention programs employ key elements such as providing basic information on the risks associated with teen sexual activity, addressing social pressures toward having sex and enabling program participants to practice communication and refusal skills.³
- Promote public awareness campaigns, like Girl Power⁴ that take a comprehensive approach to preventing teen pregnancy and other risky behaviors. Campaigns should address health issues as well as the erosion of self-confidence, motivation, and opportunity that is typical for many girls during the transitional period of 9 to 13 years of age.



Source: Connecticut Department of Public Health, Provisional Registration Reports, 1999-2001.

Births to Teens Ages 15 to 19

(Towns/cities with percentages that rank in the top quartile of the state are displayed)
Connecticut, 1999-2001

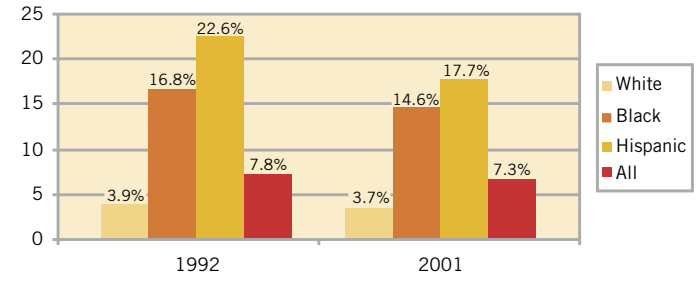
Town/City	Total Number of Births to Teens	% of Births to Teens (three-year average)
Hartford*	1,366	20.8%
New Britain*	563	18.6%
Windham*	173	17.9%
New Haven*	946	16.6%
Bridgeport*	1,130	16.2%
Waterbury*	756	15.4%
Meriden	314	13.7%
New London*	154	13.6%
Killingly	88	13.3%
North Canaan	12	12.6%
Norwich	167	11.7%
West Haven	225	11.0%
Winchester	46	10.8%
Plainfield	61	10.7%
East Hartford	210	10.7%
Groton	195	9.8%
Canterbury	14	9.2%
Franklin	5	9.1%
Ansonia	66	8.8%
Bloomfield	51	8.7%
Vernon	85	8.3%
Griswold	28	8.3%
Thompson	22	7.9%
Chaplin	5	7.9%
Sterling	9	7.8%
Bristol	173	7.8%
Putnam	26	7.7%
Derby	35	7.6%
Danbury	244	7.6%
Connecticut	9,747	7.6%
Torrington	93	7.4%
Bolton	11	7.4%
Manchester	149	7.4%
Sprague	7	7.1%
Windsor	68	7.0%
Windsor Locks	28	7.0%
Stafford	27	7.0%
Montville	38	6.9%
East Haven	65	6.7%
Brooklyn	11	6.5%
Stratford	107	6.3%
Voluntown	6	6.2%
Naugatuck	71	6.2%

For a full listing of towns/cities, see page 72.

Source: Connecticut Department of Public Health, unpublished data and Provisional Registration Reports, 1999-2001.

Note: Towns/cities with less than 5 births to teens over the three-year period are excluded due to the high degree of variability associated with small numbers.

Percent of Births to Teens Ages 15 to 19 by Race/Ethnicity Connecticut, 1992 and 2001



Source: Connecticut Department of Public Health, Registration Reports, 1992 and 2001. (Data for 2001 are provisional).

Repeat Births to Teens Ages 15 to 19 Connecticut, 1999-2001

Age	Total Number of Births	Total Number of Repeat Births	% of Repeat Births (three-year average)
15	408	11	2.7%
16	1,049	54	5.1%
17	1,817	185	10.2%
18	2,845	496	17.4%
19	3,628	956	26.4%
Total	9,747	1,702	17.5%

Source: Connecticut Department of Public Health, unpublished data, 1999-2001.

Indicator Notes and References

- 1 Maynard, R.A. (Ed). (1997). *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. Washington, DC: The Urban Institute.
- 2 For a discussion of evaluated teen pregnancy prevention programs and their efficacy, see *No Time to Waste: Programs to Reduce Teen Pregnancy Among Middle School-Aged Youth* at www.teenpregnancy.org
- 3 See Kirby, D. (2001). *Emerging Answers: Research findings on Programs to Reduce Teen Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy.
- 4 For more information, visit www.girlpower.gov



INDICATOR: Low Birthweight Infants

DEFINITION: *Low Birthweight Infants* examines how many infants weigh less than 2,500 grams (5 pounds 8 ounces) at birth.

SIGNIFICANCE: Low birthweight is a major determinant of infant deaths in developed countries. Compared to children born at a normal birthweight, low birthweight infants are more likely to experience physical and developmental problems,¹ to require special education classes or to repeat a grade.² Factors contributing to low birthweight include prematurity, multiple births (e.g. twins, triplets) and problems with fetal growth during pregnancy.

Low birthweight babies are more prevalent among mothers under age 20, mothers who smoked during pregnancy, mothers with a high school diploma or less and mothers who received late or no prenatal care. Poverty is also a risk factor for delivering low birthweight babies. Nationwide and in Connecticut, data also show that black women are most likely to deliver low birthweight infants.

HOW ARE WE DOING?

- Although the percent of low birthweight infants has declined or remained constant since 1998, overall there has been a 7% increase in babies born at low birthweight over the last decade.
- Additional progress is needed in order for Connecticut to reach the national Healthy People 2010 goal of only 5% of infants born at low birthweight. The most recent data indicates that the state is currently at 7.4%.
- In 13 of Connecticut's 169 municipalities, one out of every ten babies born between 1999 and 2001 was a low birthweight baby.
- While low birthweight births have decreased for both blacks and Hispanics over the last decade, among whites the numbers have increased. Part of this increase is likely attributable to the rise in multiple births stemming from fertility drug usage.
- Although progress has been made in reducing the number of low birthweight black babies, the latest data show that black women are still twice as likely as white women to deliver low birthweight infants.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Work to reduce low birthweight risk factors, particularly teen pregnancy, smoking during pregnancy and lack of adequate prenatal care.
- Bolster efforts that have proven effective for decreasing low birthweight among blacks and Hispanics so that the numbers will continue to decline. Promote programs, like the Hispanic Health Council's Comadrona program,³ which provide neighborhood outreach to Latina and black pregnant women and link them to health services.
- Increase outreach to uninsured women of childbearing age to inform them of the importance of early and comprehensive prenatal care and prenatal resources.
- Ensure that pregnant women eligible for Medicaid (HUSKY A) are enrolled and linked to care within 48 hours of completing an application.
- Encourage health care professionals to use a standardized risk assessment to identify women at highest risk for low birthweight babies.
- Strengthen the linkage between prenatal health care providers and social service agencies that provide case management and home visiting for high risk populations.

Percent of Low Birthweight Infants, 2001

United States	7.7%
Connecticut	7.4%

Source: *Kids Count Data Book: State Profiles in Child Well-Being 2004*. (2004). Baltimore, MD: The Annie E. Casey Foundation.

Low Birthweight Infants

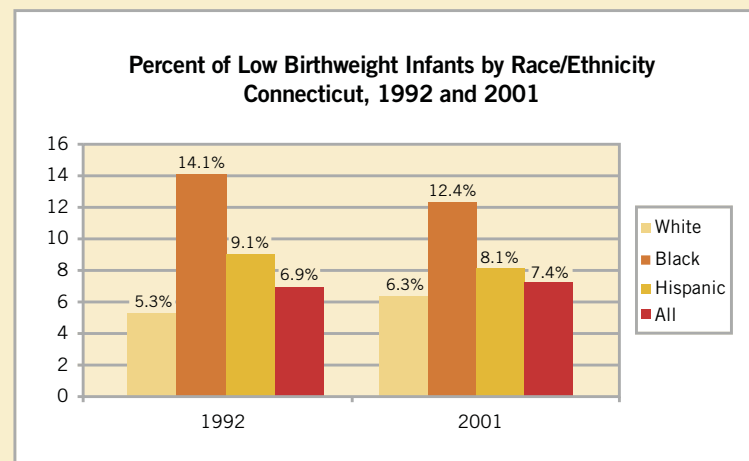
(Towns/cities with percentages that rank in the top quartile of the state are displayed)
Connecticut, 1999-2001

Town/City	Total Number of Low Birthweight Infants	% of Low Birthweight Infants (three-year average)
Norfolk	10	17.2%
Eastford	8	16.7%
Columbia	25	14.5%
Lyme	7	11.7%
Hartford*	765	11.7%
Ansonia	82	11.0%
Killingly	69	10.4%
New Haven*	585	10.2%
Andover	13	10.2%
Bridgeport*	700	10.1%
Thompson	26	9.7%
Salisbury	9	9.6%
Washington	9	9.5%
West Haven	193	9.5%
North Stonington	16	9.3%
Middlefield	12	9.2%
Goshen	5	9.1%
Waterbury*	445	9.1%
Windham*	87	9.0%
Windsor	87	9.0%
Bloomfield	52	8.9%
East Hartford	174	8.8%
Somers	23	8.8%
New London*	98	8.7%
Griswold	29	8.6%
Kent	8	8.5%
Winchester	36	8.5%
New Britain*	252	8.3%
Stratford	141	8.3%
Sharon	5	8.3%
Norwalk	314	8.3%
Berlin	46	8.3%
Guilford	55	8.1%
Killingworth	20	8.1%
Meriden	184	8.0%
Naugatuck	92	8.0%
Lisbon	8	7.9%
Plainfield	45	7.9%
Stamford	432	7.9%
Tolland	41	7.9%
Ledyard	34	7.8%
Torrington	97	7.7%
Hamden	145	7.7%
(note: 5 additional towns/cities are at or above the statewide average, but do not fall into the top quartile)		
Connecticut	9,599	7.5%

For a full listing of towns/cities, see page 72.

Source: Connecticut Department of Public Health, unpublished data and Provisional Registration Reports, 1999-2001.

Note: Towns/cities with less than 5 low birthweight infants born over the three-year time period are excluded due to the high degree of variability associated with small numbers.



Source: Connecticut Department of Public Health, Registration Reports, 1992 and 2001. (Data for 2001 are provisional).

Indicator Notes and References

1 Hediger, M.L., Overpeck, M.D., Ruan, W.J., and Troendle, J.F. (2002). Birthweight and gestational age effects on motor and social development. *Pediatric and Prenatal Epidemiology*, 16:33-46.

2 National Education Goals Panel. (1997). *Special early childhood report*. Washington, D.C.: National Education Goals Panel.

3 For more information on the Comadrona program, visit www.hispanichealthcouncil.com



INDICATOR: Access to Health Insurance and Preventive Care

DEFINITION: *Access to Health Insurance and Preventive Care* examines how many children are insured as well as how many children are receiving well-child visits and immunizations on a timely basis. The data on insurance coverage and well-child visits only reflects children on Medicaid (HUSKY A).

SIGNIFICANCE: Children with public or private health insurance are more likely than uninsured children to receive preventive care and to have a regular source of medical care (also known as a medical home).¹ In effect, health insurance is a gateway to preventive care. Access to both is critical, particularly for young children, to ensure monitoring of their development and to prevent unnecessary setbacks so they are healthy at school entry and beyond.

The majority of children are enrolled in private health insurance plans. Many low-income children in Connecticut receive health insurance through HUSKY A, the state's Medicaid program for children, which provides preventive care services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Other children are covered through HUSKY B (the state's non-Medicaid program for low- and moderate- income children) which also provides well-child services, although they are less extensive than those available through EPSDT. However, there are still thousands of children under age 18 from varying economic backgrounds who are uninsured² and without a regular source of health care.

Preventive care measures such as well-child visits and immunizations lay the groundwork for immediate and life-long health. Well-child visits that include health and developmental screenings help health care professionals diagnose and treat problems before they escalate to serious and ongoing medical conditions. Immunizations help prevent potentially life-threatening diseases such as polio and measles. Without access to preventive care and treatment, children are at greater risk for poor physical and developmental outcomes.

HOW ARE WE DOING?

- HUSKY A (Medicaid) enrollment increased 17% for young children (under age 6) from FY2000 to FY2002.
- In FY2002, nearly 90,000 young children were insured through HUSKY A for some length of time. The average length of enrollment for children under age 6 was less than 10 months cumulatively, indicating a lack of continuity of care.
- As of FY2002, the participation rate for children under age 6 in the EPSDT program was 72%³, suggesting that one in four young HUSKY A enrollees is not receiving screenings or other well-child services.
- One-third of infants and toddlers enrolled in HUSKY A are not receiving timely preventive care. The percentage increases to two-thirds for children ages 3 to 5.
- Currently, Connecticut has the highest immunization rate in the country and is the only state thus far that has achieved the national Healthy People 2010 goal - 90% of children through age 2 with up-to-date immunizations.

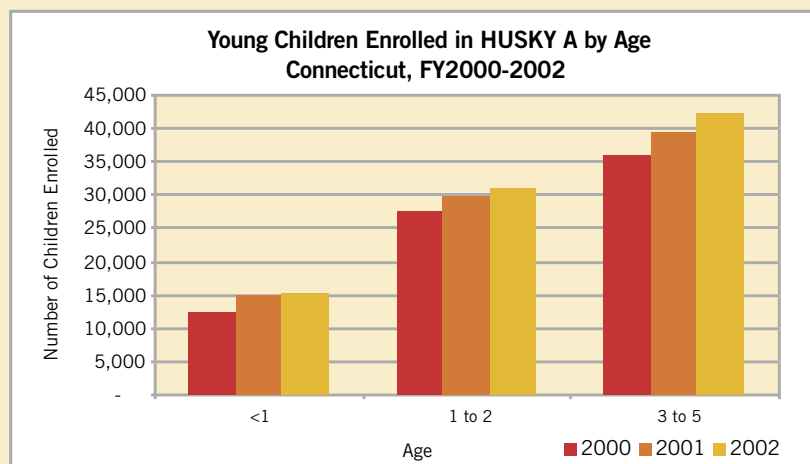
HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Build upon systemic approaches to increasing enrollment in the HUSKY program, like the Covering Connecticut's Kids and Families initiative.
- Improve the continuity of care in the HUSKY program so that children, especially young children, do not fall behind in receiving timely preventive care due to lapses in insurance coverage.
- Invest state funds in the HUSKY program so that children receive the primary and preventive care they need and health problems do not escalate to costly medical conditions.
- Increase the number of children who are screened and appropriately treated through the EPSDT program, as required by Medicaid (HUSKY A).
- Ensure that the screenings for all young children are family-centered, comprehensive and consistently address physical and social/emotional development.

Children without Health Insurance, 2001

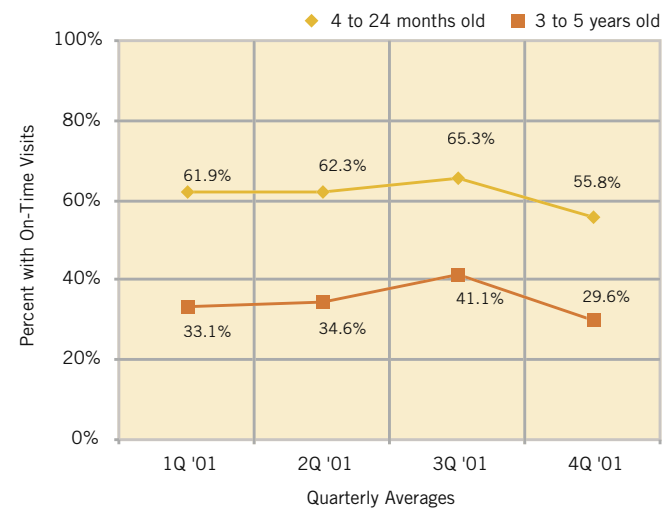
	Under 18	Under 6
United States	12%	?
Connecticut	8%	?

Source: Kids Count Data Book: State Profiles in Child Well-Being 2004. (2004). Baltimore, MD: The Annie E. Casey Foundation.



Source: Connecticut Department of Social Services, CMS Form 416, FY2000-FY2002.
 Note: "Enrollees" include those insured through HUSKY A for any length of time in the given fiscal year. Due to variations in length of enrollment, the reported number of enrollees tends to be higher than point-in-time estimates.

On-Time Well-Child Visits Among Young Medicaid (HUSKY A) Enrollees Connecticut, 2001

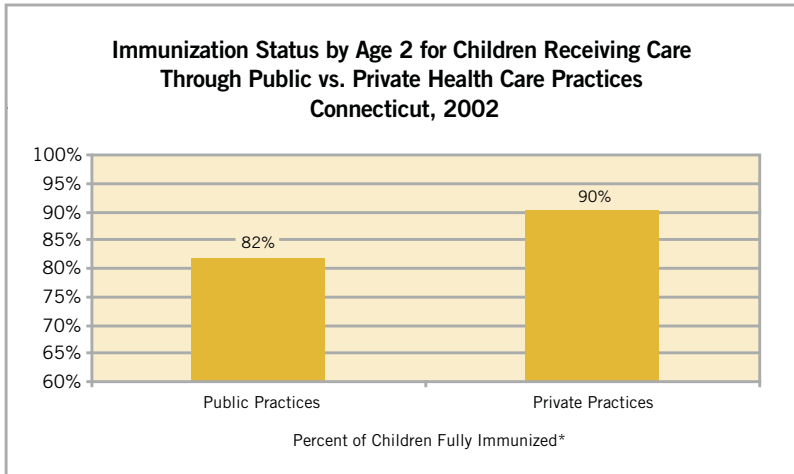


Source: Children's Health Council, EPSDT On-Time Visit Rates, First - Fourth Quarter 2001.

One-third of infants and toddlers enrolled in HUSKY A are not receiving timely preventive care. The percentage increases to two-thirds for children ages 3 to 5.



INDICATOR: Access to Health Insurance and Preventive Care (continued)



Source: Connecticut Department of Public Health, Immunization Program, 2002.
 Note: Data is for children born in the year 2000 who are enrolled in Connecticut Immunization Registry and Tracking System (CIRTS) and for whom utilization of public or private health care practices is determined. This data represents 74% of all children born in 2000.
 * Children completing the 4:3:1:3:3 immunization series are considered fully immunized.

Immunization Rates, July 2002-June 2003

United States	78%
Connecticut	91%

Source: US National Immunization Survey, Q3/2002 to Q2/2003. 4:3:1:3:3 Vaccination Series for Children Ages 19 to 35 months.

INFORMATION G - A - P - S

How many young children (under age 6) are uninsured?

How many children under age 6 are eligible for HUSKY A (Medicaid) but are still without insurance coverage?

Note: Answering these questions may require new data collection and/or methodologies to provide reliable estimates.

Connecticut has the highest immunization rate in the country and is the only state that has achieved the national Healthy People 2010 goal - 90% of children through age 2 with up-to-date immunizations.



SOCIAL AND EMOTIONAL HEALTH

A strong foundation of social and emotional health that equips a child with skills, such as the ability to cooperate and exhibit self-control, is key to readiness for school. Unfortunately, many children enter school without these necessary skills that facilitate learning. National estimates suggest that between 4 and 6 percent of preschoolers have serious emotional and behavioral disorders and between 16 and 30 percent pose on-going problems to classroom teachers.⁵ A special 2002 State Department of Education analysis of disciplinary offenses of children in kindergarten through third grade in Connecticut showed a steady increase in disruptive and aggressive behaviors that resulted in disciplinary actions for these young children.⁶

Catching social and emotional problems early can prevent behaviors that will derail school performance, making early identification, assessment and treatment important components of promoting healthy child development. Health care providers can play a pivotal role by including surveillance of social and emotional problems in comprehensive developmental screenings during well-child visits. Other prevention and early intervention strategies include helping parents

strengthen the early parent-child relationship and educating other caregivers, like child care providers, on how to promote positive social and emotional health.

In Connecticut, children enrolled in HUSKY A (Medicaid) are entitled to mental health screenings and treatment for diagnosed conditions through the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. In the field of early care and education, Early Head Start and Head Start devote many resources to fostering social and emotional well-being and the new Early Childhood Consultation Partnership program offers support, education and consultation on mental health to early childhood providers, young children and their families.

Despite recent progress in the field of young children's social and emotional health, there is still a scarcity of data. Additional research and regular data collection efforts are needed to develop a reliable and comprehensive picture of young children's mental health status, including how many children are screened, how many are identified as needing services and how many behavioral problems are detected for the first time in kindergarten and first grade.

Indicator Notes and References

The 4:3:1:3:3 vaccine series includes 4 DTP/DTap, 3 polio, 1 MMR on or after first birthday, 3 Hepatitis and 3 HIB.

1 Lewit, E.M., Bennet, C. & Behrmann, R.E. (2003). Health insurance for children: analysis and recommendations. *The Future of Children*, 13 (1): 5-30.

2 Current Population Survey, March 2003 Supplement, Table HI05.

3 Connecticut Department of Social Services, CMS Form 416, FY2002.

4 The window of time in which a visit is considered "on-time" varies by the age of the child and the frequency of recommended screens. For example, the window for a 4-month old infant is 15 days on either side of the infant's 4-month birthday (30 day window) while the window for a 5-year old is two months on either side of the birthday month (5 month window). For more information, see *EPSDT On-Time Visit Rates: First Quarter 2001* at www.childrenshealthcouncil.org.

5 Raver, C.C & Knitzer, J. (2002). *Ready to Enter: What Research Tells Policymakers About Strategies to Promote Social and Emotional School Readiness Among Three- and Four-Year-Old Children*. New York: National Center for Children in Poverty.

6 Sanders, M.R. & Lee, M.A. (2002). *Promoting Healthy Children & Families in Connecticut: Part 1: Health Problems of Infancy and Early Childhood*. Farmington, CT: Child Health and Development Institute of Connecticut.



INDICATOR: Lead Poisoning

DEFINITION: *Lead Poisoning* measures the number of children ages 1 and 2 that are screened for lead poisoning. Data is also provided for children ages 1 and 2 whose screening tests revealed elevated blood lead levels – at or above 10 micrograms of lead per deciliter of blood (ug/dL).

SIGNIFICANCE: Lead poisoning is a common pediatric health problem that can lead to learning disabilities, lowered intelligence or behavioral problems.¹ Children under age 6 are particularly susceptible to lead poisoning as their neurological systems and organs are still developing. With early detection and treatment of low levels, children can thrive. Yet children with chronic, high levels suffer significant and irreversible damage.

Lead poisoning or elevated blood lead levels are most commonly caused by inhalation of lead-contaminated dust or ingestion of lead-based paint chips. Exposure to lead-based paint is most likely in and around older homes, which are plentiful in Connecticut, although other sources exist (e.g. ceramic dishes, imported food cans, water pipes).

Screening for lead poisoning, especially among young children, is the first step in reducing the negative effects of lead exposure and preventing unnecessary setbacks in a child's development. In Connecticut, children enrolled in HUSKY A must be screened, at a minimum, at 12 and 24 months old. The same requirements do not extend to all children in the state. Yet, any child who is exposed to lead is at risk, stressing the need for a universal system of screening. A blood lead level at or above 10 ug/dL is high enough to negatively impact child development.

HOW ARE WE DOING?

- Lead screening rates for children ages 1 and 2 increased 18% from 2000 to 2002. Still, less than half (42%) of infants and toddlers across the state receive lead testing.
- Despite Connecticut's large supply of older homes (which are more likely to contain lead-based paint), in 50 towns and cities less than one in four children ages 1 and 2 were screened for lead poisoning between 2000 and 2002.

- Progress is still needed for Connecticut to achieve the national Healthy People 2010 goal of no children ages 1 to 5 with blood lead levels at or above 10ug/dL. In 2002, 2.5% of children screened exceeded this criteria, but only 26% of all children ages 1 to 5 in the state received a lead screening, limiting the representativeness of the data.²
- Although Connecticut's seven most impoverished communities accounted for only one-third of all children screened between 2000 and 2002, they accounted for 70% of the children identified with elevated blood lead levels. (For a full list of lead testing results by town, see page 72).

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Statewide, increase the number of young children screened during well-child visits for lead poisoning at key age intervals (12 months and 24 months).
- Encourage health care providers to conduct a standardized risk assessment of lead exposure for all children ages 6 months to 72 months during routine well-child visits.³
- Bolster public education campaigns on lead poisoning and underscore that any young child can develop lead poisoning, regardless of economic status, geographic location or race/ethnicity.

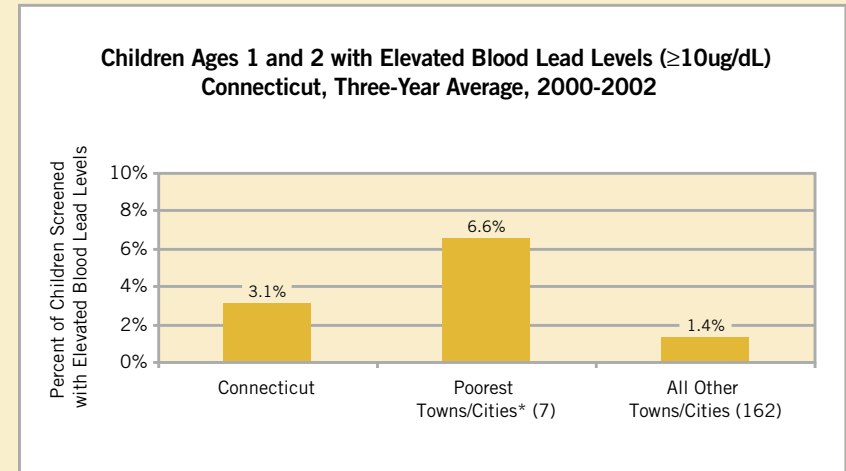
INFORMATION G - A - P

How many children identified with lead poisoning receive intervention services?

Lead Screening Rates for Children Ages 1 and 2
 (Towns/cities with lead screening rates below 25% or above 50% are displayed)
Connecticut, Three-Year Average, 2000-2002

% Screened	Town/City
Less than 10%	Andover, Columbia, Glastonbury, Goshen, North Canaan, Scotland, Torrington
10 – 15%	Bolton, Chaplin, Coventry, Greenwich, Hartland, Harwinton, Hebron, Litchfield, Mansfield, Marlborough, Newington, Norfolk, Rocky Hill, South Windsor, Union, Wethersfield, Willington, Winchester
16 – 24%	Ashford, Barkhamsted, Berlin, Burlington, Cornwall, Cromwell, East Hampton, East Windsor, Eastford, Ellington, Enfield, Farmington, Haddam, Hampton, Kent, Manchester, Morris, New Hartford, Salisbury, Sharon, Southington, Stafford, Tolland, Warren, Windsor Locks
42%	Connecticut
51 – 65%	Bozrah, Deep River, Easton, Fairfield, Killingly, Meriden, Monroe, New London*, Norwalk, Norwich, Old Lyme, Old Saybrook, Plainfield, Sprague, Stamford, Voluntown, Washington, Waterbury*, West Haven, Weston, Westport, Woodbury
66 – 75%	Bridgeport*, Essex, Hartford*, New Haven*, Westbrook
Over 75%	Canaan, Lyme
For a full listing of towns/cities, see page 72.	

Source: Connecticut Department of Public Health, Childhood Lead Poisoning Prevention Program, 2000-2002.
 Notes: Towns/cities with less than 5 children (ages 1 and 2) screened for lead over the three-year time period are excluded due to the high degree of variability associated with small numbers.
 *Denotes a town/city with over 15% of the population in poverty.



Source: Connecticut Department of Public Health, Childhood Lead Poisoning Prevention Program, 2000-2002.
 Note: This data only includes children who were screened for lead (42% of all children age 1 and 2 statewide).
 *Includes towns/cities with over 15% of the population in poverty.

Indicator Notes and References

- 1 Federal Interagency Forum in Child and Family Statistics. *America's Children: Key National Indicators of Well-Being*. 1998. Federal Interagency Forum on Child and Family Statistics. Washington, DC. <http://www.childstats.gov/ac1998/spectxt.asp>
- 2 Connecticut Department of Public Health Childhood Lead Poisoning Prevention Program, 2002.
- 3 For a list of suggested risk assessment questions for health care providers, see *Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut* (August 2001) at <http://www.dph.state.ct.us/Publications/BCH/EEOH/recommendations.pdf>



INDICATOR: Children with Special Needs

DEFINITION: *Children with Special Needs* examines the prevalence of young children in the state with developmental delays, as well as physical, behavioral and/or emotional disabilities. This indicator measures infants and toddlers enrolled in the state's early intervention system – the Connecticut Birth to Three System – as well as children ages 3 to 5 enrolled in Special Education programs within the public school system.

SIGNIFICANCE: Children with special needs are those who have a physical, developmental, behavioral and/or emotional disability that requires services above and beyond those needed by a typically-developing child. Early intervention for children with special needs or at risk of developing a special need can help with remediation or prevention of conditions. A significant body of research has shown that early intervention (targeted at school-age children or younger) reduces the need for special education and other rehabilitative services as well as grade retention.¹

In Connecticut, early intervention programs coach families with children that have developmental delays or disabilities so they can support their child's development. The Connecticut Birth to Three System provides early intervention services to families of infants and toddlers who have developmental delays or disabilities. For children ages 3 to 5 whose special needs interfere with their ability to learn, services are offered through the Local Education Agencies (local school districts' special education programs). Early intervention has proven effective. On average, 30% of children exit the Birth to Three System each year because no further services are needed.

HOW ARE WE DOING?

- In FY2003, over 9,400 infants and toddlers received early intervention services through the Birth to Three System due to developmental delays or diagnosed conditions likely to result in developmental delays (e.g. Fetal Alcohol Syndrome or Down Syndrome).
- One in four infants and toddlers referred to the Birth to Three System in FY2003 due to developmental concerns did not meet the eligibility criteria for receiving services. In FY2004, the number increased to one in three children due to the implementation of stricter eligibility criteria.

- During the 2003-2004 school year, over 8,000 children ages 3 to 5 received special education and related services through the public school system. Most of them were receiving services due to a developmental delay.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Heighten awareness among parents and caregivers of the critical development that takes place in utero and in the first five years of a child's life, as well as resources that are available (e.g. Help Me Grow²) if they are concerned about how a child is developing.
- Improve access to early intervention by expanding the eligibility criteria in the Birth to Three System. At a minimum, this would include reversing the recent changes that compressed eligibility on the basis of extremely low birthweight from less than 1000 grams to less than 750 grams (1 lb, 10 oz.).
- Support and promote programs that enhance the developmental surveillance skills of pediatric practitioners, so that problems are detected and children are referred for services as early as possible.

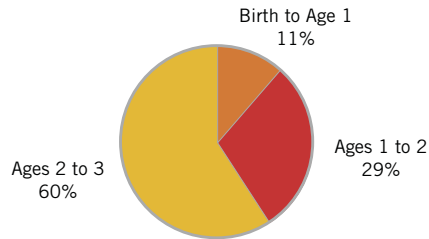
i INFORMATION G - A - P - S

How many children with developmental delays or other special needs are not identified until kindergarten entry or later?

(Note: The state Departments of Education and Mental Retardation are working on data enhancements that may help address this information gap.)

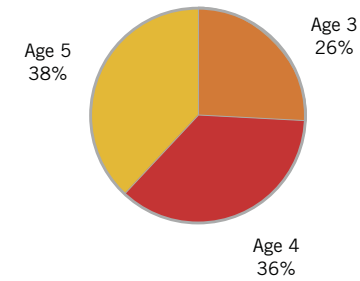
What percent of children who received early intervention services to address developmental delays later achieved learning milestones in preschool or early elementary grades?

Infants and Toddlers Receiving Early Intervention Services Through the CT Birth to Three System, by Age Connecticut, December 2003



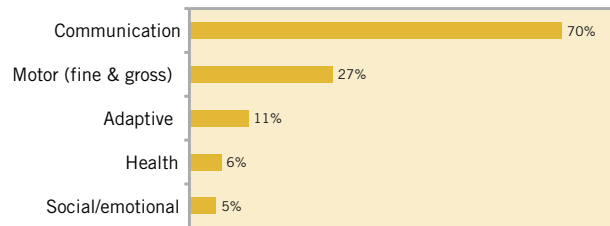
Source: Connecticut Birth to Three System, as of December 1, 2003.

Children Receiving Special Education and Related Services, by Age Connecticut, 2003-2004 School Year



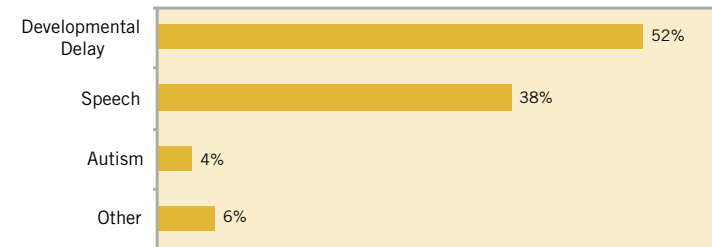
Source: Connecticut Department of Education, Preliminary Data, 2003-2004.

Developmental Concerns Among Children Referred to the CT Birth to Three System Connecticut, FY2003



Source: Connecticut Birth to Three System, FY2003.
 Note: Total percentages exceed 100 because there can be more than one concern for any one child.

Disabilities Among Children Ages 3 to 5 Receiving Special Education and Related Services Connecticut 2003-2004 School Year



Source: Connecticut Department of Education, Preliminary Data, 2003-2004.

Indicator Notes and References

- 1 Smith, B. (1988). *Does Early Intervention Help?* Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.
- 2 The Help Me Grow program is designed to help families and providers access appropriate services for young children (birth to 5) who are at risk for developmental, health or behavioral problems. The components of the program include: a statewide toll free telephone number for accessing needed care (Child Development Infoline); partnerships with community-based agencies throughout the state; and child development community liaisons that serve as a conduit between the community-based services and the telephone access point.



INDICATOR: Strong Families

DEFINITION: *Strong Families* examines two family factors that contribute to healthy child development – maternal education and parenting education and support. The indicator *Maternal Education* measures the number and percent of births to mothers with less than a high school diploma. Data on parenting education and support through the Connecticut Parents as Teachers program provides a snapshot of families and children served, as aggregate statewide data across programs is not available.

SIGNIFICANCE: Families play a vital role in a child’s development. Young children in particular are completely dependent upon their families to help them grow physically, emotionally and cognitively. Parents who provide a stable, loving home and interact frequently with their children through developmentally appropriate play help foster positive child outcomes, like self-esteem and literacy skills. Developing strong parenting skills and completing secondary education can help families achieve a healthy home environment in which children can thrive.

Given the pivotal and challenging role that parents play, parent skill-building is an important piece of promoting healthy child development. In Connecticut, several family-centered education programs recognize and address this need. The Parents as Teachers¹ program seeks to enhance young children’s development and school achievement by informing parents about their developing children and providing support services to help them further that development. Even Start² integrates adult education and child care along with parenting education and support activities to help families succeed. ASPIRA³ reaches out to Latino parents, promoting and cultivating leadership and parenting education.

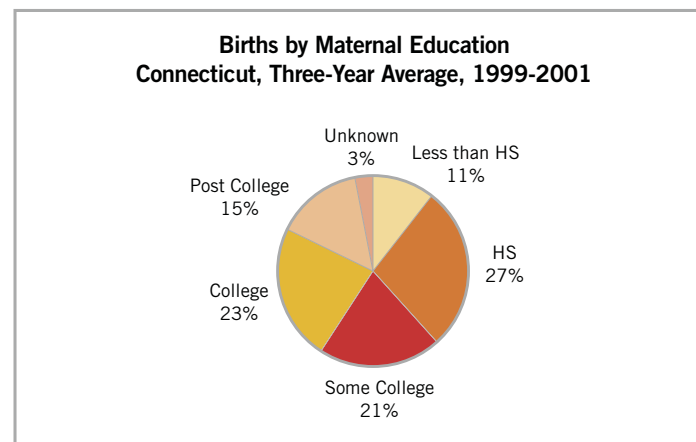
Another family factor contributing to a child’s development is maternal education. Mothers with more education are better equipped to help their children develop key school readiness skills, like color and letter recognition and counting.⁴ Compared to mothers without a high school diploma, mothers with higher education levels are more likely to foster language and preliteracy skills in the home through activities such as reading to their children or taking them to a library.⁵ In addition, for single mothers especially, education level is relevant because low educational attainment is associated with low wages. Household income also has far-reaching implications for child development, as discussed in detail in the Economic Stability section of this report.

HOW ARE WE DOING?

- Statewide, approximately 4,500 children per year (11%) are born to mothers who did not finish high school. Over half (59%) of these children are concentrated in nine of Connecticut’s 169 municipalities, each of which report that 20% or more of all births are to mothers without a high school diploma.
- During FY2003, nearly 2,400 families with young children received parenting education and support services through the Connecticut Parents as Teachers program.

HOW CAN WE DO BETTER FOR CONNECTICUT’S CHILDREN?

- Promote programs that support teen mothers and fathers in their efforts to finish high school and go on to higher education. Employ multi-generational strategies, as the Polly T. McCabe Center in New Haven does, so that both the young parent and the child are supported.
- Create an integrated system of community-based parent education and support programs rooted in sound child development research and available to all parents on a voluntary basis.⁶
- Support programs that seek to help first-time parents expand their knowledge of child development and strengthen parenting skills, like the Nurturing Families Network.



Source: Connecticut Department of Public Health, Provisional Data, 1999-2001.

Births to Mothers with Less Than a High School Diploma
 (Towns/cities with percentages that rank in the top quartile of the state are displayed)
 Connecticut, 1999-2001

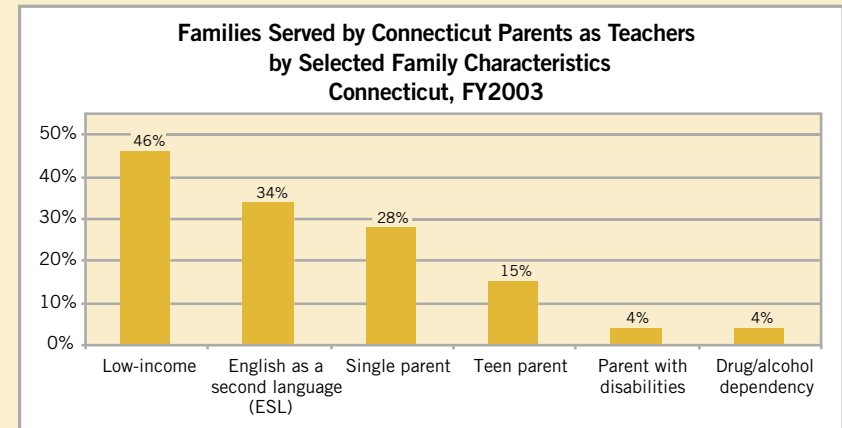
Town/City	Total Number of Births to Mothers with Less Than a High School Diploma	% of Births to Mothers with Less Than a High School Diploma (three-year average)
Hartford	1,857	30.8%
Windham*	265	28.8%
New Britain*	765	28.3%
Bridgeport*	1,826	27.1%
New Haven*	1,426	26.0%
Meriden	554	24.6%
Waterbury*	1,027	22.0%
New London*	246	21.8%
Killingly	132	20.1%
Norwich	278	19.5%
North Canaan	18	19.4%
Plainfield	95	17.0%
Putnam	55	16.4%
East Hartford	291	15.7%
West Haven	301	15.1%
Winchester	62	14.7%
Danbury	392	13.3%
Sprague	13	13.3%
Torrington	165	13.2%
Ansonia	94	12.8%
Thompson	34	12.3%
Bristol	254	11.6%
Vernon	115	11.5%
Canterbury	17	11.3%
Sterling	13	11.3%
Griswold	38	11.3%
Derby	50	11.0%
Connecticut	13,762	11.0%
Stafford	40	10.5%
Middletown	168	10.2%
Brooklyn	17	10.1%
East Haven	93	9.6%
Goshen	5	9.3%
Norwalk	344	9.2%
Manchester	182	9.2%
Franklin	5	9.1%
Naugatuck	102	9.0%
Groton	175	8.9%
Sharon	5	8.6%
Plymouth	29	7.8%
Montville	42	7.7%
Bloomfield	39	7.0%
Windsor Locks	27	7.0%

For a full town/city listing, see page 72.

Source: Connecticut Department of Public Health, Provisional Registration Reports and unpublished data, 1999-2001.

Note: Towns/cities with less than 5 births to mothers without a high school diploma over the three-year period are excluded due to the high degree of variability associated with small numbers.

* Denotes a town/city with more than 15% of the population in poverty.



Source: Connecticut Parents as Teachers, FY2003.

Note: Families may have more than one characteristic. A total of 2,393 families and 3,144 children received services in FY2003.

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Statewide, how many families with young children are receiving parent education and support services?

Indicator Notes and References

The Parents as Teachers program serves families throughout pregnancy until their child enters kindergarten. It offers families personal visits by certified parent educators; group meetings; developmental, health, hearing and vision screening; and linkage with community resources.

1 For additional information on the national Parents as Teachers model, visit www.patnc.org

2 For additional information on the Even Start program, visit www.evenstart.org

3 For additional information on ASPIRA, visit <http://www.ctaspira.org/apexparentsprogram.html>

4 Magnuson, K.A. & McGroder, S.M. (2002). *The Effect of Increasing Welfare Mothers' Education on their Young Children's Academic Problems and School Readiness*. JCPR Working Paper 280. Evanston, IL: Joint Center for Poverty Research.

5 Chandler, K., Nord, C. W., Lennon, J., & Liu, B. (1999, November). *Statistics in Brief: Home Literacy Activities & Signs of Children's Emerging Literacy, 1993 and 1999*. Washington, DC: National Center for Education Statistics.

6 For further discussion on developing a system-wide parenting education model, see the National Extension Parenting Education Model at <http://www.ksu.edu/wparent/nepem/nepam.pdf>





STEPPING STONE 2: SAFETY AND CHILD WELFARE

*Goal: All children grow up in safe,
stable and nurturing homes*



Stepping Stone 2: Safety and Child Welfare



INDICATOR: Children in Foster Care

DEFINITION: *Children in Foster Care* measures the number of children under age six who live in relative or non-relative foster care.

SIGNIFICANCE: Foster children are at great risk for poor outcomes in school and throughout their lifetime. Even before foster care entry, many children are susceptible to developmental problems due to abuse and/or neglect.

Young children in foster care are particularly vulnerable. Although foster children overall tend to be in poorer health than other children, the gap is greatest among children under age 6. Furthermore, many young children in foster care experience developmental delays. A national study reported that 59% of infants and toddlers in foster care were at high risk for neurological and cognitive impairment.¹

Foster children are also susceptible to emotional and behavioral problems given their living arrangements, which often lack stability.² All of these factors can hinder a child's academic achievement and educational attainment.

HOW ARE WE DOING?

- One in four (1,600) children living in a foster family is under the age of 6.
- The majority of young children in foster care are white (51%), with a disproportionately large number of black children in the foster care system (39%).
- Most young foster children (74%) live with non-relatives. One out of every four foster children under age 6 resides with a family member.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Improve collection of and access to data on young foster children, particularly on length of stay in foster care and frequency of relocation to different foster placements.
- Continue efforts to increase the supply of nurturing foster homes by promoting best practice and providing adequate support to foster families to help them address any special needs the children in their care may have.

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What is the average length of stay in foster care for young children?

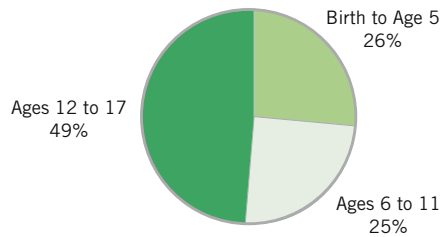
On average, how many different foster placements does a young child experience in one year?

What is the number of foster placements available as compared to the number of children needing placements?

Note: As a result of the *Juan F. v Rowland* lawsuit and consent decree, the Connecticut Department of Children and Families is collecting new data that may help address some of these data gaps. For more information, visit www.state.ct.us/dcf

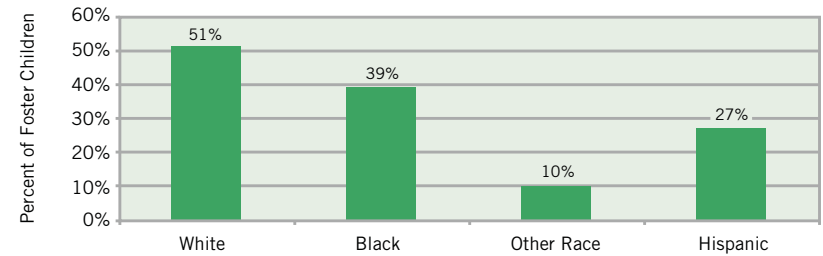
One in four children living in a foster family is under the age of 6.

**Children in Foster Care by Age
Connecticut, August 2003**



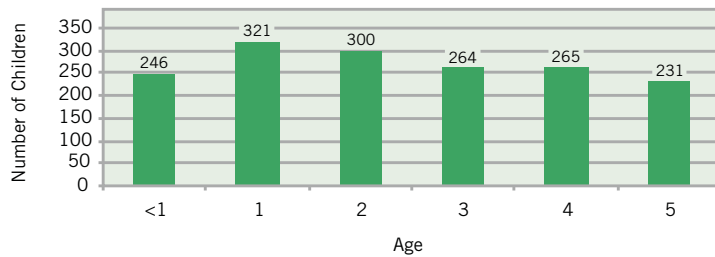
Source: Connecticut Department of Children and Families, as of August 31, 2003.

**Foster Children Under Age 6 by Race/Ethnicity
Connecticut, June 2004**



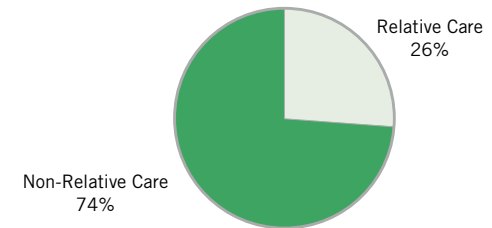
Source: Connecticut Department of Children and Families, as of June 30, 2004.
Note: Hispanic children may be included in any race category.

**Young Children in Foster Care
Connecticut, August 2003**



Source: Connecticut Department of Children and Families, as of August 31, 2003.

**Foster Children Under Age 6 by Placement Type
Connecticut, June 2004**



Source: Connecticut Department of Children and Families, as of June 30, 2004.

Indicator Notes and References

1 Vandivere, S., Chalk, R., Anderson Moore, K. (2003). *Child Trends Research Brief, December 2003: Children in Foster Homes: How Are They Faring*. Child Trends.

2 Dicker, S., Gordon, E., Knitzer, J. (2001). *Improving the Odds for the Healthy Development of Young Children in Foster Care*.

National Center for Children in Poverty.



INDICATOR: Child Abuse and Neglect

DEFINITION: *Child Abuse and Neglect* measures children who are substantiated as abused and/or neglected. Abuse and neglect includes physical, sexual or emotional abuse as well as physical, medical, educational or emotional neglect. Substantiated cases are those in which investigation determined there is reasonable cause to believe that abuse/neglect occurred. Data is displayed for all children and is broken down by age groups to show the specific impact on young children where possible.

SIGNIFICANCE: Examining child abuse and neglect is important in gaining an understanding of child well-being. Child maltreatment comes in many forms, from physical injury and/or sexual contact to, more commonly, deprivation of needed age-appropriate care. Regardless of what form it takes, child maltreatment can result in developmental deficiencies and delays, permanent or long-lasting physical and emotional problems or death. Unfortunately young children, especially those under age 1, are disproportionately affected by abuse and neglect.

During the early years, children are particularly vulnerable to harm. Child abuse and neglect can cause permanent damage to the neural structure and functions of the child's developing brain.¹ Early experiences of trauma can impede healthy brain development, resulting in extreme anxiety, depression, inability to form healthy attachments to others and impaired cognitive abilities.²

Child maltreatment interferes with a child's ability to succeed in school. Abused and neglected children have been found to have lower grades, more suspensions, disciplinary referrals and grade repetitions, and to be more likely to drop out of school than their peers, independent of the effects of poverty.³ In recognition of the devastating effects of child maltreatment, a new federal mandate requires that the Department of Children and Families (child protection agency) develop a procedure with the Birth to Three early intervention program to provide developmental evaluations and, as appropriate, services for all infants and toddlers in substantiated cases of child abuse/neglect.

HOW ARE WE DOING?

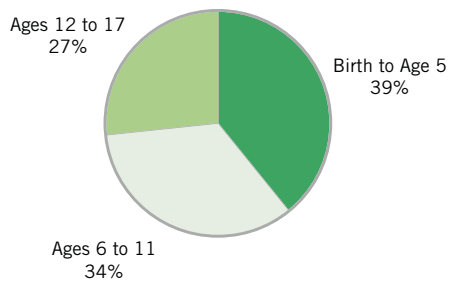
- In 2002, there were nearly 5,000 abused/neglected children under age 6 in Connecticut (39% of all victims under 18). Over 1,100 of these children were less than one year old.

- The majority of substantiated child maltreatment allegations are attributed to neglect, particularly physical neglect. In FY2003, neglect accounted for 88%⁴ of all substantiated child abuse/neglect allegations. Some of these neglected children also experience abuse.
- Child abuse and neglect rates are high compared to the national rates for all age groups. Nearly 20 out of every 1,000 Connecticut children from birth to age 3 are victims of maltreatment, compared to 16 nationwide.
- From 1999 to 2003, there was a 40% decline in substantiated child abuse and neglect cases despite an increase in the total number of abuse/neglect reports. Possible reasons for this trend include an increase in questionable allegations and/or implementation of stricter criteria for proving a claim of abuse/neglect.
- Connecticut has one of the highest rates of maltreatment recurrence in the nation. In 2002, 11.8% of all substantiated child victims experienced a second incident of substantiated maltreatment within six months of the first incident. Despite improvement in the past few years, the 2002 rate shows a slight increase from the previous year (11%). Both of these rates are significantly higher than the national standard (6.1%).⁵

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Ensure that the state, through the Birth to Three early intervention program or the Department of Children and Families, has the capacity to evaluate all infants and toddlers in substantiated child abuse/neglect cases and to provide follow-up services, as appropriate, especially for children with social and emotional needs. Extend evaluation and treatment services to abused/neglected preschool children as well through programs serving 3 to 5 year olds.
- Promote programs, like the Nurturing Families Network, that provide home visitation services to families in need of support due to financial insecurity, mental health issues or other factors known to increase the risk of child maltreatment.
- Help connect family members with drug or alcohol problems to substance abuse treatment programs, as substance abuse is involved in the majority of child abuse and neglect cases.

Children Substantiated as Abused/Neglected by Age Connecticut, 2002



Source: US Department of Health and Human Services, Administration for Children and Families, 2002.

Children Substantiated as Abused and/or Neglected by Age Connecticut and the United States, 2002

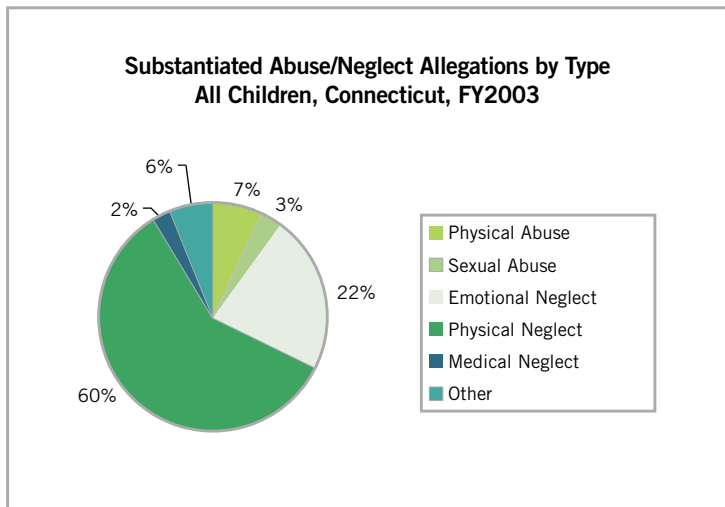
	Connecticut		United States
	# of Child Victims	Rate Per 1,000 Children	Rate Per 1,000 Children
Ages Birth to 3	3,522	19.8	16.0
Ages 4 to 7	2,925	15.3	13.7
Ages 8 to 11	2,883	14.1	11.9
Ages 12 to 15	2,783	13.5	10.6
Ages 16 to 17	620	6.6	6.0

Source: US Department of Health and Human Services, Administration for Children and Families, 2002.

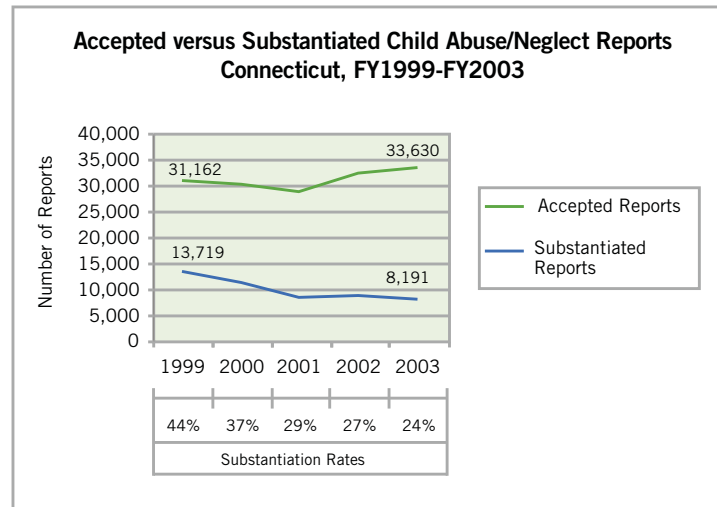
Nearly 20 out of every 1,000 Connecticut children from birth to age 3 are victims of maltreatment, compared to 16 nationwide.



INDICATOR: Child Abuse and Neglect (continued)



Source: Connecticut Department of Children and Families, FY2003.
 Note: Children may experience more than one type of abuse.



Source: Connecticut Department of Children and Families, FY1999-FY2003.

The majority of substantiated child maltreatment allegations are attributed to neglect, particularly physical neglect. In FY2003, neglect accounted for 88% of all substantiated child abuse/neglect allegations.

Children Substantiated as Abused/Neglected by Age

(Towns/cities with rates that rank in the top quartile of the state are displayed)

Connecticut, FY2003

Town/City	Under Age 18		Under Age 6	
	# Child Victims	Rate Per 1,000 Children	# Child Victims	Rate Per 1,000 Children
Windham*	227	42.9		
Killingly	169	39.3		
Plainfield	137	33.9		
Norwich	278	32.0		
New Haven*	988	31.3		
New Britain*	527	30.5		
Putnam	65	30.4		
Ansonia	130	28.7		
Vernon	172	27.1		
Waterbury*	773	27.0		
East Hartford	317	26.5		
Meriden	383	25.4		
Hartford*	908	24.2		
New London*	145	23.9		
Bridgeport*	936	23.5		
Sterling	21	23.3		
Canterbury	28	22.6		
Bristol	300	21.4		
Sprague	16	20.7		
Manchester	259	20.7		
Lisbon	22	20.3		
Griswold	57	20.2		
Derby	53	19.5		
East Windsor	42	18.8		
Preston	19	17.8		
Brooklyn	30	17.2		
Pomfret	17	16.2		
Stafford	48	16.2		
West Haven	191	15.7		
Enfield	160	15.6		
Middletown	153	15.2		
East Haven	95	15.0		
Plymouth	46	14.9		
Voluntown	10	14.6		
Plainville	53	14.3		
Thompson	30	13.2		
Connecticut	11,288	13.2		
Danbury	215	12.9		
Stamford	329	12.4		
Seymour	46	12.3		
Groton	122	12.2		
Windsor Locks	35	12.1		



For a full listing of towns/cities, see page 72.

Source: Connecticut Department of Children and Families, FY2003 and the Connecticut Association for Human Services, 2004.

*Denotes a town/city with more than 15% of the population in poverty.

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What are the substantiated abuse/neglect rates in Connecticut's cities and towns for children under age 6?

How many young children are involved in unsubstantiated reports of abuse and/or neglect?

How many families with young children at-risk of child abuse and neglect are receiving prevention services?

What is the number of non-fatal child maltreatment cases among children under the supervision of the state Department of Children and Families?

Indicator Notes and References

- Teicher, M. (2002). Scars that won't heal: The neurobiology of child abuse. *Scientific American*, 68-75.
- Shore, Rima. (1997). *Rethinking the Brain*. New York: Families and Work Institute, p. xi.
- Eckenrode, J., Laird, M., & Doris, J. (1993). School performance and disciplinary problems among abused and neglected children. *Developmental Psychology*, 29, 53-62.
- Calculations include emotional, physical, medical and educational neglect.
- Child Maltreatment: Reports From the States to the National Child Abuse and Neglect Data System*. (2002). Washington, DC: US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.



INDICATOR: Child Deaths

DEFINITION: *Child Deaths* is expressed as a rate – the number of deaths per 100,000 children ages one to 14. Additional data on abuse/neglect related fatalities and fatalities among children in active Child Protective Services cases are also presented, although these data are not limited to children ages one to 14.

SIGNIFICANCE: The child death rate is a measure of the health and safety of children. Fortunately, the mortality rate among infants and children ages one to 14 has declined significantly nationwide over the last twenty years.¹ Infant deaths are mostly attributable to health problems, such as low birthweight, prematurity, or birth defects. On the other hand, deaths to children age 1 and above are more likely the result of unintentional injuries (accidents). Leading causes of unintentional injuries include poisoning, falls, drowning, motor vehicle accidents and fires. Unintentional injuries disproportionately impact young children, males, minorities and especially poor children.²

Child maltreatment is another cause of child fatalities. Young children (under age 6) are the most likely to die as a result of abuse or neglect and the younger they are, the more vulnerable they are. Nationwide, 86% of victims of fatal child abuse are under age 6 and approximately 42% of all victims are less than one year old.³ On average, five children die each year in Connecticut as a result of child maltreatment.⁴

As of 2001, Connecticut had the lowest child death rate among all states for children ages one to 14 (14 deaths per 100,000 children).

HOW ARE WE DOING?

- As of 2001, Connecticut had the lowest child death rate among all states for children ages one to 14 (14 deaths per 100,000 children).
- Progress is still needed in order for Connecticut to reach the national Healthy People 2010 Goals with respect to child death rates among children ages 1 to 4. As of 2001, the child death rate among children ages 1 to 4 was 19.3 deaths per 100,000 children, while the target rate is 18.6. Connecticut has already reached the goals for children ages 5 to 9 and 10 to 14, which are 12.3 and 16.8, respectively.
- Although the number of child fatalities due to abuse and neglect is relatively low, the most recent data show an increase from 4 deaths in 2001 to 7 deaths in 2002.
- A very small number of children in active Child Protective Services cases are fatality victims, however data show modest increases in the number of victims between 2000 and 2002 (from 9 to 11 victims).

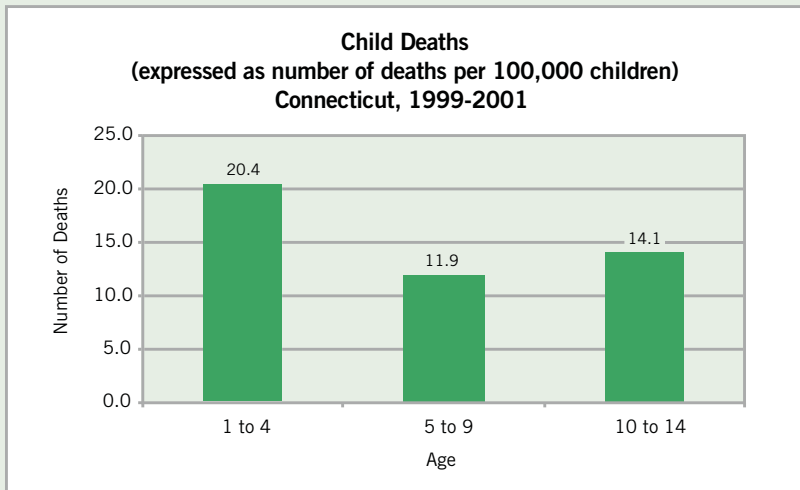
HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Support programs that promote injury prevention through dissemination of and information on safety devices such as car seats, bicycle helmets and smoke detectors.
- Provide adequate access to treatment and/or support for caregivers who may be at risk of harming a child due to mental health issues, developmental delays or substance abuse problems.

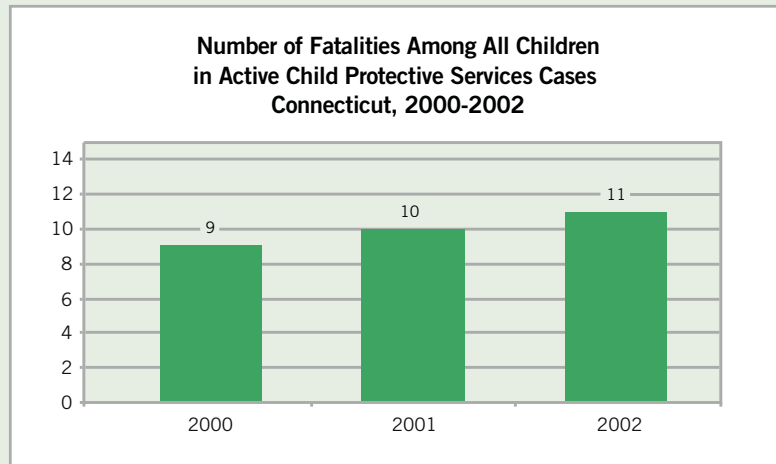
Child Death Rate, 2001
(deaths per 100,000 children ages 1 to 14)

United States	22
Connecticut	14

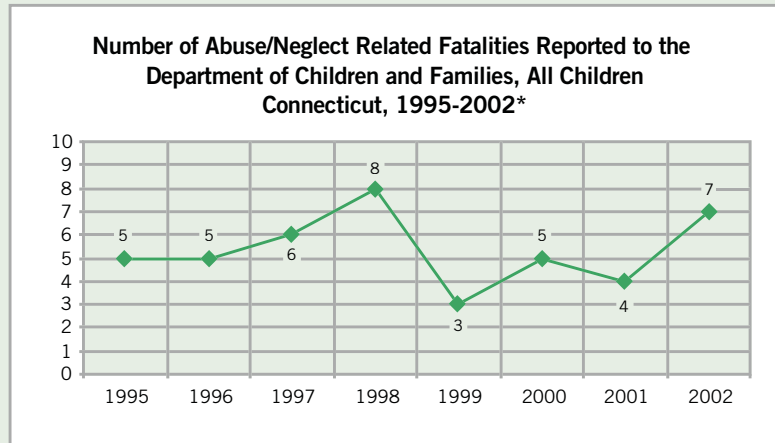
Source: *Kids Count Data Book: State Profiles in Child Well-Being 2004*. (2004). Baltimore, MD: The Annie E. Casey Foundation.



Source: Connecticut Department of Public Health, Provisional Registration Reports, 1999 to 2001.



Source: Connecticut Department of Children and Families, Annual Reports on Child Fatalities in Connecticut, 2000-2002.



Source: Connecticut Department of Children and Families. 2002 Annual Report on Child Fatalities in Connecticut.

*1995 is the earliest year of data available.

Indicator Notes and References

- 1 *Infant, Child and Youth Mortality*. ChildTrends Data Bank. www.childtrendsdatabank.org
- 2 *Injury Facts: Children At Risk*. Washington, DC: National Safe Kids Campaign. www.safekids.org
- 3 *2002 Annual Report on Child Fatalities in Connecticut*. Bureau of Quality Management Special Review Unit, Department of Children and Families.
- 4 Calculation based on data from abuse and neglect related fatalities, 1995 to 2002.





STEPPING STONE 3: ECONOMIC STABILITY

*Goal: All children live in economically
self-sufficient families*





INDICATOR: Median Family Income

DEFINITION: *Median Family Income* measures a family's annual income and indicates the midpoint of income distribution in a community. Half of the families in the community have annual earnings less than the median and half have earnings above it.

SIGNIFICANCE: Median family income is helpful in assessing the economic status of families across Connecticut and within individual communities. It speaks to a family's ability to afford expenses such as food, shelter, clothing, health care, transportation and education-related costs. Some state agencies that provide services, like child care subsidies, also use median income figures to determine financial need and establish family fee guidelines because of its significance as a benchmark. Further, research shows an important connection between socioeconomic status (SES) and children's school readiness. For example, children from families with higher SES tend to develop larger vocabularies.¹ This preliteracy skill is predictive of positive academic performance, leaving children in lower SES households at a marked disadvantage without effective interventions.

Connecticut is one of the richest states in the country, therefore in many communities the median family income is quite high. However, there is great disparity in income between the state's 169 municipalities. For example, the median family income in Greenwich is nearly \$155,000 while in Hartford it is only \$22,000.² Income inequality among the various regions of the state has widened significantly over the past decade. In the northeastern part of the state (Windham County), there was only 37% income growth, compared to 62% income growth in the more affluent southwestern region, represented by Fairfield County.³

For a family to afford basic necessities like food and shelter, it is estimated that household income must be roughly double the federal poverty level, or \$37,700 for a family of four.^{4,5} For many Connecticut families, reaching this standard of living is a struggle given that two full-time workers earning the current minimum wage (\$7.10/hour) would only generate \$29,536 in annual income.

HOW ARE WE DOING?

- Over 40,000 young children in Connecticut live in the five municipalities with the lowest median family income (all under \$35,000): Hartford, New Haven, New London, Windham and Bridgeport.
- One in four Connecticut children under age 6 lives in a household that struggles to afford basic necessities like food and shelter.
- For a family of four to maintain self-sufficiency, two full-time workers would need to earn at least \$9.08/hour, which is approximately \$2.00/hour more than Connecticut's minimum wage (\$7.10/hour).

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Promote efforts to institute a "living wage" so that earnings from full-time employment are sufficient to support a family without public assistance.
- Bolster financial aid programs, as well as mentoring programs, to help encourage and enable low-income individuals to pursue post-secondary education or vocational training and increase potential earnings.
- Institute a state Earned Income Tax Credit (EITC) to parallel the federal EITC and allow low-income families to have financial resources to be self-sufficient.
- Expand the state's Individual Development Account (IDA) program to assist low-income families to accumulate assets for purchasing a home or car, making the deposit on an apartment, paying for education and starting a business.

Median Family Income for Families with Children (Under 18), 2000

United States	\$48,196
Connecticut	\$64,692

Source: US Census 2000, based on 1999 income data.

Towns/Cities with Highest and Lowest Median Family Income
 (Towns/cities with median family incomes above \$100,000 and below \$50,000 are displayed)
Connecticut, 2000*

Town/City	Median Family Income for Families with Children Under 18	Median Family Income for Families with Children Under 6
New Canaan	\$200,000+	
Darien	\$200,000+	
Weston	\$188,595	
Westport	\$178,843	
Wilton	\$167,298	
Easton	\$159,974	
Greenwich	\$154,586	
Ridgefield	\$139,011	
Avon	\$115,965	
Fairfield	\$113,536	
Redding	\$112,068	
Woodbridge	\$111,550	
Madison	\$105,715	
Glastonbury	\$102,919	
Monroe	\$102,237	
Newton	\$101,283	
Simsbury	\$101,008	
Bridgewater	\$100,862	
Meriden	\$49,738	
West Haven	\$48,406	
Plainfield	\$46,674	
Sprague	\$44,107	
Groton	\$43,573	
Killingly	\$43,443	
East Hartford	\$42,440	
Norwich	\$41,660	
Waterbury	\$35,586	
New Britain	\$35,285	
Bridgeport	\$34,103	
Windham	\$33,032	
New London	\$31,773	
New Haven	\$28,847	
Hartford	\$21,997	
Connecticut	\$64,692	

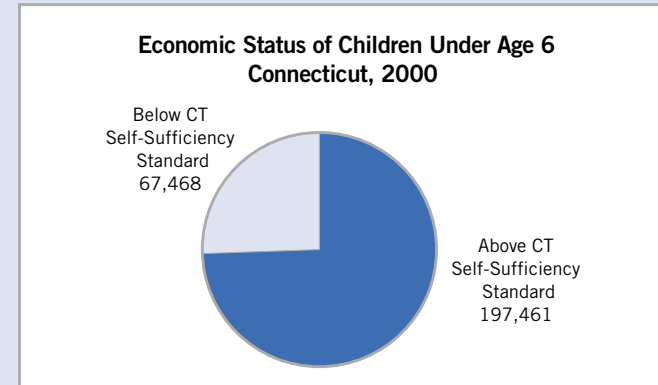


For a full listing of towns/cities, see page 72.

Source: US Census 2000, Table PCT39.
 *Census data is based on 1999 income.

i INFORMATION G - A - P

What is the median family income for families with young children (under age 6)?



Source: US Census 2000, Table PCT50.

Note: The Connecticut Self-Sufficiency Standard⁶ is a measure of a family's ability to afford basic necessities and is estimated to be approximately 200% of the federal poverty level.

Indicator Notes and References

For more discussion on median family income and other measures of family economic security, see the 2004 Connecticut KIDS COUNT Data Book "Investing in Families...Investing in Our Future" at www.cahs.org

- Hart, B. & Risley, T. (1995). *Meaningful Differences in the Everyday Experiences of Young American Children*. Baltimore, MD: Paul H. Brookes.
- US Census Bureau 2000, Table PCT39.
- Miringoff, M. *The Social State of Connecticut*. (2003). Tarrytown, NY: Fordham Institute for Innovation in Social Policy.
- Low Income Children in the United States*. (August 2003). New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University. (Dollar figures based on 2004 Poverty Guidelines issued by the federal Health and Human Services Department).
- Canny, P. & Hall, D. (2003). *Child Poverty and Poverty Measures in Connecticut*. Connecticut Voices for Children.
- Pearce, D. & Brooks, J. (1999). *The Self-Sufficiency Standard for Connecticut*. Hartford, CT: Office of Policy and Management.



INDICATOR: Children in Poverty

DEFINITION: The *Children in Poverty* indicator displays how many children under age 6 live below the poverty threshold, an official measure of poverty established by the US Office of Management and Budget and used by the US Census Bureau in data collection.

SIGNIFICANCE: Examining how many young children are in poverty and where they live is an important step in identifying and assisting many of Connecticut's most at-risk children. Children in poverty are extremely vulnerable. Financial hardship can lead to unhealthy living conditions, inadequate nutrition and a stressful home environment. In contrast to children raised in more affluent homes, poor children are at risk for lower school achievement¹ and a host of health and developmental problems² that can have negative effects that last a lifetime.

Multiple factors are correlated with child poverty. Children living in single-parent households, especially households headed by single mothers, are more likely to experience poverty than children in two-parent families. The educational attainment of single mothers is also a strong predictor of poverty, therefore children whose mothers drop out of high school due to pregnancy or other circumstances are often at a disadvantage.

From 1990 to 2000, the percent of children (under age 18) in poverty in Connecticut declined slightly from 10.7% to 10.4%. However, the percent of children living in neighborhoods with high concentrations of poverty increased from 11% to 12.1%.³ Although Connecticut's child poverty rates are lower than most states, more than one in ten young children (under age 6) in Connecticut lives in poverty. Poverty disproportionately impacts young children, underscoring the need to address this problem so these children do not experience the debilitating effects of poverty.

HOW ARE WE DOING?

- Young children (under age 6) are more likely to live in poverty than older children.
- Although Connecticut's child poverty rates are lower than most states, more than one in ten young children (nearly 30,000) lives in poverty. More than 14,000 of those children live in extreme poverty (below 50% of the federal poverty level).
- Black and Hispanic children are disproportionately affected by poverty. Nearly one in three young Hispanic children are in poverty and more than one in four black children are in poverty. By comparison, one in 25 young white children are in poverty.
- Despite the fact that impoverished young children represent a small share of the population in more affluent communities, pockets of poverty do exist in communities like Greenwich (205 children – 4%) and West Hartford (226 children – 5%).

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Decrease the number of children born to teen mothers by supporting teen pregnancy prevention strategies such as increasing participation in school sports and community service activities, improving communication between parents and children, and reducing substance abuse.
- Strengthen programs that work to secure child support from non-residential parents.
- Provide supports to keep two-parent families healthy and intact.

Percent of Children Under Age 6 in Poverty, 2000

United States	18.1%
Connecticut	11.1%

Source: US Census 2000

Children Under Age 6 in Poverty

(Towns/cities with percentages that rank in the top quartile of the state are displayed)
Connecticut, 2000

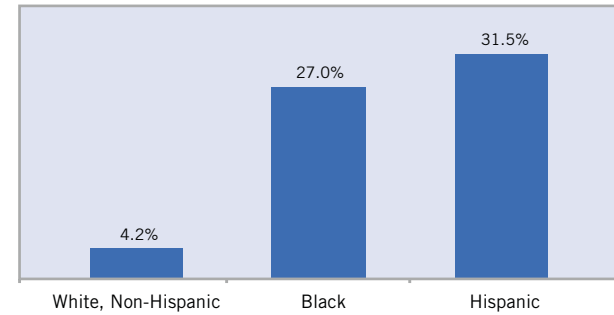
Town/City	# of Children Under Age 6 in Poverty	% of Children Under Age 6 in Poverty
Hartford	4,849	40.7%
New Haven	3,334	33.7%
Sharon	40	29.9%
New London	591	29.4%
Windham	492	28.9%
Waterbury	2,577	26.8%
New Britain	1,346	25.7%
Bridgeport	3,337	25.5%
Meriden	963	20.0%
Norwich	494	19.0%
Putnam	114	19.0%
East Hartford	690	18.0%
Morris	25	16.2%
Eastford	18	14.4%
Ansonia	196	13.6%
West Haven	521	13.1%
Stafford	121	12.9%
Groton	478	12.6%
Thompson	75	12.1%
Winchester	85	11.7%
Manchester	474	11.7%
Naugatuck	286	11.2%
Connecticut	29,348	11.1%
Barkhamsted	23	10.7%
Killingly	133	10.7%
Plainfield	122	10.6%
Vernon	201	9.9%
Stamford	902	9.7%
Mansfield	69	9.6%
Torrington	223	9.1%
Scotland	13	9.0%
Brooklyn	38	8.8%
Seymour	98	8.8%
Norwalk	562	8.7%
Danbury	485	8.3%
Bristol	369	8.3%
Ledyard	90	8.2%
Middletown	272	8.2%
Stonington	99	8.1%
Thomaston	46	8.0%
Westbrook	37	8.0%
Bloomfield	93	8.0%

For a full listing of towns/cities, see page 72.

Source: US Census 2000, Table P87.

Note: Percentages not calculated for towns/cities with less than 5 children under age 6 in poverty due to the high variability associated with small numbers.

Percent of Children Under Age 6 in Poverty by Race/Ethnicity
Connecticut, 2000



Source: US Census 2000, Tables P159I, P159B and P159H.

2004 Federal Poverty Guidelines

Size of Family Unit	D.C. and All States (excluding Alaska and Hawaii)
1	\$ 9,310
2	\$ 12,490
3	\$ 15,670
4	\$ 18,850
5	\$ 22,030
6	\$ 25,210
7	\$ 28,390
8	\$ 31,570
For each additional person, add	\$ 3,180

Source: Federal Register, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.

Indicator Notes and References

1 Smith, J.R., Brooks-Gunn, J., & Klebanov, P.K. (1997). Consequences of Living in Poverty for Young Children's Cognitive and Verbal Ability and Early School Achievement. In Duncan, G.J. and Brooks-Gunn, J. (Eds.), *Consequences of Growing Up Poor*. New York: Russell Sage Foundation.

2 Korenman, S. & Miller, J.E. (1997). Effects of Long-term Poverty on Physical Health of Children in the National Longitudinal Survey of Youth. In Duncan, G.J. and Brooks-Gunn, J. (Eds.), *Consequences of Growing Up Poor*. New York: Russell Sage Foundation.

3 KIDS COUNT 2003 Data Book Online. www.aecf.org/kidscount/census/

Stepping Stone 3: Economic Stability



INDICATOR: Children Receiving Welfare Benefits (TFA – Temporary Family Assistance)

DEFINITION: *Children Receiving Welfare Benefits* measures the number of children under age 6 receiving cash assistance through the state's Temporary Family Assistance (TFA) program.

SIGNIFICANCE: The Temporary Family Assistance (TFA) program is the state's financial assistance/welfare program and is administered by the Department of Social Services. Families are generally eligible for TFA if their income is 40% or less of the federal poverty level. Parents who go to work can continue to stay on assistance until their income exceeds the poverty threshold or they reach their time limit for benefits (lifetime limit of 21 months with limited extensions).

For a family of four to meet the general income eligibility criteria for TFA (40% of poverty), their income would be approximately \$7,500/year or less. Thus, the number of children in the TFA program is an indication of extreme child poverty in Connecticut, although it does not capture the full scope of extreme poverty in the state. It is important to recognize that with eligibility for TFA set so low, many children living in extreme poverty (below 50% of poverty) are not receiving TFA benefits. Examining the number of children enrolled in TFA in contrast to the number of children in poverty and extreme poverty helps provide insight on the extent to which poor families are receiving financial assistance.

HOW ARE WE DOING?

- Approximately 15,000 young children (under age 6) in Connecticut are on welfare.
- Children under age 6 account for 42% of all children (under age 18) on TFA and one-third of all welfare recipients.
- The majority (58%) of young children on welfare are infants and toddlers (ages 2 and under).

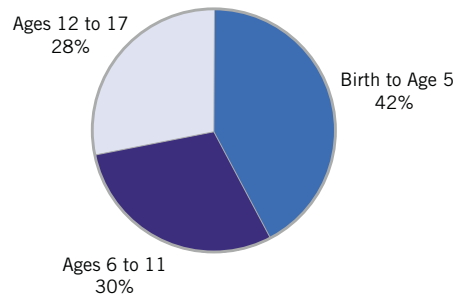
- More than half (54%) of young children on welfare reside in Hartford, Bridgeport, New Haven or Waterbury.
- In most Connecticut municipalities (94 towns/cities), there are less than 10 young children on welfare. For a full listing of towns/cities, see page 72.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Make sure that parents on TFA can access quality early care and education through child care subsidies (Care 4 Kids) so their children are well cared for while they are at work.
- Ensure that the health needs of children on TFA are being met by educating parents on the need for primary and preventive health care, especially in the early years, and removing barriers to health care utilization where they exist.
- Before sanctioning families on welfare for failure to meet work requirements, assess whether learning disabilities or other severe educational barriers to employment exist. Where such problems exist, work with the families to ameliorate them and provide a successful transition into the workforce.
- Support parents on TFA to help them upgrade their skills and education while maintaining employment.

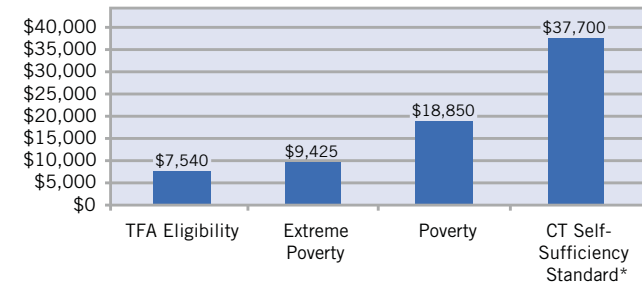
Approximately 15,000 young children are on welfare.

Children Receiving Welfare (TFA) Benefits by Age Connecticut, October 2003



Source: Connecticut Department of Social Services, Form 8017, October 31, 2003.

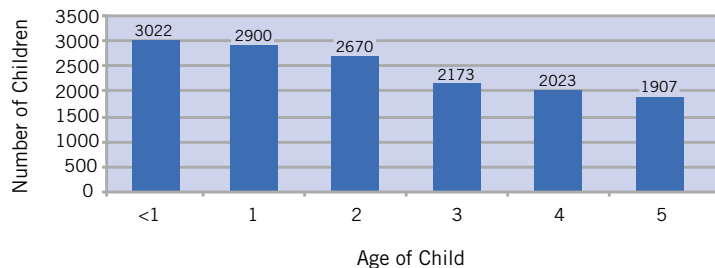
Comparison of Key Income Measures Connecticut, 2004



Notes: Income calculations are based on 2004 poverty guidelines for a family of four established by the US Department of Health and Human Services. Each of the above income measures is expressed as a percent of the federal poverty level: TFA Eligibility (40%), Extreme Poverty (50%), Poverty (100%) and CT Self-Sufficiency Standard (200%).

* The Connecticut Self-Sufficiency Standard¹ is a measure of a family's ability to afford basic necessities like food and shelter.

Young Children Receiving Welfare (TFA) Benefits Connecticut, October 2003



Source: Connecticut Department of Social Services, Form 8017, October 31, 2003.

Indicator Notes and References

¹ Pearce, D. & Brooks, J. (1999). *The Self-Sufficiency Standard for Connecticut*. Hartford, CT: Office of Policy and Management.





STEPPING STONE 4: EARLY CARE AND EDUCATION

*Goal: All children have access to quality
early care and education*



Stepping Stone 4: Early Care and Education



INDICATOR: Supply of Regulated Early Care and Education

DEFINITION: *Supply of Regulated Early Care and Education* measures the number of slots offered in regulated child care programs statewide. The term “regulated” encompasses both licensed child care and license-exempt school programs¹. Distinctions are made between “Family Child Care,” which refers to licensed family child care homes, and “Center-Based Care,” which includes licensed group and center programs and license-exempt preschool programs operated by schools. In this publication, the terms “child care” and “early care and education” are used interchangeably.

SIGNIFICANCE: The majority of Connecticut parents are working when their children are young. The 2000 Census reported that 92% of children under the age of 6 had at least one working parent and 62% had both parents or their only parent employed full-time. Parents try to use early care and education services to meet their need for substitute care while they work and at the same time provide a stimulating and nurturing environment in which their children can thrive. For parents to find child care arrangements that meet these needs, it is essential to have an adequate supply of child care that offers a variety of choices.

Beyond meeting the standard measures of high quality care and education, an adequate supply should enable parents to choose a program that meets their needs for affordable services and consistent, reliable caregivers. Schedules have to match work hours. For families with erratic schedules, flexibility is key. Therefore, a supply which offers a variety of child care settings (e.g. home-based, center-based) is important. The child care supply should also be robust enough that parents can choose arrangements that meet a number of personal criteria including a strong feeling of trust and compatibility with the adults who will assist them in teaching and caring for their young children.

HOW ARE WE DOING?

- Statewide, the supply of early care and education is distributed unevenly when factors of age, geography and wealth of the municipality are considered. Shortages are particularly evident for infant, toddler and school-age care, and in low-income rural communities and the largest cities.
- Infant and toddler spaces are in short supply throughout the state with only 15 slots per 100 children under age 3. Most of the lower income municipalities including the largest cities and the very small, rural towns have even fewer slots available than this already depressed statewide rate.

- Preschool children are the best accommodated. With the public funding available for School Readiness², Head Start and state-funded center programs, the poorest communities have made strides over the past seven years. Statewide there are 75 preschool slots per 100 children ages 3 and 4. Almost half of the center-based slots, however, are part-time, making it more difficult for working parents to satisfy their child care needs.
- School-age care is in short supply, with a statewide rate of only 9 slots per 100 children between ages 5 and 12. Even considering that there is lower demand for child care among families with school-age children, the supply is clearly not adequate. Although rates in several large cities exceed the statewide average (Bridgeport: 15 per 100, New Haven: 26 per 100, Waterbury: 32 per 100, and Hartford: 60 per 100), overall, school-age care is scarce.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Devise incentives to attract new providers serving infants, toddlers and school-age children, focusing special attention on family child care providers as the supply of family child care has declined by more than one-third over the past decade.³
- Expand the Department of Education’s School Readiness program in priority school and severe need school districts⁴ to offer full access for families with three and four year olds. Continue to use schools and community providers and to include full day, year-round programming as an option.
- Develop more options that enable parents to care for their children themselves, such as paid family leave and extending the work exemption to all families on public assistance who have children under age one.
- Increase the availability of school-age care in schools and community facilities.
- Expand the local planning for early care and education that is currently focused mostly on preschool children to address infant, toddler and school-age issues.

Supply of Regulated Early Care and Education for Children Under Age 5
(Towns/cities with 30 or less slots per 100 children or more than 70 slots per 100 children are displayed)
Connecticut, 2003

Slots per 100 Children	Town/City
0-10	Colebrook, Hampton, Hartland, Lisbon, Lyme, Morris, North Canaan, Union, Warren
11-20	Beacon Falls, Bethlehem, Norfolk, Weston
21-30	Ansonia, Bozrah, Derby, Eastford, Franklin, Goshen, Hebron, Killingly, Naugatuck, New Britain, New Fairfield, North Stonington, Old Lyme, Preston, Putnam, Redding, Sherman, Sterling, Voluntown, Waterbury, Windham
39.9	Connecticut
71-80	Bloomfield, Bolton, Brookfield, Farmington, Mansfield, Monroe, Plainville, Wallingford, Westbrook
81-90	Cromwell, Pomfret, Woodbridge
91-100	Brooklyn, Orange
Above 100	Canaan, Columbia

For a listing of child care supply for all towns/cities, by age group, see page 72.

Source: Child Care Infoline Provider Database, June, 2003.

Supply of Center-Based Early Care and Education for Children Ages 3 and 4
(expressed as number of slots per 100 children)
Connecticut, Priority School Districts*, 2003

Priority School District	Total Slots/100	Part Time Care Slots/100	Full Time Care Slots/100
Connecticut	64	31	33
Ansonia	56	37	19
Bloomfield	131	21	110
Bridgeport	65	17	47
Bristol	73	21	52
Danbury	78	34	44
East Hartford	76	31	46
Hartford	67	14	53
Meriden	50	16	34
Middletown	86	41	45
New Britain	52	21	30
New Haven	68	32	37
New London	83	17	66
Norwalk	86	46	40
Putnam	38	18	20
Stamford	88	35	53
Waterbury	48	14	34
West Haven	55	34	21
Windham	46	16	29

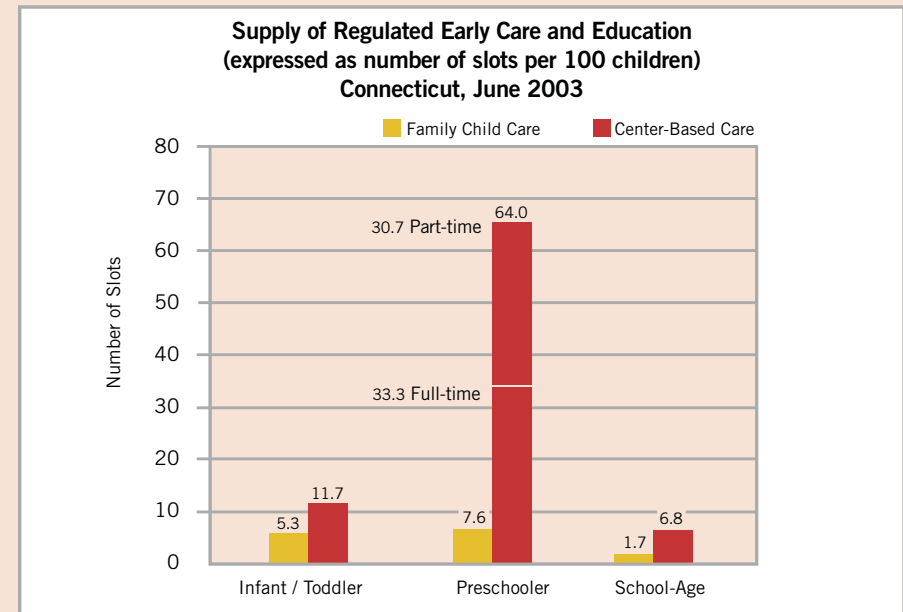
Source: Child Care Infoline Provider Database, June, 2003.

* "Priority school districts" are located in high-poverty schools. Three- and four-year old children attending priority schools are eligible for the state's School Readiness high-quality preschool program.

i INFORMATION G - A - P - S

Of the total child care market, what proportion is supplied by regulated providers, parents and informal providers (e.g. family, friends and neighbors)?

How well does the supply of care meet family needs and preferences (e.g. type of care, location, hours of operation, language and culture)?



Source: Child Care Infoline Provider Database, June 2003.

Note: Family child care and center-based care rates cannot be added together because the denominators used in these calculations vary by care setting, reflecting the different age groupings outlined in child care licensing. For details, see Methodology on page 98.

Indicator Notes and References

- 1 Connecticut licenses child care centers, group family homes and family child care homes through the Department of Public Health. Classrooms and programs operated by public and private schools are exempt from licensing because they are presumably monitored through school accreditation and other means.
- 2 Connecticut's School Readiness program was created in 1997 to provide high-quality preschool services in accredited or approved programs for three- and four-year old children in urban and high poverty districts or in high-need schools within other districts.
- 3 Connecticut Department of Social Services. *The Status of Child Care in Connecticut*, Annual reports, 1995-2003.
- 4 "Priority school districts" are located in high-poverty communities. "Severe need school districts" have one or more schools with a concentration of poverty.



INDICATOR: Supply of Quality Early Care and Education

DEFINITION: *Supply of Quality Early Care and Education* measures the number of programs and slots within those programs that are designated as quality. Quality programs are defined as those that have received accreditation (through the National Association for the Education of Young Children, American and International Montessori Associations, National Association of Family Child Care and/or the National School-Age Care Association) as well as those that are in compliance with Head Start standards.

SIGNIFICANCE: Quality early care and education helps guide the healthy development of young children, provides good learning experiences and supports families by allowing parents to work or pursue training and education. When programs intentionally and consistently foster the cognitive, language, physical, social and emotional development of young children, they produce positive child outcomes. When they do not, they can actually do harm.¹

Children who exhibit strong or multiple risk factors are the most likely to be affected by the quality of the early care and education program. If the experience is high quality, these children show the most progress. If it is low quality, they are harmed the most. It is appropriate for public policy to focus on communities where the risk factors associated with poverty are most prevalent, but promoting high quality programs for all children ensures that all children are prepared to succeed in school.

HOW ARE WE DOING?

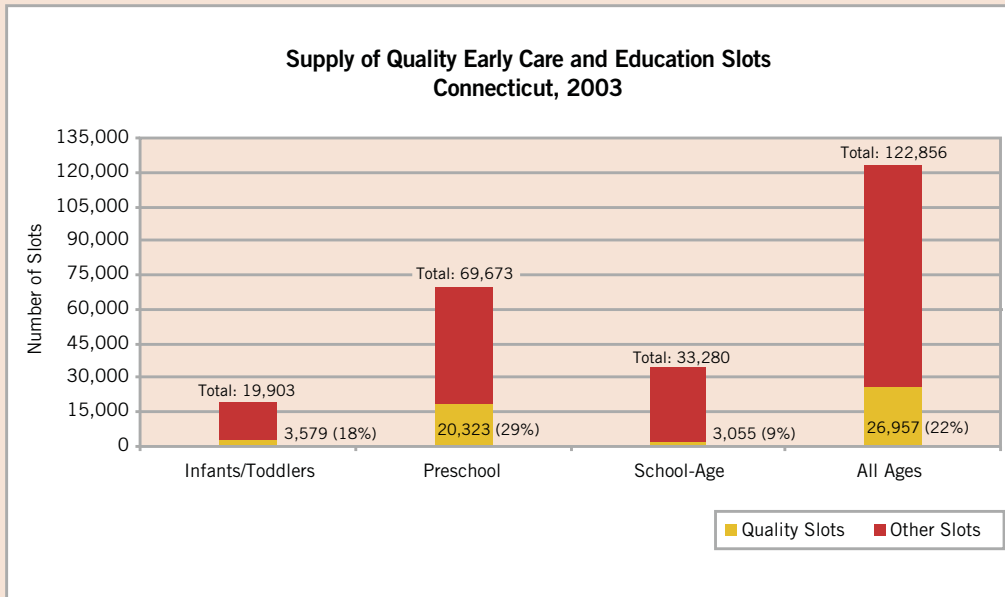
- Overall, 465 (8.4%) of Connecticut's 5,512 early care and education facilities have attained the designation of quality through accreditation or compliance with Head Start standards.
- Connecticut has a much higher percentage of accredited programs than most states, due in part to the Accreditation Facilitation Project, operated by the professional development program, Connecticut Charts-A-Course. Still, 66 communities (39%) have no accredited child care slots of any type for any age group.
- Less than a third of all preschool slots are in quality programs. Moreover, this low supply of quality child care for preschool children (ages 3 and 4) is still significantly greater than for infants and toddlers (under age 3) or school-age children (ages 5 to 12).

- Only 18% of the infant and toddler slots meet the quality criteria. The federal Early Head Start program accounts for slightly less than 3% of the total supply, with other public and private accredited programs providing the other 15%.
- Only 9% of the 33,280 regulated school-age slots are accredited.

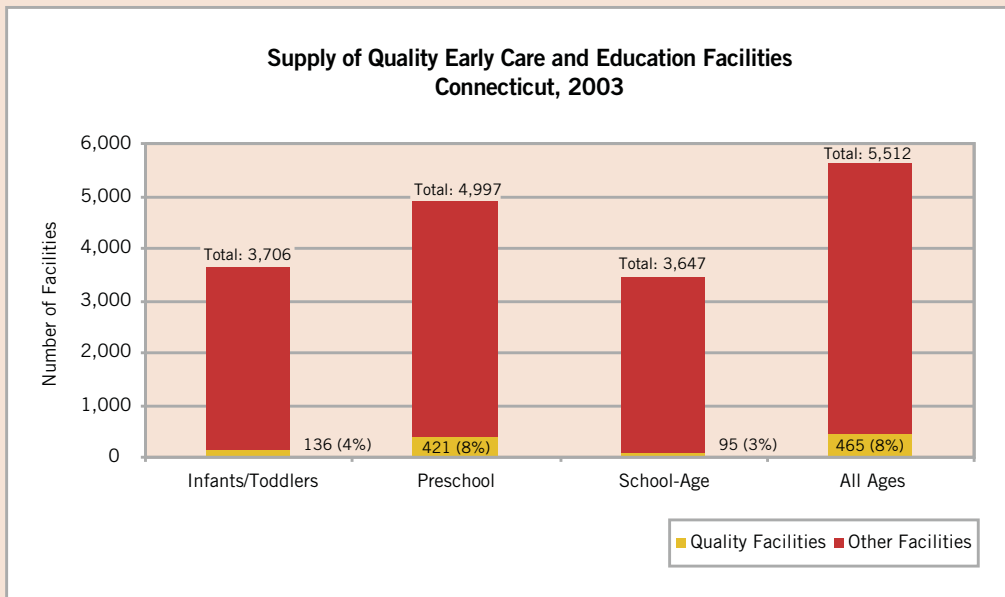
HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Step up the Accreditation Facilitation Project and recruit programs in areas of the state that lack quality early care and education. Also target family child care, infant and toddler care and school-age programs.
- Continue to require accreditation in publicly funded programs.
- Extend the use of *Connecticut's Preschool Curriculum Framework and Benchmarks for Children in Preschool Programs* and the infant and toddler benchmarks that are being developed.
- Implement a comprehensive initiative to improve the qualifications and retention of teaching staff including raising the requirements for licensed teaching staff and family child care providers, providing scholarships and bonuses to upgrade training and education, developing a credentialing system for early childhood teachers and supplementing salaries of teachers as they move along the career ladder.
- Develop a quality rating system (e.g. four stars for high quality). Include accreditation as one criterion for rating programs and publicize the ratings.
- Expand the capacity to train and deploy consultants to child care programs in the areas of health, social and emotional development, education and disabilities.

Only 22% of children in regulated child care are enrolled in programs designated as quality.



Source: Child Care Infoline Provider Database, June 2003.



Source: Child Care Infoline Provider Database, June 2003.

i INFORMATION G - A - P - S

How do early care and education programs in various sectors (e.g. public, private, school-based, family child care) rate on quality scales?

What is the profile of early care and education teaching/caregiving staff in regards to compensation and qualifications?

What is the rate and nature of turnover in early care and education?

Indicator Notes and References

It should be noted that Connecticut school districts provide slots for more than 5,200 preschool children, mostly as part of their preschool special education program. About half of them are accredited or within Head Start programs. Those programs/slots are captured in the data presented here. The unaccredited programs/slots are likely to be quality by virtue of having credentialed teachers, but we have chosen to exclude them from the quality count because they are not part of a rigorous outside monitoring system.

1 Shonkoff, J.P. & Phillips, D.A. eds. (2000) *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academy Press.

Stepping Stone 4: Early Care and Education



INDICATOR: Children Receiving Child Care Subsidies (Care4Kids)

DEFINITION: *Children Receiving Child Care Subsidies* measures the number of children whose child care is subsidized by the Department of Social Services' Care4Kids program. Distinctions are made in this section between "Formal Care," which includes care from regulated providers, and "Informal Care," which describes non-regulated care provided by family, friends and neighbors.

SIGNIFICANCE: Two-thirds of children under age 6 have one or both parents in the workforce, underscoring the need for access to early care and education services that accommodate families with young children.¹ A major barrier to access for families is the cost. Low-income families are priced out of the private regulated market because care is so expensive. In Connecticut, child care is estimated to demand from 17 to 30% of a young family's household budget, just behind housing as an expense.²

Portable subsidies are funded by federal and state dollars to help low-income families (primarily those on welfare) afford child care while they work. Portable subsidies are unique in that they allow parents to choose among an array of providers. Teen parents and a limited number of families on welfare who attend school or training are also eligible for these subsidies. The Connecticut subsidy program administered by the Department of Social Services (DSS) is called Care4Kids. It uses a sliding fee scale to determine how the state and the family will share the cost of care. Subsidies are an important component in helping children from low-income families benefit from early care and education.

HOW ARE WE DOING?

- The number of children receiving subsidies peaked in 2000 (29,485) and has dropped every year since then to a five-year low of 22,633 in 2003 because of severe budget cuts. Between 2002 and 2003, the caseload declined by 20%. The state fiscal year 2004-05 budget allocated \$72 million -- an \$8 million increase in funding, but far below the \$110-121 million of the 2000-2002 period.
- As of February 2004, over 10,000 families including over 17,000 children were on the Care4Kids waiting list because families who were not current or former recipients of Temporary Family Assistance (welfare) were excluded from the program.

- Four municipalities have more than 1,000 children enrolled in Care4Kids – Bridgeport, Hartford, New Haven and Waterbury. For a full town/city list of subsidy enrollment, see page 72.
- There has been a shift among subsidy recipients in the use of formal care from approximately 20% in the 1990s to 46% in 2003. The shift is generally attributed to a change in the rate structure for the program that increased the state's subsidy rates for regulated care and reduced the rates for informal providers.
- The utilization of formal care varies with the age of the children receiving subsidies. Half (50%) of the subsidies for infants and toddlers are applied toward formal care, compared to 57% of the subsidies for preschoolers and 27% for school-age children.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Fund Care4Kids at a level at least equal to State Fiscal Year 2000, increasing the appropriations by \$50 million.
- Develop an entitlement provision in the Care4Kids program for eligible families, similar to the Rhode Island statute.³
- Once fully funded, establish a strong outreach program for Care4Kids to inform eligible families and assist them in applying for the program.

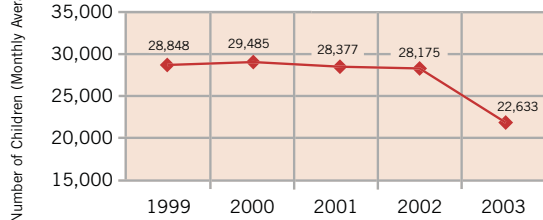
i INFORMATION G - A - P - S

How many children are eligible for subsidized child care because of family income and employment and have a need for child care?

How have changes in Care4Kids regulations affected the child care choices of families?

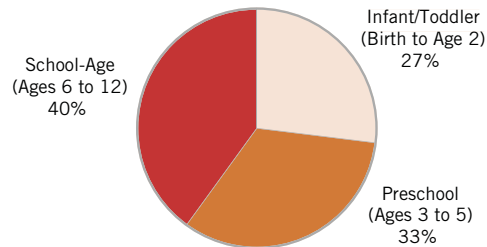
What employment sectors have concentrations of families using Care4Kids subsidies?

Children Receiving Child Care Subsidies (Care4Kids) Connecticut, 1999 - 2003



Source: Connecticut Department of Social Services, 2003.

Care4Kids Recipients by Age Connecticut, 2003



Source: Connecticut Department of Social Services, 2003.

Care4Kids and Special Populations Average Monthly Enrollment Connecticut, 2003

Foster Children	120
Children with Special Needs	200-215*
Children of Teen Parents (non-welfare)	20-40

Source: Connecticut Department of Social Services, 2003.
*This figure may not capture all children with special needs. It only accounts for those children whose families applied for and were granted a 15% bonus payment for their provider due to the child's disability status.

Utilization of Formal Child Care by Families with Subsidies Connecticut, Priority School Districts*, December 2003

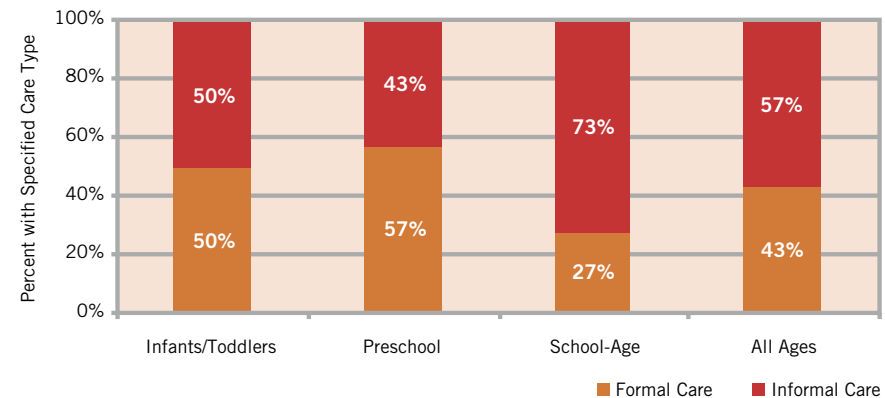
Priority School District	% Using Formal Care
Connecticut	45.9%
Ansonia	43.0%
Bloomfield	69.4%
Bridgeport	47.5%
Bristol	67.4%
Danbury	73.5%
East Hartford	44.0%
Hartford	26.2%
Meriden	40.2%
Middletown	60.0%
New Britain	30.0%
New Haven	32.0%
New London	44.0%
Norwalk	63.6%
Putnam	66.6%
Stamford	65.4%
Waterbury	45.6%
West Haven	47.3%
Windham	39.2%

For a full listing of towns/cities, see page 72.

Source: Connecticut Department of Social Services, December 2003.

* "Priority school districts" are located in high-poverty school districts/towns. Three- and four-year old children attending priority schools are eligible for the state's School Readiness high-quality preschool program.

Child Care Utilization Among Families with Subsidies by Age and Care Type Connecticut, October 2003



Source: Connecticut Department of Social Services, October 2003.

Indicator Notes and References

Other methods of public subsidies are available to qualifying families through federal tax credits and grants to providers to supply care (e.g. School Readiness, Head Start and DSS-funded centers). These subsidies are not included in the preceding calculations.

1 US Census Bureau 2000.

2 Pearce, D. & Brooks, J. (1999). *The Self-Sufficiency Standard for Connecticut*. Hartford, CT: Office of Policy and Management.

3 Rhode Island Department of Human Services. (2004). *DHS Child Care Assistance Program* at

www.dhs.state.ri.us/dhs/famchild/dcspgm.htm

Stepping Stone 4: Early Care and Education



INDICATOR: Kindergarten Children with a Preschool Experience

DEFINITION: *Kindergarten Children with a Preschool Experience* measures the percent of children entering kindergarten who “had a preschool experience” according to parent reporting.

SIGNIFICANCE: The term “school readiness” has been coined to describe the capacity of young children to enter formal education with the skills, knowledge and attitudes to be successful students. That capacity has been identified as a broad foundation that includes language, basic concepts, physical development, curiosity and positive attitudes about learning. It also involves the development of social skills that will be necessary for the child to operate in a classroom, stay on task, wait for a turn, etc. ¹

For most children, a group preschool program is a valuable component of that preparation and the successful transition to school. The National Research Council made a strong case for preschool, especially for children who are at risk for school failure.² The preschool experience is a contributor to positive child outcomes for those children who are the most disadvantaged because of poverty and other risk factors. The experience of a quality preschool tends to narrow the preparation gap and later the achievement gap for these children.

The short-term effects of a quality preschool experience are exhibited in a child’s ability to learn in the school environment. Longer-term, these children are more likely to progress without the need for special education, remediation or grade retention.³

HOW ARE WE DOING?

- Statewide, 76% of children enter kindergarten having had a preschool experience.
- Fifty-five Connecticut school districts fall below the statewide average, with less than 76% of their kindergarten students attending preschool. These communities comprise the largest cities and many of the most rural towns.
- Wide disparities exist between communities of wealth (ERGs⁴ A and B) and those with a preponderance of poverty (ERGs H and I).
- Since the 1997-1998 school year (which marked the initiation of the School Readiness program⁵ in 18 priority school districts), preschool attendance has increased 5-24% in 15 of those high priority districts. Still, only 5 of those districts exceeded the statewide average for children with a preschool experience (Bloomfield, Meriden, Middletown, Norwalk and Stamford).

HOW CAN WE DO BETTER FOR CONNECTICUT’S CHILDREN?

- Expand the School Readiness program for three and four year olds in the communities that have concentrations of poverty.
- Develop and implement a plan to reach the Connecticut State Board of Education’s goal of “providing universal access to high-quality preschool based on parent and community ability to pay.”⁶
- Develop a methodology for schools to collect the information on preschool experience of incoming kindergarteners that incorporates a uniform definition of preschool experience and a measure of the quality, duration and intensity of the experience.

A quality preschool experience tends to narrow the preparation gap and later the achievement gap for children.

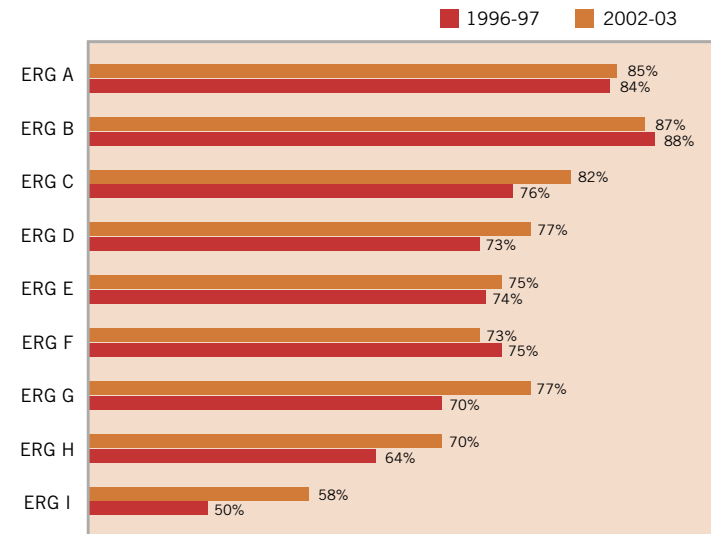
Kindergarten Children with a Preschool Experience
 (School districts with percentages that rank in the bottom quartile of the state are displayed)
Connecticut, 2002-2003 School Year

School District	% of Kindergarteners with a Preschool Experience
Connecticut	75.9%
(note: 13 additional school districts are below the statewide average, but do not fall into the bottom quartile)	
Clinton	71.6%
Scotland	71.4%
Montville	71.3%
Enfield	71.2%
New Haven	71.2%
Ansonia	70.3%
Danbury	70.1%
Colchester	70.0%
Windham	69.8%
Groton	69.4%
Plainfield	69.2%
Thomaston	68.9%
West Haven	68.6%
Stonington	68.5%
Coventry	67.9%
Naugatuck	67.9%
Eastford	66.7%
Stratford	65.8%
Bozrah	65.0%
North Canaan	64.9%
Putnam	64.2%
New Milford	62.8%
Regional School District 13 (Durham and Middlefield)	62.8%
Hamden	61.9%
Killingly	61.7%
Bridgeport	61.1%
Derby	60.4%
Manchester	60.2%
Salisbury	59.4%
Sharon	59.1%
Litchfield	59.0%
Tolland	58.4%
Chaplin	58.3%
Lebanon	58.3%
New London	55.8%
Sprague	55.6%
Hartford	50.8%
Waterbury	49.3%
East Hartford	48.6%
Ashford	47.9%
New Britain	47.0%
Canaan	42.9%

For a full listing of school districts, see page 72.

Source: Connecticut Department of Education, Strategic School Profiles, 2002-2003.

**Kindergarten Children with a Preschool Experience
 by Education Reference Group (ERG)*
 Connecticut, School Years 1996-97 and 2002-03**



Percent of Kindergarteners with a Preschool Experience

Source: Connecticut State Board of Education, 2003.

*The state's 166 school districts and 3 academies are divided into 9 Education Reference Groups (ERGs) based on socioeconomic status, indicators of need and enrollment. ERG A is the wealthiest and ERG I is the poorest.

Indicator Notes and References

- 1 National Education Goals Panel. (1997). *Getting a Good Start in School*. Washington, DC: National Education Goals Panel.
- 2 National Research Council. (2000). *Eager to Learn. Educating Our Preschoolers*. Washington, DC: National Academy Press.
- 3 Gomby, D.S. et al. (1995). Long-Term Outcomes of Early Childhood Programs: Analysis and Recommendations. *The Future of Children*, 5 (3): 6-24.
- 4 The state's 166 school districts and 3 academies are divided into 9 Education Reference Groups (ERGs) based on socioeconomic status, indicators of need and enrollment. ERG A is the wealthiest and ERG I is the poorest.
- 5 Connecticut's School Readiness program was created in 1997 to provide high-quality preschool services in accredited or approved programs for three- and four-year old children in urban and high poverty districts or in high-need schools within other districts.
- 6 Connecticut State Board of Education. (2003). *Closing the Achievement Gaps: Removing the Barriers to Preschool in Connecticut*.





STEPPING STONE 5: READY SCHOOLS

Goal: All children attend schools that continue to support their learning and development





INDICATOR: Average Kindergarten Class Size

DEFINITION: *Average Kindergarten Class Size* measures the average number of students in a kindergarten classroom.

SIGNIFICANCE: School success not only requires that children are ready to learn, but also that schools are ready to support learning throughout a child's academic career. In addition to providing high quality teachers, monitoring class size in the early grades (K to 3) is one effective way schools can enhance learning and help students achieve long-term academic success.

Research has shown that children - especially poor and minority children - in smaller classes exhibit stronger academic performance than their peers in larger classes.¹ Studies also indicate that smaller class size contributes to reductions in grade retention and school drop out.² Generally, small class size is considered to be between 15 and 20 students. In kindergarten, a limit of sixteen students per class is recommended.³ Reducing the number of children in a classroom helps teachers provide more individualized attention to students and can lead to overall improvement in the quality of classroom activities.

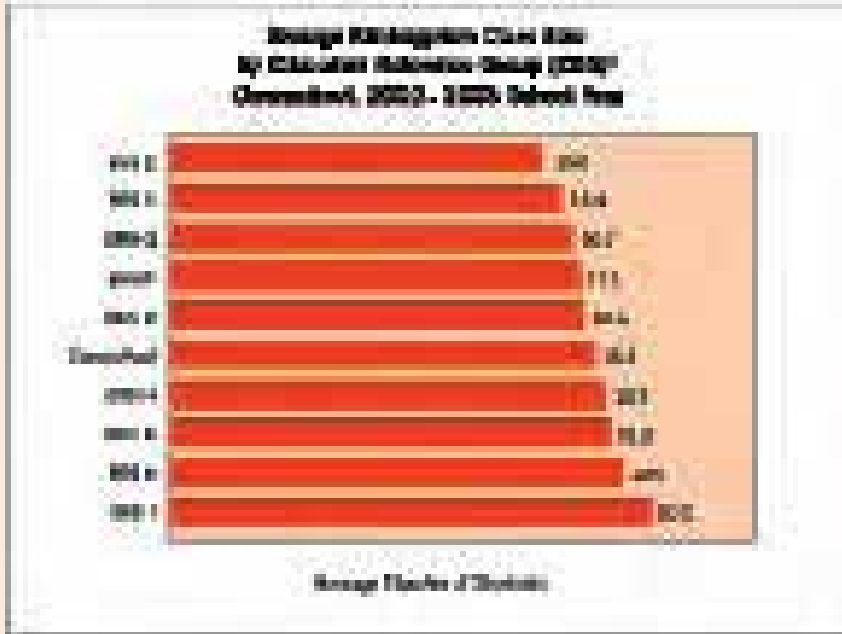
Education Reference Group (ERG) I, which includes Connecticut's poorest schools, has the highest average kindergarten class size. Nearly half of all schools in ERG I have an average class size of more than 20 kindergarteners.

HOW ARE WE DOING?

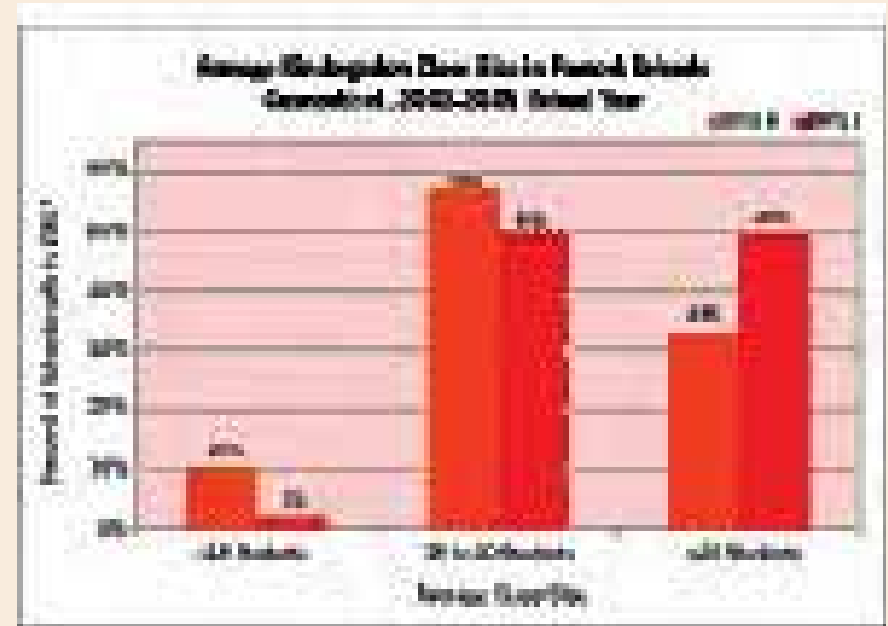
- Education Reference Group (ERG) I, which includes Connecticut's poorest schools, has the highest average kindergarten class size. Nearly half of all schools in ERG I offering kindergarten have an average class size of more than 20 students. In the New Haven school district, the average class size is 24.
- The majority (58%) of schools in ERGs H and I, which include most of Connecticut's at-risk children, average 20 kindergarteners or less per classroom. However, in 91 schools the average class size exceeds 20 students. The at-risk children that attend these schools are particularly vulnerable to the negative impact larger class sizes can have on academic development.
- The two wealthiest and poorest ERGs (A, B, H and I) have class sizes that exceed the statewide average of 18.3 students per classroom.

HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Take incremental steps to reduce class size, ensuring that adequate facilities and qualified teachers are available as the effort moves forward.
- Focus initial efforts to reduce class size in lower-income schools, as research has shown the positive effects of smaller classes are greater among poor and minority students.
- Integrate class size reduction efforts with other quality improvement initiatives, such as professional development for staff and curriculum evaluation/enhancement.
- Ensure that all kindergarten teachers have early childhood certification and receive ongoing early childhood training.



Source: Connecticut State Department of Education, Strategic School Profiles, 2002-2003.
 *The state's 166 school districts and 3 academies are divided into 9 Education Reference Groups (ERGs), based on socioeconomic status, indicators of need and enrollment. ERG A is the wealthiest and ERG I is the poorest.



Source: Connecticut State Department of Education, 2002-2003.
 *The state's 166 school districts and 3 academies are divided into 9 Education Reference Groups (ERGs), based on socioeconomic status, indicators of need and enrollment. ERG A is the wealthiest and ERG I is the poorest.
 Note: Totals do not sum to 100% due to rounding.

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How many kindergarten teachers have certification in early childhood?

How many classrooms have additional staff (e.g. aides) on a regular basis?

Indicator Notes and References

- 1 Mosteller, F. (1995). The Tennessee study of class size in the early grades. *The Future of Children*, (5) 2:113-127.
- 2 Schwartz, W. (2003). *Class Size Reduction and Urban Students*. New York, NY: ERIC Clearinghouse on Urban Education.
- 3 Kagan, S.L., and Rigby, E. (2003). *Improving the Readiness of Children for School: A Series of Policy Briefs from the Policy Matters Project, Brief No. 2*. Washington, DC: Center for the Study of Social Policy.



INDICATOR: Children in Full-Day Kindergarten

DEFINITION: *Children in Full-Day Kindergarten* measures the number of children enrolled in a full-day kindergarten program. A full-day kindergarten program provides 900 hours of actual schoolwork for a minimum of 180 days (5 hours a day), compared to only 450 hours in a half-day program and between 450 and 900 hours in an extended day program.

SIGNIFICANCE: Over the past few decades, there has been a national shift from half-day to full-day kindergarten, particularly for low-income and minority children. Currently, 44% (18,338) of Connecticut's 42,000 kindergarteners are enrolled in full-day programs, which run the full length of the school day. Parent preference has contributed to this trend, as many full-time workers need all day care for their young children. In addition, a strong body of research attesting to positive outcomes for children in full-day versus half-day kindergarten has given the movement momentum.

Among the many academic and social benefits of full-day kindergarten are higher standardized test performance, lower grade retention and better-developed social skills.¹ An all-day program limits the number of daily transitions a child experiences and, most importantly, provides more time for the teacher to offer individualized guidance. With a child-centered and developmentally appropriate curriculum as the foundation, full-day kindergarten can help promote continued school success.

Although nationally 60% of kindergarteners attend full-day programs, in Connecticut full-day kindergarten accounts for only 44% of all kindergarten enrollment.

HOW ARE WE DOING?

- Although nationally 60%² of kindergarteners attend full-day programs, in Connecticut full-day kindergarten accounts for only 44% of all kindergarten enrollment. The remaining children are enrolled in either half-day (44%) or extended day (12%) programs.
- The majority of children in Connecticut's poorest schools (ERGs H and I) are enrolled in full-day kindergarten. ERG I has the highest enrollment in the state – 95% of all kindergarteners are in full-day programs.
- Among Connecticut's school districts with kindergarten classrooms, more than half (56%) have no children enrolled in full-day kindergarten. However, in 17% of school districts all kindergarteners are enrolled in a full-day program. (For a complete listing of full-day enrollment by school district, see page 72.)

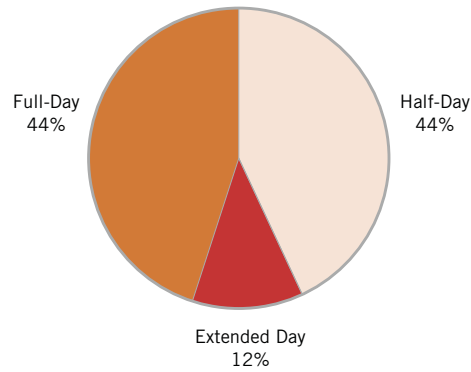
HOW CAN WE DO BETTER FOR CONNECTICUT'S CHILDREN?

- Increase the availability of full-day kindergarten, particularly in ERG H, which serves many at-risk children. Phase in changes incrementally so that quality facilities and skilled instructors are in place.
- As the shift from half-day to full-day kindergarten programs continues, evaluate the need for professional development among teaching staff so that students can benefit from new opportunities afforded by the lengthening of the school day.
- In all kindergarten programs, ensure that the curriculum remains developmentally appropriate and refrain from certain academic instruction that is inappropriate for young children.

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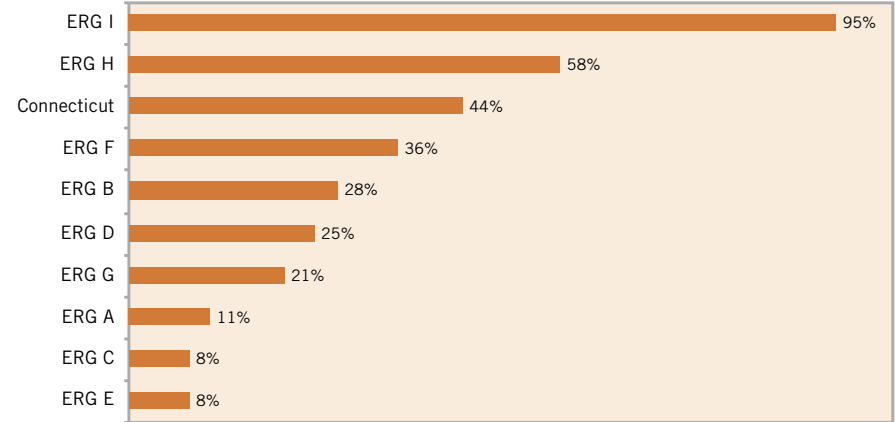
How many schools have plans in place to help children successfully transition from preschool into kindergarten?

**Kindergarten Enrollment by Type
Connecticut, 2003-2004 School Year**



Source: Connecticut State Department of Education, 2003-2004.

**Children Enrolled in Full-Day Kindergarten by Education Reference Group (ERG)*
Connecticut, 2003-2004 School Year**

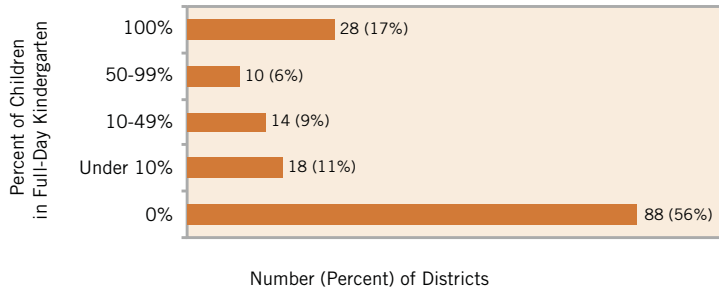


Percent of Children in Full-Day Kindergarten

Source: Connecticut State Department of Education, Strategic School Profiles, 2002-2003.

*The state's 166 school districts and 3 academies are divided into 9 Education Reference Groups, based on socioeconomic status, indicators of need and enrollment. ERG A is the wealthiest and ERG I is the poorest.

**Children Enrolled in Full-Day Kindergarten by School District
Connecticut, 2003-2004 School Year**



Source: Connecticut State Department of Education, 2003-2004.

Notes: Data excludes districts without any kindergarten enrollees. Totals do not sum to 100% due to rounding.

Indicator Notes and References

1 Clark, P. (2001). *Recent Research on All-Day Kindergarten*. Champaign, IL: ERIC Clearinghouse on Elementary and Early Childhood Education.

2 Wirt, J., Choy, S., Rooney, P., Provasnik, S., Sen, A., & Tobin, R. (2004). *The Condition of Education 2004* (NCES 2004-077). U.S. Department of Education, National Center for Education Statistics. Washington, DC: U.S. Government Printing Office.





OUTCOMES:

Are Connecticut's Children Succeeding in School?





INDICATOR: Children Meeting State Goal¹ for Connecticut Mastery Test (4th Grade)

DEFINITION: *Children Meeting State Goal for Connecticut Mastery Test (4th Grade)* measures the percent of fourth grade students who met the state goal for the Connecticut Mastery Test (CMT) on all three test subjects: Reading, Writing and Mathematics.

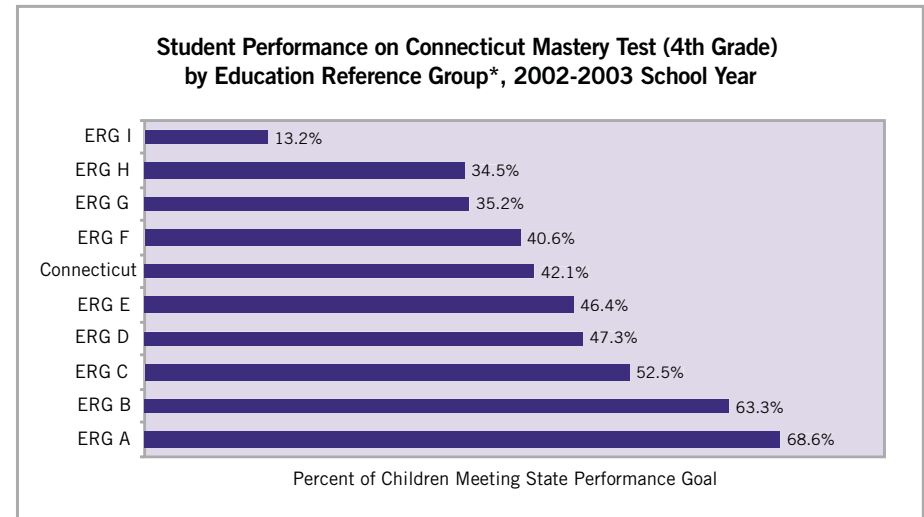
SIGNIFICANCE: Tracking school outcome measures, like CMT performance, helps assess how Connecticut children are doing once they cross the threshold of the school building. The Connecticut Mastery Test is administered for the first time in fourth grade and measures student performance in reading, writing and mathematics. The skills and concepts covered in the examination are those which students are expected to have mastered during the previous school year. Mastery of the basic skills taught through third grade are particularly predictive of future academic success, as these skills form the foundation upon which higher learning is developed.

In collaboration with Connecticut educators, the state establishes performance goals that are used to assess how well individual children are doing and identify subject areas where a child may need help. The performance goals also provide a benchmark for schools and school districts to assess their progress in fostering student achievement and ultimately, to promote continuous improvement of instruction and learning.

HOW ARE WE DOING?

- In ERG I, which includes Bridgeport, Hartford, New Britain, New Haven, New London, Waterbury and Windham school districts, only 13% of children met the state performance goal.

- Statewide, less than half (42%) of Connecticut 4th graders are meeting the performance goals in reading, writing and mathematics.
- In the state's wealthiest school districts (ERGs A and B) roughly two-thirds of students are reaching the performance goals.



Source: Connecticut State Department of Education, Strategic School Profiles, 2002-2003.
*The state's 166 school districts and 3 academies are divided into 9 Education Reference Groups (ERGs), based on socioeconomic status, indicators of need and enrollment. ERG A is the wealthiest and ERG I is the poorest.

To move toward better outcomes, like improved state mastery test performance, focusing on early childhood and preparing young children for school success is essential.

STUDENT RETENTION

Grade retention (holding a child back) is a common way that parents and educators address students with low academic performance or behavioral concerns. The intent is to reduce the chances of failure at a higher grade level by giving the child another year to mature and/or to master certain skills. However, the preponderance of research indicates that students generally do not benefit from grade retention, particularly in the early years.²

Although there may be positive results for individual children, especially if remedial services are provided along the way, for most being held back lowers self-esteem and ultimately undermines long-term academic success.³ For example, students who are retained at any age are more likely to eventually drop out of school.⁴ Given the significant expense to the school system of grade repetition and the relative ineffectiveness of this practice, ensuring that children enter school ready to succeed is a sound policy direction from both a social and fiscal perspective.

INFORMATION G - A - P

How many children are retained in grade in their early years of schooling (kindergarten through grade 3)?

Indicator Notes and References

1 The state performance goal on the Connecticut Mastery Test was developed in collaboration with Connecticut educators. The Goal level is more demanding than the state Proficient level, but less demanding than the Advanced level reported in the No Child Left Behind Report Cards.

2 Jimerson, S.R. (2001). Meta-analysis of grade retention research: Implications for practice in the 21st century. *School Psychology Review*, 30: 313-330.

3 Thompson, C.L., and Cunningham, E.K. (2000). *Retention and Social Promotion: Research and Implications for Policy: ERIC Digest Number 161*. New York, NY: ERIC Clearinghouse on Urban Education.

4 Jimerson, S.R., Anderson, G.E., & Whipple, A.D. (2002). Winning the battle and losing the war: Examining the relation between grade retention and dropping out of high school. *Psychology in the Schools*, 39: 441-457.





TOWN/CITY DATA AT-A-GLANCE AND INDICATOR METHODOLOGY



Town/City Data: Part 1



	Children Under Age 6 2000 (1)	Births to Women Receiving Late or No Prenatal Care 1999-2001 (2)		Infant Deaths 1997-2001 (3)		Births to Teens Ages 15 to 19 1999-2001 (4)		Low Birthweight Births 1999-2001 (5)		Children (<19) Enrolled in HUSKY A July 2003- June 2004 (6)
	#	Total #	% of Births (3-year avg.)	Total #	Rate per 1,000 Live Births (5-year avg.)	Total #	% of Births (3-year avg.)	Total #	% of Births (3-year avg.)	Avg. Monthly Enrollment
Connecticut	270,187	13,519	10.9%	1,422	6.6	9,747	7.6%	9,599	7.5%	208,147
Andover	280	9	7.1%	1	-	3	-	13	10.2%	85
Ansonia	1,529	72	10.0%	11	8.9	66	8.8%	82	11.0%	1,656
Ashford	306	14	10.9%	1	-	4	-	9	6.8%	247
Avon	1,269	33	6.6%	4	6.0	2	-	24	4.8%	143
Barkhamsted	237	5	4.5%	1	-	1	-	5	4.5%	121
Beacon Falls	408	5	2.7%	2	-	5	2.6%	12	6.2%	155
Berlin	1,284	67	12.2%	4	-	15	2.7%	46	8.3%	371
Bethany	399	4	-	1	-	3	-	12	7.5%	85
Bethel	1,505	30	4.1%	2	-	15	2.2%	30	4.4%	476
Bethlehem	220	2	-	2	-	3	-	5	6.5%	107
Bloomfield	1,206	62	10.8%	11	11.2	51	8.7%	52	8.9%	1,174
Bolton	380	12	8.3%	3	-	11	7.4%	5	3.4%	96
Bozrah	157	12	15.2%	0	-	3	-	2	-	77
Branford	1,846	34	4.2%	8	5.3	22	2.6%	55	6.5%	830
Bridgeport	13,635	1,229	19.7%	141	12.2	1,130	16.2%	700	10.1%	21,039
Bridgewater	96	0	-	0	-	0	-	3	-	26
Bristol	4,497	184	8.4%	17	4.5	173	7.8%	159	7.2%	3,693
Brookfield	1,268	22	4.0%	1	-	5	0.9%	39	7.1%	224
Brooklyn	471	13	7.9%	0	-	11	6.5%	11	6.5%	235
Burlington	752	18	6.0%	0	-	2	-	12	4.0%	149
Canaan	73	4	-	1	-	0	-	4	-	81
Canterbury	307	13	8.6%	1	-	14	9.2%	6	3.9%	222
Canton	698	13	4.4%	3	-	2	-	11	3.6%	160
Chaplin	187	6	9.5%	0	-	5	7.9%	3	-	106
Cheshire	2,010	41	4.7%	5	3.4	12	1.4%	36	4.1%	341
Chester	284	12	10.1%	0	-	3	-	5	4.0%	94
Clinton	1,041	30	6.0%	3	-	17	3.3%	31	6.0%	440
Colchester	1,515	57	8.6%	1	-	22	3.3%	40	6.0%	573
Colebrook	115	3	-	0	-	1	-	2	-	12
Columbia	393	16	9.4%	1	-	3	-	25	14.5%	120
Cornwall	86	6	20.0%	1	-	3	-	1	-	60
Coventry	983	30	6.6%	9	11.8	15	3.3%	28	6.1%	419

	Children Under Age 6 2000 (1)	Births to Women Receiving Late or No Prenatal Care 1999-2001 (2)		Infant Deaths 1997-2001 (3)		Births to Teens Ages 15 to 19 1999-2001 (4)		Low Birthweight Births 1999-2001 (5)		Children (<19) Enrolled in HUSKY A July 2003-June 2004 (6)
	#	Total #	% of Births (3-year avg.)	Total #	Rate per 1,000 Live Births (5-year avg.)	Total #	% of Births (3-year avg.)	Total #	% of Births (3-year avg.)	Avg. Monthly Enrollment
Connecticut	270,187	13,519	10.9%	1,422	6.6	9,747	7.6%	9,599	7.5%	208,147
Cromwell	833	44	11.0%	1	-	6	1.5%	31	7.6%	378
Danbury	5,846	306	9.6%	21	4.0	244	7.6%	197	6.1%	4,338
Darien	2,442	36	4.0%	4	-	3	-	48	5.2%	90
Deep River	318	15	8.7%	1	-	10	5.7%	11	6.3%	283
Derby	927	38	8.6%	3	-	35	7.6%	35	7.6%	851
Durham	556	16	6.6%	3	-	6	2.4%	13	5.3%	162
East Granby	396	11	6.7%	1	-	3	-	6	3.6%	116
East Haddam	696	21	7.1%	2	-	9	3.0%	17	5.7%	259
East Hampton	853	33	8.8%	2	-	11	2.9%	19	5.0%	333
East Hartford	3,885	287	15.0%	37	11.2	210	10.7%	174	8.8%	4,792
East Haven	1,930	70	7.5%	13	7.8	65	6.7%	66	6.8%	1,467
East Lyme	1,086	31	6.8%	4	-	12	2.6%	27	5.9%	443
East Windsor	645	24	7.3%	5	6.4	16	4.8%	24	7.2%	574
Eastford	123	2	-	0	-	3	-	8	16.7%	28
Easton	694	4	-	1	-	1	-	11	4.0%	52
Ellington	1,007	26	5.3%	2	-	18	3.6%	32	6.4%	274
Enfield	3,083	94	6.9%	14	5.8	79	5.7%	96	6.9%	1,869
Essex	511	11	5.4%	2	-	1	-	16	7.6%	133
Fairfield	4,910	63	2.9%	15	3.9	20	0.9%	133	5.8%	717
Farmington	1,667	46	6.6%	9	7.5	8	1.1%	40	5.6%	394
Franklin	130	7	12.7%	0	-	5	9.1%	3	-	55
Glastonbury	2,766	62	5.7%	9	4.8	10	0.9%	70	6.3%	506
Goshen	173	3	-	2	-	1	-	5	9.1%	71
Granby	872	22	5.8%	6	9.2	5	1.3%	25	6.5%	168
Greenwich	5,221	116	5.8%	10	2.6	26	1.2%	85	4.2%	758
Griswold	782	31	9.2%	5	9.3	28	8.3%	29	8.6%	694
Groton	3,836	270	13.9%	20	6.0	195	9.8%	128	6.5%	1,644
Guilford	1,571	25	3.8%	5	4.5	13	1.9%	55	8.1%	333
Haddam	515	14	6.8%	2	-	7	3.4%	12	5.8%	164
Hamden	3,675	147	8.1%	12	3.9	67	3.5%	145	7.7%	2,488
Hampton	130	6	11.5%	2	-	3	-	2	-	103
Hartford	12,134	1,243	19.6%	144	13.0	1366	20.8%	765	11.7%	25,324

Town/City Data: Part 1



	Children Under Age 6 2000 (1)	Births to Women Receiving Late or No Prenatal Care 1999-2001 (2)		Infant Deaths 1997-2001 (3)		Births to Teens Ages 15 to 19 1999-2001 (4)		Low Birthweight Births 1999-2001 (5)		Children (<19) Enrolled in HUSKY A July 2003-June 2004 (6)
	#	Total #	% of Births (3-year avg.)	Total #	Rate per 1,000 Live Births (5-year avg.)	Total #	% of Births (3-year avg.)	Total #	% of Births (3-year avg.)	Avg. Monthly Enrollment
Connecticut	270,187	13,519	10.9%	1,422	6.6	9,747	7.6%	9,599	7.5%	208,147
Hartland	134	5	9.4%	0	-	1	-	1	-	50
Harwinton	366	6	4.0%	1	-	2	-	6	4.0%	104
Hebron	928	15	3.9%	3	-	6	1.6%	8	2.1%	182
Kent	215	11	11.7%	0	-	2	-	8	8.5%	88
Killingly	1,231	98	15.0%	11	9.9	88	13.3%	69	10.4%	1,632
Killingworth	549	9	3.7%	2	-	1	-	20	8.1%	99
Lebanon	554	18	25.7%	4	-	9	4.2%	15	7.0%	250
Ledyard	1,125	54	12.3%	10	13.1	20	4.6%	34	7.8%	489
Lisbon	307	6	5.9%	1	-	4	-	8	7.9%	149
Litchfield	521	8	4.0%	1	-	4	-	9	4.5%	319
Lyme	120	6	10.2%	0	-	0	-	7	11.7%	27
Madison	1,504	19	3.5%	7	7.5	4	-	28	5.1%	196
Manchester	4,129	198	9.9%	19	5.7	149	7.4%	149	7.4%	3,640
Mansfield	740	31	9.6%	2	-	17	5.2%	14	4.3%	438
Marlborough	484	22	10.3%	1	-	4	-	13	6.0%	113
Meriden	4979	429	18.9%	18	4.5	314	13.7%	184	8.0%	6,290
Middlebury	434	7	4.1%	0	-	2	-	7	4.1%	91
Middlefield	294	11	8.5%	5	23.8	3	-	12	9.2%	66
Middletown	3,330	233	14.2%	18	6.4	98	5.9%	98	5.9%	2,886
Milford	3,749	129	7.3%	25	8.0	53	2.9%	113	6.2%	1,657
Monroe	1,772	22	3.4%	5	4.2	8	1.2%	47	6.9%	311
Montville	1,267	54	9.9%	2	-	38	6.9%	37	6.8%	701
Morris	157	4	-	0	-	3	-	5	6.0%	76
Naugatuck	2,593	97	8.7%	9	4.6	71	6.2%	92	8.0%	1919
New Britain	5,685	630	21.3%	52	10.4	563	18.6%	252	8.3%	9,590
New Canaan	1,934	20	3.2%	4	-	4	-	28	4.4%	91
New Fairfield	1,347	21	4.1%	3	-	17	3.3%	32	6.2%	325
New Hartford	496	17	7.1%	0	-	4	-	16	6.7%	140
New Haven	10,431	954	18.2%	84	9.0	946	16.6%	585	10.2%	19,480
New London	2,034	239	21.3%	23	12.0	154	13.6%	98	8.7%	3,348
New Milford	2,362	72	6.7%	7	4.0	41	3.8%	62	5.8%	856
Newington	1,873	81	10.2%	6	4.3	19	2.3%	45	5.5%	785

	Children Under Age 6 2000 (1)	Births to Women Receiving Late or No Prenatal Care 1999-2001 (2)		Infant Deaths 1997-2001 (3)		Births to Teens Ages 15 to 19 1999-2001 (4)		Low Birthweight Births 1999-2001 (5)		Children (<19) Enrolled in HUSKY A July 2003-June 2004 (6)
	#	Total #	% of Births (3-year avg.)	Total #	Rate per 1,000 Live Births (5-year avg.)	Total #	% of Births (3-year avg.)	Total #	% of Births (3-year avg.)	Avg. Monthly Enrollment
Connecticut	270,187	13,519	10.9%	1,422	6.6	9,747	7.6%	9,599	7.5%	208,147
Newtown	2,427	41	4.0%	6	3.4	10	1.0%	56	5.4%	411
Norfolk	120	4	-	0	-	2	-	10	17.2%	71
North Branford	1,113	11	2.5%	4	-	6	1.3%	28	6.1%	329
North Canaan	217	11	11.6%	1	-	12	12.6%	7	7.4%	159
North Haven	1,523	33	5.1%	6	5.3	13	1.9%	47	6.9%	503
North Stonington	348	13	7.6%	1	-	8	4.7%	16	9.3%	216
Norwalk	6,747	425	11.6%	37	5.7	202	5.3%	314	8.3%	4,361
Norwich	2,808	223	15.6%	19	8.0	167	11.7%	92	6.4%	3,594
Old Lyme	519	9	4.6%	5	14.5	5	2.5%	12	6.1%	127
Old Saybrook	727	26	9.0%	4	-	12	4.1%	19	6.5%	300
Orange	931	14	4.0%	2	-	2	-	19	5.2%	162
Oxford	795	19	5.3%	0	-	6	1.6%	17	4.6%	262
Plainfield	1,157	57	10.2%	10	10.7	61	10.7%	45	7.9%	1,114
Plainville	1,035	45	8.9%	11	12.7	26	5.1%	36	7.0%	669
Plymouth	881	23	6.3%	3	-	15	4.0%	21	5.6%	660
Pomfret	277	13	10.2%	0	-	5	3.9%	5	3.9%	133
Portland	738	29	8.9%	4	-	9	2.7%	20	6.1%	299
Preston	260	9	7.8%	1	-	7	6.0%	4	-	160
Prospect	666	14	5.1%	3	-	12	4.3%	17	6.0%	228
Putnam	645	40	12.5%	6	11.2	26	7.7%	25	7.4%	749
Redding	705	8	3.1%	0	-	1	-	15	5.5%	69
Ridgefield	2,356	27	3.0%	2	-	6	0.7%	42	4.7%	156
Rocky Hill	1,104	55	10.1%	6	6.4	12	2.2%	36	6.5%	275
Roxbury	124	1	-	0	-	0	-	2	-	32
Salem	316	10	7.8%	2	-	3	-	5	3.9%	97
Salisbury	184	16	17.2%	3	-	3	-	9	9.6%	131
Scotland	137	4	-	2	-	1	-	1	-	59
Seymour	1,104	32	6.3%	3	-	26	4.9%	27	5.1%	590
Sharon	154	8	14.0%	2	-	3	-	5	8.3%	90
Shelton	2,817	58	4.8%	12	5.5	39	3.1%	83	6.6%	1,041
Sherman	298	7	6.6%	1	-	1	-	6	5.7%	84
Simsbury	2,044	39	5.1%	7	6.4	10	1.3%	49	6.3%	253

Town/City Data: Part 1



	Children Under Age 6 2000 (1)	Births to Women Receiving Late or No Prenatal Care 1999-2001 (2)		Infant Deaths 1997-2001 (3)		Births to Teens Ages 15 to 19 1999-2001 (4)		Low Birthweight Births 1999-2001 (5)		Children (<19) Enrolled in HUSKY A July 2003-June 2004 (6)
	#	Total #	% of Births (3-year avg.)	Total #	Rate per 1,000 Live Births (5-year avg.)	Total #	% of Births (3-year avg.)	Total #	% of Births (3-year avg.)	Avg. Monthly Enrollment
Connecticut	270,187	13,519	10.9%	1,422	6.6	9,747	7.6%	9,599	7.5%	208,147
Somers	559	20	7.9%	2	-	10	3.8%	23	8.8%	169
South Windsor	1,939	43	5.8%	6	4.6	8	1.1%	52	7.0%	424
Southbury	1,207	17	3.2%	1	-	6	1.4%	16	3.6%	231
Southington	2,866	115	8.4%	9	4.0	45	3.3%	98	7.1%	1,089
Sprague	185	8	8.2%	3	-	7	7.1%	7	7.1%	188
Stafford	886	28	7.4%	7	10.6	27	7.0%	24	6.2%	557
Stamford	9,647	599	11.4%	25	2.7	240	4.3%	432	7.9%	6,075
Sterling	286	15	13.0%	0	-	9	7.8%	6	5.2%	177
Stonington	1,192	49	10.0%	4	-	29	5.8%	20	4.0%	795
Stratford	3,613	106	6.6%	19	6.6	107	6.3%	141	8.3%	2,370
Suffield	876	20	5.2%	5	7.7	10	2.5%	26	6.6%	217
Thomaston	534	15	5.9%	0	-	13	5.1%	10	3.9%	295
Thompson	634	30	12.7%	4	-	22	7.9%	26	9.7%	383
Tolland	1,213	12	2.3%	7	8.3	8	1.5%	41	7.9%	218
Torrington	2,513	122	9.7%	13	6.4	93	7.4%	97	7.7%	2,387
Trumbull	2,849	78	6.8%	13	6.4	12	1.0%	61	5.0%	516
Union	53	2	-	0	-	0	-	0	-	14
Vernon	2,069	102	10.2%	17	10.1	85	8.3%	60	5.9%	1,655
Voluntown	202	7	7.2%	0	-	6	6.2%	5	5.2%	92
Wallingford	3,216	129	8.8%	10	3.9	40	2.7%	101	6.7%	1,249
Warren	88	0	-	0	-	2	-	4	-	33
Washington	190	6	6.4%	1	-	3	-	9	9.5%	126
Waterbury	9,785	940	19.9%	78	9.5	756	15.4%	445	9.1%	15,850
Waterford	1,168	45	9.1%	3	-	26	5.2%	26	5.2%	616
Watertown	1,568	50	7.6%	5	4.6	18	2.7%	48	7.2%	662
West Hartford	4,384	192	9.5%	14	4.2	92	4.4%	144	6.9%	1,757
West Haven	3,896	246	12.8%	24	6.9	225	11.0%	193	9.5%	4,638
Westbrook	423	18	8.2%	0	-	3	-	16	7.2%	222
Weston	1,014	15	4.2%	2	-	1	-	25	6.9%	35
Westport	2,392	25	3.0%	9	5.7	7	0.8%	57	6.7%	185
Wethersfield	1,684	52	6.7%	7	5.3	18	2.3%	41	5.2%	625
Willington	351	13	5.7%	3	-	5	3.1%	9	5.7%	152



	Children Under Age 6 2000 (1)	Births to Women Receiving Late or No Prenatal Care 1999-2001 (2)		Infant Deaths 1997-2001 (3)		Births to Teens Ages 15 to 19 1999-2001 (4)		Low Birthweight Births 1999-2001 (5)		Children (<19) Enrolled in HUSKY A July 2003-June 2004 (6)
	#	Total #	% of Births (3-year avg.)	Total #	Rate per 1,000 Live Births (5-year avg.)	Total #	% of Births (3-year avg.)	Total #	% of Births (3-year avg.)	Avg. Monthly Enrollment
Connecticut	270,187	13,519	10.9%	1,422	6.6	9,747	7.6%	9,599	7.5%	208,147
Wilton	1,725	17	10.6%	1	-	2	-	35	5.5%	70
Winchester	731	42	10.0%	2	-	46	10.8%	36	8.5%	906
Windham	1,773	167	17.5%	11	6.9	173	17.9%	87	9.0%	3,044
Windsor	2,065	78	8.3%	19	11.6	68	7.0%	87	9.0%	1,327
Windsor Locks	842	29	7.5%	10	14.8	28	7.0%	30	7.5%	524
Wolcott	1,192	36	7.9%	4	-	13	2.8%	33	7.2%	506
Woodbridge	636	6	3.1%	0	-	2	-	11	5.5%	87
Woodbury	671	12	4.0%	0	-	3	-	13	4.3%	212
Woodstock	499	13	6.8%	0	-	11	5.2%	13	6.5%	225

Town/City Data: Part 2



	Lead Screening and Results for Children Ages 1 & 2 2000-2002 (7)			Young Children (<6) with Special Needs		Births to Mothers with Less than a High School Diploma 1999-2001 (10)		Child Abuse/Neglect for Children < 18 2003 (11)		Young Children (< 6) in Poverty 2000 (12)		Median Family Income for Families with Children < 18 2000 (20)
	Total # Screened	% Screened (3-year avg.)	Total # with Blood Lead Levels ≥10 ug/dL	# Enrolled in Birth to Three Program (Ages 0 to 3) FY2003 (8)	# Enrolled in Preschool Special Education (Ages 3 to 5) 2003-2004 School Year (9)	Total #	% of Births (3-year avg.)	# Substantiated Children	Rate per 1,000 Children	#	%	\$
Connecticut	111,047	42.0%	3,399	9,403	8,144	13,762	11.0%	11,288	13.2	29,348	11.1%	64692
Andover	23	8.3%	0	16	9	7	5.6%	*	*	0	-	\$69,674
Ansonia	629	41.4%	33	47	33	94	12.8%	130	28.7	196	13.6%	\$51,156
Ashford	50	16.3%	0	17	29	7	5.4%	11	10.2	8	2.7%	\$57,750
Avon	386	31.8%	1	43	35	5	1.0%	*	*	0	-	\$115,965
Barkhamsted	41	18.0%	0	10	14	3	-	*	*	23	10.7%	\$70,938
Beacon Falls	132	33.3%	2	12	see RSD 16	6	3.1%	10	7.2	28	6.8%	\$65,428
Berlin	214	17.5%	1	36	54	14	2.6%	13	2.8	10	0.8%	\$80,282
Bethany	104	29.6%	0	6	23	4	-	*	*	9	2.1%	\$81,617
Bethel	536	37.9%	2	61	43	20	3.0%	32	6.4	20	1.4%	\$80,937
Bethlehem	61	33.9%	0	7	see RSD 14	3	-	*	*	0	-	\$78,774
Bloomfield	494	40.7%	8	35	42	39	7.0%	40	9.4	93	8.0%	\$61,229
Bolton	45	13.3%	0	18	9	6	4.1%	11	8.2	18	5.1%	\$81,903
Bozrah	85	57.8%	3	9	6	4	-	*	*	7	4.7%	\$57,063
Branford	561	31.6%	4	59	45	32	3.8%	64	10.7	86	4.8%	\$71,343
Bridgeport	9,553	71.3%	758	409	336	1,826	27.1%	936	23.5	3,337	25.5%	\$34,103
Bridgewater	23	25.6%	0	6	see RSD 12	0	-	*	*	0	-	\$100,862
Bristol	1,703	36.2%	20	159	151	254	11.6%	300	21.4	369	8.3%	\$57,074
Brookfield	341	29.6%	0	47	31	9	1.7%	14	3.2	26	2.2%	\$95,060
Brooklyn	130	30.3%	3	12	21	17	10.1%	30	17.2	38	8.8%	\$62,679
Burlington	160	22.2%	0	24	see RSD 10	5	1.7%	18	7.4	6	0.8%	\$84,705
Canaan	58	96.7%	1	5	2	1	-	*	*	1	-	\$63,929
Canterbury	139	42.9%	0	14	11	17	11.3%	28	22.6	18	6.0%	\$64,120
Canton	211	35.3%	3	27	18	3	-	11	4.8	21	3.1%	\$79,475
Chaplin	21	13.5%	0	9	13	2	-	*	*	5	3.0%	\$61,364
Cheshire	598	29.5%	1	57	62	7	0.8%	13	1.8	43	2.1%	\$96,171
Chester	139	46.8%	1	8	6	2	-	*	*	0	-	\$80,000
Clinton	393	37.2%	4	31	19	31	6.0%	*	*	68	6.6%	\$71,952
Colchester	533	36.0%	2	69	62	24	3.6%	20	4.5	39	2.6%	\$72,335
Colebrook	4	-	1	5	4	2	-	*	*	0	-	\$61,094

Note: RSD (Regional School District) data is displayed at the end of this section.

	Lead Screening and Results for Children Ages 1 & 2 2000-2002 (7)			Young Children (<6) with Special Needs		Births to Mothers with Less than a High School Diploma 1999-2001 (10)		Child Abuse/Neglect for Children < 18 2003 (11)		Young Children (< 6) in Poverty 2000 (12)		Median Family Income for Families with Children < 18 2000 (20)
	Total # Screened	% Screened (3-year avg.)	Total # with Blood Lead Levels ≥10 ug/dL	# Enrolled in Birth to Three Program (Ages 0 to 3) FY2003 (8)	# Enrolled in Preschool Special Education (Ages 3 to 5) 2003-2004 School Year (9)	Total #	% of Births (3-year avg.)	# Substantiated Children	Rate per 1,000 Children	#	%	\$
Connecticut	111,047	42.0%	3,399	9,403	8,144	13,762	11.0%	11,288	13.2	29,348	11.1%	64692
Columbia	20	5.3%	0	13	19	2	-	*	*	19	5.1%	\$77,577
Cornwall	16	19.0%	0	1	4	2	-	*	*	2	-	\$65,750
Coventry	114	13.2%	2	30	36	19	4.2%	29	9.0	5	0.5%	\$68,954
Cromwell	156	18.4%	1	13	28	10	2.5%	17	5.9	48	6.1%	\$72,106
Danbury	2,437	42.2%	27	218	145	392	13.3%	215	12.9	485	8.3%	\$59,820
Darien	790	32.5%	2	89	78	2	-	*	*	47	2.0%	200,000+
Deep River	194	63.4%	2	11	10	7	4.0%	11	9.6	22	7.2%	\$62,361
Derby	370	38.5%	8	33	19	50	11.0%	53	19.5	47	5.1%	\$50,225
Durham	161	34.2%	3	9	see RSD 13	6	2.4%	*	*	0	-	\$86,726
East Granby	110	27.2%	0	12	9	5	3.0%	*	*	8	2.1%	\$79,626
East Haddam	216	31.2%	3	19	19	7	2.4%	*	*	8	1.2%	\$70,181
East Hampton	197	22.7%	3	31	34	13	3.5%	18	7.4	0	-	\$73,138
East Hartford	1,367	35.0%	27	152	91	291	15.7%	317	26.5	690	18.0%	\$42,440
East Haven	685	35.3%	11	55	68	93	9.6%	95	15.0	69	3.8%	\$57,304
East Lyme	471	45.4%	6	30	38	10	2.2%	23	5.8	38	3.3%	\$76,159
East Windsor	162	23.5%	3	23	8	15	4.5%	42	18.8	34	5.3%	\$59,926
Eastford	22	19.3%	2	2	3	2	-	*	*	18	14.4%	\$61,625
Easton	370	56.3%	2	31	22	1	-	*	*	13	1.9%	\$159,974
Ellington	231	24.1%	1	32	25	14	2.8%	14	4.1	36	3.7%	\$81,599
Enfield	694	22.9%	17	106	88	91	6.7%	160	15.6	169	5.5%	\$61,036
Essex	330	71.4%	2	11	13	4	-	*	*	14	2.9%	\$86,653
Fairfield	3,048	59.8%	11	183	127	30	1.3%	38	2.8	81	1.7%	\$113,536
Farmington	340	22.6%	4	57	41	8	1.1%	17	2.9	72	4.3%	\$88,404
Franklin	46	45.1%	0	3	6	5	9.1%	*	*	7	4.9%	\$68,182
Glastonbury	232	8.8%	2	88	81	7	0.6%	29	3.3	67	2.4%	\$102,919
Goshen	7	4.9%	1	5	see RSD 06	5	9.3%	*	*	5	3.0%	\$68,125
Granby	230	27.4%	0	27	27	2	-	14	4.8	62	7.3%	\$90,490
Greenwich	543	10.8%	5	179	94	34	1.7%	88	5.6	205	3.9%	\$154,586
Griswold	350	50.3%	5	23	39	38	11.3%	57	20.2	43	6.2%	\$55,096

Town/City Data: Part 2



	Lead Screening and Results for Children Ages 1 & 2 2000-2002 (7)			Young Children (<6) with Special Needs		Births to Mothers with Less than a High School Diploma 1999-2001 (10)		Child Abuse/Neglect for Children < 18 2003 (11)		Young Children (< 6) in Poverty 2000 (12)		Median Family Income for Families with Children < 18 2000 (20)
	Total # Screened	% Screened (3-year avg.)	Total # with Blood Lead Levels ≥10 ug/dL	# Enrolled in Birth to Three Program (Ages 0 to 3) FY2003 (8)	# Enrolled in Preschool Special Education (Ages 3 to 5) 2003-2004 School Year (9)	Total #	% of Births (3-year avg.)	# Substantiated Children	Rate per 1,000 Children	#	%	\$
Connecticut	111,047	42.0%	3,399	9,403	8,144	13,762	11.0%	11,288	13.2	29,348	11.1%	64692
Groton	1,302	34.0%	5	145	143	175	8.9%	122	12.2	478	12.6%	\$43,573
Guilford	382	25.4%	3	58	31	11	1.6%	23	4.1	82	5.0%	\$87,649
Haddam	124	24.2%	1	9	see RSD 17	9	4.3%	10	5.5	17	3.5%	\$88,365
Hamden	1,495	40.4%	30	141	96	88	4.7%	122	10.1	262	7.5%	\$68,223
Hampton	24	22.9%	0	8	2	0	-	*	*	2	-	\$65,500
Hartford	8,927	73.8%	496	506	386	1,857	30.8%	908	24.2	4,849	40.7%	\$21,997
Hartland	14	11.4%	0	2	0	0	-	*	*	0	-	\$64,792
Harwinton	43	12.1%	2	15	see RSD 10	2	-	*	*	0	-	\$81,888
Hebron	88	9.8%	4	29	33	5	1.3%	*	*	0	-	\$80,075
Kent	49	21.8%	1	9	7	3	-	*	*	0	-	\$60,795
Killingly	706	58.5%	19	61	71	132	20.1%	169	39.3	133	10.7%	\$43,443
Killingworth	169	27.6%	0	17	see RSD 17	1	-	*	*	0	-	\$91,574
Lebanon	135	27.1%	1	13	17	6	2.9%	17	8.6	14	2.8%	\$67,321
Ledyard	297	26.8%	6	40	44	27	6.2%	20	4.8	90	8.2%	\$67,561
Lisbon	95	29.1%	2	18	7	5	5.0%	22	20.3	20	7.0%	\$61,719
Litchfield	67	14.6%	1	20	15	5	2.5%	*	*	3	-	\$71,467
Lyme	89	98.9%	1	2	see RSD 18	1	-	*	*	0	-	\$80,777
Madison	393	28.9%	2	44	51	7	1.3%	*	*	8	0.5%	\$105,715
Manchester	767	18.8%	31	154	127	182	9.2%	259	20.7	474	11.7%	\$53,368
Mansfield	97	14.3%	2	28	31	18	5.6%	32	11.2	69	9.6%	\$67,463
Marlborough	48	11.2%	1	20	18	3	-	15	9.2	0	-	\$88,456
Meriden	2,667	52.8%	119	162	162	554	24.6%	383	25.4	963	20.0%	\$49,738
Middlebury	166	39.2%	5	10	see RSD 15	2	-	*	*	0	-	\$77,048
Middlefield	72	27.6%	1	6	see RSD 13	2	-	*	*	8	3.0%	\$76,490
Middletown	1,133	33.6%	10	96	70	168	10.2%	153	15.2	272	8.2%	\$58,624
Milford	1,640	45.4%	9	112	91	63	3.5%	105	8.8	89	2.4%	\$72,192
Monroe	859	52.5%	3	67	64	7	1.0%	17	3.0	70	3.7%	\$102,237
Montville	538	45.4%	2	54	36	42	7.7%	45	9.7	77	6.4%	\$61,882
Morris	32	21.8%	0	4	see RSD 06	5	6.1%	*	*	25	16.2%	\$63,021

Note: RSD (Regional School District) data is displayed at the end of this section.

	Lead Screening and Results for Children Ages 1 & 2 2000-2002 (7)			Young Children (<6) with Special Needs		Births to Mothers with Less than a High School Diploma 1999-2001 (10)		Child Abuse/Neglect for Children < 18 2003 (11)		Young Children (< 6) in Poverty 2000 (12)		Median Family Income for Families with Children < 18 2000 (20)
	Total # Screened	% Screened (3-year avg.)	Total # with Blood Lead Levels ≥10 ug/dL	# Enrolled in Birth to Three Program (Ages 0 to 3) FY2003 (8)	# Enrolled in Preschool Special Education (Ages 3 to 5) 2003-2004 School Year (9)	Total #	% of Births (3-year avg.)	# Substantiated Children	Rate per 1,000 Children	#	%	\$
Connecticut	111,047	42.0%	3,399	9,403	8,144	13,762	11.0%	11,288	13.2	29,348	11.1%	64692
Naugatuck	739	29.4%	16	83	54	102	9.0%	96	11.4	286	11.2%	\$55,125
New Britain	2,732	47.4%	125	214	252	765	28.3%	527	30.5	1,346	25.7%	\$35,285
New Canaan	695	41.6%	4	50	34	1	-	*	*	46	2.4%	200,000+
New Fairfield	364	27.1%	1	73	52	14	2.8%	22	5.2	31	2.2%	\$96,222
New Hartford	94	19.1%	0	18	10	5	2.1%	*	*	0	-	\$85,563
New Haven	7,261	68.4%	676	365	279	1426	26.0%	988	31.3	3,334	33.7%	\$28,847
New London	1,280	61.0%	40	69	68	246	21.8%	145	23.9	591	29.4%	\$31,773
New Milford	648	27.6%	0	92	63	64	6.0%	80	10.4	52	2.3%	\$75,600
Newington	218	12.1%	1	44	56	18	2.3%	39	6.4	62	3.3%	\$69,307
Newtown	958	41.1%	5	87	84	11	1.1%	42	5.5	57	2.4%	\$101,283
Norfolk	15	12.5%	2	1	4	3	-	*	*	8	6.4%	\$61,786
North Branford	278	25.5%	2	30	28	4	-	18	5.0	0	-	\$73,511
North Canaan	8	5.2%	0	1	12	18	19.4%	*	*	0	-	\$50,139
North Haven	377	26.3%	1	43	43	22	3.3%	39	7.4	47	3.2%	\$78,366
North Stonington	95	29.3%	0	11	13	9	5.2%	*	*	16	4.5%	\$65,143
Norwalk	3,861	56.2%	41	198	144	344	9.2%	177	9.5	562	8.7%	\$64,532
Norwich	1,517	56.8%	66	112	89	278	19.5%	278	32.0	494	19.0%	\$41,660
Old Lyme	276	60.1%	3	14	see RSD 18	7	3.6%	14	7.8	37	7.7%	\$74,150
Old Saybrook	442	61.9%	1	21	22	17	5.9%	11	4.8	-	-	\$74,871
Orange	300	32.9%	3	33	36	2	-	14	4.3	-	-	\$92,693
Oxford	320	44.4%	1	28	26	10	2.7%	*	*	5	0.6%	\$82,035
Plainfield	627	52.5%	23	51	36	95	17.0%	137	33.9	122	10.6%	\$46,674
Plainville	260	25.6%	7	45	40	30	6.0%	53	14.3	75	7.4%	\$59,205
Plymouth	300	38.2%	3	30	34	29	7.8%	46	14.9	46	5.3%	\$64,227
Pomfret	110	47.0%	0	10	12	7	5.5%	17	16.2	9	3.5%	\$68,150
Portland	233	31.8%	1	24	12	8	2.5%	13	5.6	41	5.5%	\$72,250
Preston	109	43.3%	0	12	10	6	5.2%	19	17.8	0	-	\$65,492
Prospect	199	29.5%	0	27	see RSD 16	15	5.4%	18	8.0	0	-	\$86,962
Putnam	295	44.9%	7	34	34	55	16.4%	65	30.4	114	19.0%	\$52,609

Town/City Data: Part 2



	Lead Screening and Results for Children Ages 1 & 2 2000-2002 (7)			Young Children (<6) with Special Needs		Births to Mothers with Less than a High School Diploma 1999-2001 (10)		Child Abuse/Neglect for Children < 18 2003 (11)		Young Children (< 6) in Poverty 2000 (12)		Median Family Income for Families with Children < 18 2000 (20)
	Total # Screened	% Screened (3-year avg.)	Total # with Blood Lead Levels ≥10 ug/dL	# Enrolled in Birth to Three Program (Ages 0 to 3) FY2003 (8)	# Enrolled in Preschool Special Education (Ages 3 to 5) 2003-2004 School Year (9)	Total #	% of Births (3-year avg.)	# Substantiated Children	Rate per 1,000 Children	#	%	\$
Connecticut	111,047	42.0%	3,399	9,403	8,144	13,762	11.0%	11,288	13.2	29,348	11.1%	64692
Redding	259	37.9%	0	25	17	1	-	23	9.3	10	1.4%	\$112,068
Ridgefield	768	34.5%	1	81	88	5	0.6%	11	1.5	52	2.3%	\$139,011
Rocky Hill	116	10.4%	0	37	39	14	2.6%	17	4.7	34	3.2%	\$73,887
Roxbury	42	31.1%	0	5	see RSD 12	0	-	*	*	9	7.1%	\$89,180
Salem	108	39.1%	5	16	4	1	-	*	*	9	2.9%	\$72,955
Salisbury	41	23.6%	0	4	6	5	5.5%	*	*	6	3.0%	\$67,321
Scotland	11	7.3%	0	7	4	1	-	*	*	13	9.0%	\$59,444
Seymour	398	37.1%	3	44	31	21	4.0%	46	12.3	98	8.8%	\$65,439
Sharon	32	21.8%	3	5	6	5	8.6%	*	*	40	29.9%	\$72,552
Shelton	1,316	45.9%	14	95	81	50	4.0%	57	6.2	107	3.8%	\$77,480
Sherman	78	28.9%	0	19	11	0	-	*	*	4	-	\$83,918
Simsbury	496	25.6%	5	71	82	9	1.2%	26	3.8	34	1.7%	\$101,008
Somers	131	27.5%	0	20	14	15	5.7%	10	4.5	28	5.0%	\$78,153
South Windsor	258	14.7%	4	69	46	10	1.0%	32	4.7	18	1.0%	\$85,541
Southbury	577	50.1%	0	51	see RSD 15	13	2.4%	13	3.0	27	2.3%	\$91,115
Southington	631	21.7%	3	99	89	48	4.7%	54	5.5	92	3.2%	\$72,633
Sprague	104	63.0%	0	7	5	13	13.3%	16	20.7	7	3.6%	\$44,107
Stafford	165	21.6%	5	25	9	40	10.5%	48	16.2	121	12.9%	\$55,772
Stamford	4,914	51.0%	60	370	219	370	6.8%	329	12.4	902	9.7%	\$65,697
Sterling	118	45.2%	1	11	12	13	11.3%	21	23.3	5	1.9%	\$56,193
Stonington	371	33.8%	9	24	35	28	5.7%	28	7.1	99	8.1%	\$68,097
Stratford	1,717	50.2%	26	134	88	110	6.6%	107	9.3	209	6.0%	\$64,135
Suffield	207	25.0%	1	25	44	6	1.5%	20	6.5	27	3.1%	\$83,692
Thomaston	182	34.3%	4	23	26	9	3.5%	*	*	46	8.0%	\$59,695
Thompson	167	29.1%	4	28	30	34	12.3%	30	13.2	75	12.1%	\$53,214
Tolland	206	17.3%	1	28	50	9	1.8%	17	4.3	12	0.9%	\$82,620
Torrington	163	6.4%	11	80	84	165	13.2%	91	11.1	223	9.1%	\$52,045
Trumbull	1,228	43.2%	2	103	73	10	0.8%	29	3.2	82	2.9%	\$97,825
Union	6	10.0%	1	0	3	1	-	*	*	2	-	\$66,250

Note: RSD (Regional School District) data is displayed at the end of this section.

	Lead Screening and Results for Children Ages 1 & 2 2000-2002 (7)			Young Children (<6) with Special Needs		Births to Mothers with Less than a High School Diploma 1999-2001 (10)		Child Abuse/Neglect for Children < 18 2003 (11)		Young Children (< 6) in Poverty 2000 (12)		Median Family Income for Families with Children < 18 2000 (20)
	Total # Screened	% Screened (3-year avg.)	Total # with Blood Lead Levels ≥10 ug/dL	# Enrolled in Birth to Three Program (Ages 0 to 3) FY2003 (8)	# Enrolled in Preschool Special Education (Ages 3 to 5) 2003-2004 School Year (9)	Total #	% of Births (3-year avg.)	# Substantiated Children	Rate per 1,000 Children	#	%	\$
Connecticut	111,047	42.0%	3,399	9,403	8,144	13,762	11.0%	11,288	13.2	29,348	11.1%	64692
Vernon	545	26.5%	16	65	58	115	11.5%	172	27.1	201	9.9%	\$58,716
Voluntown	111	62.7%	2	4	4	6	6.2%	10	14.6	5	2.5%	\$56,944
Wallingford	1,402	44.4%	6	102	76	90	6.1%	106	10.1	168	5.2%	\$69,435
Warren	14	16.7%	0	2	see RSD 06	1	-	*	*	5	6.2%	\$64,167
Washington	76	51.7%	1	11	see RSD 12	1	-	*	*	12	7.4%	\$80,807
Waterbury	5,917	60.4%	262	351	398	1,027	22.0%	773	27.0	2,577	26.8%	\$35,586
Waterford	304	29.1%	1	38	38	26	5.2%	35	8.5	61	5.3%	\$71,284
Watertown	518	37.8%	4	59	51	28	4.3%	21	3.8	35	2.3%	\$72,945
West Hartford	1,229	28.5%	20	176	170	94	4.7%	60	4.4	226	5.2%	\$81,255
West Haven	1,969	50.6%	54	117	94	301	15.1%	191	15.7	521	13.1%	\$48,406
Westbrook	246	67.2%	3	12	11	12	5.4%			37	8.0%	\$73,750
Weston	555	60.7%	2	35	22	1	-	*	*	9	0.8%	\$188,595
Westport	1,392	64.4%	2	77	31	2	-	22	3.0	40	1.7%	\$178,843
Wethersfield	237	14.5%	2	62	68	12	1.6%	17	3.2	44	2.8%	\$71,320
Willington	43	12.7%	0	14	13	2	-	*	*	7	2.2%	\$70,568
Wilton	774	48.9%	1	77	56	3	-	*	*	33	1.9%	\$167,298
Winchester	68	9.5%	7	30	30	62	14.7%	29	11.6	85	11.7%	\$52,300
Windham	520	29.1%	19	82	55	265	28.8%	227	42.9	492	28.9%	\$33,032
Windsor	542	27.7%	13	64	60	54	5.8%	51	7.3	106	5.1%	\$55,234
Windsor Locks	159	20.6%	3	35	40	27	7.0%	35	12.1	31	3.7%	\$72,840
Wolcott	385	34.0%	6	27	40	14	3.1%	26	6.4	39	3.2%	\$65,318
Woodbridge	159	26.4%	2	12	11	0	-	*	*	4	-	\$111,550
Woodbury	320	51.3%	3	21	see RSD 14	5	1.7%	18	7.9	17	2.7%	\$89,475
Woodstock	188	39.7%	1	10	24	8	3.8%	14	7.1	33	6.8%	\$65,029

Town/City Data: Part 3



	Young Children (< 6) Receiving Welfare (TFA) 2003 (13)	Supply of Regulated Early Care and Education 2003 (14)						Supply of Quality Early Care and Education 2003 (14)		
		Infants and Toddlers		Preschool Children		School-Age Children		Infants and Toddlers	Preschool Children	School-Age Children
		#	Slots per 100 Children	# of Slots	Slots per 100 Children	# of Slots	Slots per 100 Children	% of Slots	% of Slots	% of Slots
Connecticut	14,694	19,903	15.1	69,673	75.3	33,280	8.5	18.0%	29.2%	9.2%
Andover	4	11	8.0	80	82.9	63	16.3	-	-	-
Ansonia	135	37	4.9	346	65.8	166	8.1	-	49.4%	6.3%
Ashford	7	6	3.8	106	100.5	56	11.2	-	23.8%	74.6%
Avon	1	203	35.0	415	94.0	216	10.6	19.1%	25.9%	8.0%
Barkhamsted	3	5	3.6	83	116.5	40	9.8	-	-	-
Beacon Falls	3	7	3.4	59	38.8	152	25.0	-	-	-
Berlin	14	134	23.1	445	102.9	301	14.1	-	-	13.6%
Bethany	3	15	7.6	104	72.1	87	13.1	-	-	85.9%
Bethel	8	178	25.4	665	122.7	276	12.1	43.5%	53.8%	38.6%
Bethlehem	0	7	8.3	24	27.6	19	4.6	-	-	-
Bloomfield	44	123	20.7	638	148.0	337	17.1	32.9%	57.6%	-
Bolton	3	32	20.4	195	133.5	80	13.0	-	-	-
Bozrah	6	3	-	30	54.1	14	5.5	-	-	-
Branford	49	190	20.7	748	112.9	382	14.0	15.6%	9.4%	-
Bridgeport	1,536	616	9.2	3,392	73.2	2,660	14.7	27.1%	40.8%	4.0%
Bridgewater	1	14	35.2	18	55.0	4	-	-	-	-
Bristol	273	260	11.2	1,313	88.7	890	14.0	-	20.4%	8.0%
Brookfield	6	177	32.6	593	125.8	273	12.8	15.9%	32.0%	5.3%
Brooklyn	10	48	22.5	295	184.3	114	14.0	25.0%	7.4%	-
Burlington	7	65	17.1	148	59.5	114	10.8	-	-	-
Canaan	1	28	103.6	64	230.3	25	23.9	-	-	-
Canterbury	6	20	14.1	81	79.8	60	11.1	-	-	-
Canton	4	87	27.1	285	111.3	99	9.2	-	17.9%	-
Chaplin	4	20	23.5	52	72.7	6	2.4	-	-	-
Cheshire	6	220	23.1	676	95.2	459	13.8	-	15.0%	-
Chester	3	6	4.1	109	123.4	65	17.7	-	-	-
Clinton	13	61	11.5	349	111.3	180	11.7	-	26.2%	-
Colchester	5	98	13.7	373	71.5	268	13.1	-	8.9%	35.4%
Colebrook	0	0	-	0	-	18	10.1	-	-	-
Columbia	4	84	45.2	424	288.3	62	9.7	62.8%	25.6%	-
Cornwall	4	2	-	25	82.1	13	7.0	-	-	-
Coventry	10	40	8.7	407	108.4	163	101.7	-	-	-
Cromwell	12	146	33.5	449	164.3	205	14.6	31.4%	16.6%	13.0%

	Young Children (< 6) Receiving Welfare (TFA) 2003 (13)	Supply of Regulated Early Care and Education 2003 (14)						Supply of Quality Early Care and Education 2003 (14)		
		Infants and Toddlers		Preschool Children		School-Age Children		Infants and Toddlers	Preschool Children	School-Age Children
		#	Slots per 100 Children	# of Slots	Slots per 100 Children	# of Slots	Slots per 100 Children	% of Slots	% of Slots	% of Slots
Connecticut	14,694	19,903	15.1	69,673	75.3	33,280	8.5	18.0%	29.2%	9.2%
Danbury	120	340	11.4	1,646	84.5	1,329	65.1	14.7%	42.8%	1.6%
Darien	0	14	1.2	767	88.6	27	0.4	-	34.8%	-
Deep River	5	8	5.5	92	99.4	46	1.7	-	-	-
Derby	54	38	8.2	160	53.5	112	18.4	-	34.7%	-
Durham	1	42	16.2	126	62.4	122	10.4	-	-	-
East Granby	3	51	28.3	122	92.1	140	24.1	-	-	-
East Haddam	2	40	12.3	236	91.8	105	10.8	-	-	-
East Hampton	10	82	21.0	347	119.2	197	15.1	-	-	-
East Hartford	307	273	14.5	1,181	90.2	621	11.2	-	24.3%	8.3%
East Haven	79	59	6.4	454	65.6	309	10.7	-	-	-
East Lyme	14	162	33.9	346	88.3	138	7.2	77.2%	66.8%	36.7%
East Windsor	27	47	14.0	260	112.0	97	38.5	-	-	-
Eastford	1	0	-	27	64.6	22	2.8	-	-	-
Easton	1	3	-	237	97.2	71	6.6	-	11.5%	33.2%
Ellington	12	76	15.5	327	95.5	194	18.7	-	-	-
Enfield	107	405	27.4	1,275	119.2	724	38.7	19.3%	35.1%	20.9%
Essex	2	59	24.5	126	69.8	84	1.9	-	-	-
Fairfield	14	230	9.4	1,184	71.7	359	26.6	37.1%	31.6%	-
Farmington	15	328	43.4	644	107.2	528	9.1	17.2%	6.4%	-
Franklin	6	2	-	19	44.8	9	0.4	-	-	-
Glastonbury	18	327	26.5	1,229	123.3	585	85.1	12.9%	4.9%	10.6%
Goshen	0	3	-	32	46.5	12	0.3	-	-	-
Granby	2	84	19.7	302	100.3	148	36.4	37.7%	8.6%	15.5%
Greenwich	18	408	16.3	1,700	92.8	327	15.4	30.0%	26.1%	14.1%
Griswold	31	35	9.5	172	68.7	83	1.2	24.3%	52.0%	-
Groton	144	530	27.3	1,030	80.8	521	29.2	6.6%	29.7%	28.4%
Guilford	6	111	15.0	421	77.6	333	8.0	-	7.1%	-
Haddam	6	56	24.6	116	61.5	247	10.8	-	-	-
Hamden	146	342	18.7	1,130	93.2	445	32.5	-	-	-
Hampton	0	2	-	6	11.9	18	0.4	-	-	-
Hartford	2,847	676	11.0	3,132	78.5	1,310	59.6	43.5%	67.3%	11.9%
Hartland	2	0	-	9	19.8	5	0.0	-	-	-
Harwinton	4	41	21.6	61	47.2	58	19.3	-	-	-

Town/City Data: Part 3



	Young Children (< 6) Receiving Welfare (TFA) 2003 (13)	Supply of Regulated Early Care and Education 2003 (14)						Supply of Quality Early Care and Education 2003 (14)		
		Infants and Toddlers		Preschool Children		School-Age Children		Infants and Toddlers	Preschool Children	School-Age Children
		#	Slots per 100 Children	# of Slots	Slots per 100 Children	# of Slots	Slots per 100 Children	% of Slots	% of Slots	% of Slots
Connecticut	14,694	19,903	15.1	69,673	75.3	33,280	8.5	18.0%	29.2%	9.2%
Hebron	1	40	8.7	201	59.2	82	11.8	-	-	-
Kent	2	11	8.7	67	100.8	9	0.8	-	-	-
Killingly	86	40	6.2	200	49.5	219	43.8	-	-	28.9%
Killingworth	3	21	7.3	179	103.6	113	6.1	-	-	-
Lebanon	6	19	7.7	121	58.2	118	14.6	-	-	-
Ledyard	11	66	12.9	363	90.8	186	19.2	-	-	-
Lisbon	0	5	3.2	18	17.7	23	1.2	-	-	-
Litchfield	2	36	15.3	237	131.1	60	10.8	-	21.3%	-
Lyme	0	0	-	0	-	26	2.9	-	-	-
Madison	2	74	11.7	510	92.3	261	54.1	-	18.8%	-
Manchester	261	371	17.9	1,477	103.5	765	26.8	25.5%	37.8%	-
Mansfield	12	96	28.7	355	134.6	149	2.9	85.0%	47.8%	27.0%
Marlborough	6	48	22.3	214	129.7	96	7.6	-	-	-
Meriden	566	314	12.6	1,000	60.4	467	31.3	23.6%	47.5%	23.6%
Middlebury	4	39	19.5	174	115.0	85	1.4	-	-	-
Middlefield	5	19	14.6	128	121.1	44	6.1	-	-	-
Middletown	199	262	15.5	1,125	99.9	639	65.2	14.8%	39.6%	34.1%
Milford	55	383	20.4	1,254	97.7	675	15.8	-	15.4%	-
Monroe	8	172	21.6	931	143.7	214	4.3	-	13.0%	-
Montville	36	71	12.0	264	60.6	174	6.7	-	5.3%	5.7%
Morris	1	0	-	0	-	0	-	-	-	-
Naugatuck	72	95	7.8	502	55.3	268	39.0	-	25.1%	26.4%
New Britain	870	199	7.0	1,171	61.1	482	11.2	39.3%	59.1%	45.0%
New Canaan	1	26	3.2	628	86.3	136	1.8	-	74.1%	-
New Fairfield	7	46	7.2	182	39.0	118	4.0	60.7%	27.4%	22.7%
New Hartford	4	39	16.8	169	95.9	116	6.3	-	-	-
New Haven	2,068	526	9.8	2,631	77.3	626	26.3	26.6%	58.8%	4.6%
New London	215	226	21.1	604	90.8	153	5.7	41.3%	62.1%	43.8%
New Milford	20	177	15.3	572	72.9	506	14.2	-	11.6%	7.5%
Newington	23	284	32.7	650	97.7	523	4.0	-	-	15.1%
Newtown	5	69	5.9	612	69.8	301	10.4	-	39.6%	-
Norfolk	0	11	17.6	6	12.6	5	0.2	-	-	-
North Branford	11	131	24.3	307	81.8	187	48.5	16.1%	36.7%	-

	Young Children (< 6) Receiving Welfare (TFA) 2003 (13)	Supply of Regulated Early Care and Education 2003 (14)						Supply of Quality Early Care and Education 2003 (14)		
		Infants and Toddlers		Preschool Children		School-Age Children		Infants and Toddlers	Preschool Children	School-Age Children
		#	Slots per 100 Children	# of Slots	Slots per 100 Children	# of Slots	Slots per 100 Children	% of Slots	% of Slots	% of Slots
Connecticut	14,694	19,903	15.1	69,673	75.3	33,280	8.5	18.0%	29.2%	9.2%
North Canaan	7	2	-	6	8.7	5	0.3	-	-	-
North Haven	16	151	21.1	573	103.0	172	29.9	11.7%	21.6%	43.5%
North Stonington	5	6	4.0	62	51.0	22	1.0	-	-	-
Norwalk	257	492	13.8	2,113	96.5	710	46.0	7.5%	26.5%	2.2%
Norwich	247	184	13.0	638	68.3	478	6.2	7.4%	18.7%	12.2%
Old Lyme	7	27	10.9	92	47.0	222	6.2	-	-	-
Old Saybrook	9	56	16.5	191	74.5	162	17.5	25.0%	22.4%	5.8%
Orange	3	208	49.7	487	156.1	240	21.1	40.6%	33.8%	33.5%
Oxford	3	28	7.8	267	91.5	189	12.6	-	-	-
Plainfield	39	60	10.3	269	70.9	133	10.0	-	20.9%	-
Plainville	36	149	30.2	524	150.7	387	21.5	-	65.3%	7.8%
Plymouth	30	56	14.3	225	69.7	234	13.3	31.3%	35.7%	20.2%
Pomfret	2	10	7.6	171	180.4	59	4.6	53.7%	29.8%	8.7%
Portland	13	55	15.0	238	94.5	174	31.1	-	11.8%	7.0%
Preston	4	8	5.7	45	45.9	23	2.3	-	-	-
Prospect	5	53	15.5	138	60.6	79	14.2	-	-	-
Putnam	33	46	13.8	102	50.8	64	6.3	-	49.9%	-
Redding	0	40	12.2	120	47.4	93	10.0	17.7%	8.7%	5.8%
Ridgefield	0	149	14.1	819	97.8	164	10.8	17.7%	5.8%	-
Rocky Hill	7	209	37.4	398	106.3	323	9.8	8.4%	5.4%	-
Roxbury	0	2	-	57	139.2	0	-	-	-	-
Salem	1	29	20.1	108	92.7	66	24.8	-	-	-
Salisbury	3	31	35.8	68	111.5	53	9.3	34.2%	25.9%	-
Scotland	0	6	8.2	33	74.3	18	4.6	-	-	-
Seymour	27	53	10.1	343	89.2	267	68.9	39.8%	6.3%	-
Sharon	2	12	16.3	46	100.9	27	1.7	60.7%	75.5%	79.4%
Shelton	41	388	26.9	895	95.3	287	38.7	18.2%	7.2%	4.5%
Sherman	1	9	6.7	65	53.9	16	0.4	-	-	-
Simsbury	4	124	13.3	686	92.7	296	35.9	5.7%	25.7%	-
Somers	7	17	6.5	158	78.4	32	1.1	-	69.4%	-
South Windsor	10	270	30.7	799	116.1	458	20.5	7.2%	25.0%	7.6%
Southbury	10	156	29.6	315	70.3	120	10.5	-	24.8%	-
Southington	39	284	19.6	915	95.3	555	16.5	-	2.9%	-

Town/City Data: Part 3



	Young Children (< 6) Receiving Welfare (TFA) 2003 (13)	Supply of Regulated Early Care and Education 2003 (14)						Supply of Quality Early Care and Education 2003 (14)		
		Infants and Toddlers		Preschool Children		School-Age Children		Infants and Toddlers	Preschool Children	School-Age Children
		#	Slots per 100 Children	# of Slots	Slots per 100 Children	# of Slots	Slots per 100 Children	% of Slots	% of Slots	% of Slots
Connecticut	14,694	19,903	15.1	69,673	75.3	33,280	8.5	18.0%	29.2%	9.2%
Sprague	8	14	18.0	54	77.7	45	1.2	-	-	-
Stafford	30	53	13.3	277	85.2	211	40.3	26.4%	13.4%	18.3%
Stamford	196	661	13.2	2,948	93.4	781	29.3	28.0%	32.4%	5.5%
Sterling	9	16	11.1	53	57.2	32	0.3	-	-	-
Stonington	39	67	11.9	244	56.0	134	24.4	-	22.8%	-
Stratford	117	124	7.0	1,010	81.4	586	26.3	-	25.1%	3.2%
Suffield	4	24	5.6	280	92.3	113	2.3	-	-	-
Thomaston	20	36	14.3	156	84.2	88	6.7	-	26.7%	-
Thompson	19	70	23.3	114	50.4	60	6.4	-	-	-
Tolland	5	53	9.6	415	95.2	243	21.6	-	-	-
Torrington	135	215	16.8	579	68.7	358	18.8	38.4%	46.9%	19.8%
Trumbull	9	155	11.1	988	97.5	524	13.6	20.4%	24.0%	11.0%
Union	0	0	-	0	-	0	-	-	-	-
Vernon	121	191	18.8	637	92.3	363	87.1	7.4%	21.7%	-
Voluntown	2	8	8.8	30	45.4	9	0.4	-	-	-
Wallingford	56	474	30.4	1,416	133.1	702	79.4	8.9%	4.6%	1.5%
Warren	3	0	-	0	-	0	-	-	-	-
Washington	0	10	12.4	42	57.0	9	5.7	-	-	-
Waterbury	1,441	563	11.6	1,897	57.1	643	32.1	47.1%	47.9%	4.1%
Waterford	14	76	13.8	222	54.0	131	1.1	18.6%	37.8%	-
Watertown	23	107	15.7	374	66.3	268	13.1	16.4%	5.3%	3.6%
West Hartford	59	429	20.4	1,357	89.1	900	14.0	46.0%	49.4%	30.4%
West Haven	312	160	8.0	867	68.5	455	8.2	22.0%	29.5%	11.2%
Westbrook	3	84	43.7	162	114.8	104	4.5	-	3.1%	-
Weston	1	8	1.9	88	23.9	59	7.6	-	-	-
Westport	4	160	15.7	1,064	121.7	124	6.1	67.2%	63.0%	-
Wethersfield	30	91	11.4	608	101.6	267	7.8	-	3.5%	4.1%
Willington	7	11	7.0	97	80.6	44	2.0	-	-	-
Wilton	1	175	21.9	674	112.1	109	13.3	8.0%	38.8%	72.2%
Winchester	66	44	11.7	224	93.3	65	2.5	64.2%	72.4%	56.4%
Windham	236	59	6.6	334	60.3	158	11.8	48.9%	49.9%	24.4%
Windsor	65	278	27.9	792	110.9	484	19.6	41.8%	33.6%	21.3%
Windsor Locks	21	121	29.7	302	99.3	145	11.0	-	-	-



	Young Children (< 6) Receiving Welfare (TFA) 2003 (13)	Supply of Regulated Early Care and Education 2003 (14)						Supply of Quality Early Care and Education 2003 (14)		
		Infants and Toddlers		Preschool Children		School-Age Children		Infants and Toddlers	Preschool Children	School-Age Children
		#	# of Slots	Slots per 100 Children	# of Slots	Slots per 100 Children	# of Slots	Slots per 100 Children	% of Slots	% of Slots
Connecticut	14,694	19,903	15.1	69,673	75.3	33,280	8.5	18.0%	29.2%	9.2%
Wolcott	11	82	15.6	220	50.2	244	8.0	17.2%	7.0%	5.8%
Woodbridge	1	78	27.9	360	150.8	106	5.8	32.8%	61.0%	-
Woodbury	1	75	25.0	202	83.2	141	11.4	-	53.0%	-
Woodstock	6	39	17.5	186	107.6	70	6.7	-	-	-

Town/City Data: Part 4



	Children Receiving Child Care Subsidies 2003 (15)					Kindergarteners with a Preschool Experience 2002-2003 School Year (16)	Average Kindergarten Class Size 2002-2003 School Year (17)	Children Enrolled in Full-Day Kindergarten 2003-2004 School Year (18)		Students Meeting State Performance Goal on 4th Grade Connecticut Mastery Test 2002-2003 School Year (19)
	All Children		Infants and Toddlers	Preschool Children	School-Age Children			#	%	
	#	% in Formal Care	#	#	#					
Connecticut	14,779	45.9%	4,046	5,078	5,655	75.9%	18.3	18,338	43.9%	42.1%
Andover	1	-	0	1	0	78.0%	13.7	0	-	41.1%
Ansonia	121	43.0%	36	38	47	70.3%	20.8	238	100.0%	22.1%
Ashford	15	75.0%	4	9	2	47.9%	15.0	0	-	34.0%
Avon	5	100.0%	0	3	2	86.8%	17.8	0	-	68.1%
Barkhamsted	2	-	0	2	0	82.4%	17.0	0	-	46.8%
Beacon Falls	6	100.0%	2	2	2	see RSD 16	see RSD 16	see RSD 16	see RSD 16	see RSD 16
Berlin	10	58.3%	0	7	3	97.9%	16.5	2	-	57.1%
Bethany	1	-	0	0	1	90.0%	17.5	79	100.0%	38.8%
Bethel	19	89.5%	4	8	7	79.8%	18.3	0	-	50.2%
Bethlehem	0	-	0	0	0	see RSD 14	see RSD 14	see RSD 14	see RSD 14	see RSD 14
Bloomfield	100	69.4%	23	40	37	86.7%	16.3	164	100.0%	34.1%
Bolton	2	-	1	1	0	81.0%	14.8	0	-	66.2%
Bozrah	2	-	0	2	0	65.0%	10.0	0	-	25.0%
Branford	55	71.4%	9	24	22	83.6%	13.8	0	-	47.4%
Bridgeport	1,097	37.5%	366	356	375	61.1%	21.7	1,925	100.0%	10.9%
Bridgewater	0	-	0	0	0	see RSD 12	see RSD 12	see RSD 12	see RSD 12	see RSD 12
Bristol	291	67.4%	78	109	104	75.0%	18.6	0	-	38.8%
Brookfield	5	80.0%	2	1	2	95.4%	17.5	0	-	47.6%
Brooklyn	6	100.0%	3	3	0	80.6%	15.2	0	-	45.4%
Burlington	2	-	1	1	0	see RSD 10	see RSD 10	see RSD 10	see RSD 10	see RSD 10
Canaan	7	68.4%	2	2	3	42.9%	7.0	0	-	33.3%
Canterbury	9	63.6%	1	4	4	87.5%	15.7	0	-	35.0%
Canton	5	100.0%	2	2	1	90.6%	17.7	0	-	62.5%
Chaplin	2	-	1	1	0	58.3%	17.5	23	100.0%	38.9%
Cheshire	8	100.0%	5	2	1	92.2%	17.9	0	-	62.7%
Chester	9	75.0%	3	3	3	93.5%	15.7	0	-	65.9%
Clinton	17	81.0%	2	9	6	71.6%	19.7	175	98.9%	45.8%
Colchester	31	52.8%	7	16	8	70.0%	17.6	0	-	38.9%
Colebrook	1	-	1	0	0	76.9%	13.0	0	-	22.2%
Columbia	4	-	2	1	1	91.8%	12.5	1	-	43.0%
Cornwall	0	-	0	0	0	78.6%	14.0	0	-	50.0%

Note: RSD (Regional School District) data is displayed at the end of this section.

	Children Receiving Child Care Subsidies 2003 (15)					Kindergarteners with a Preschool Experience 2002-2003 School Year (16)	Average Kindergarten Class Size 2002-2003 School Year (17)	Children Enrolled in Full-Day Kindergarten 2003-2004 School Year (18)		Students Meeting State Performance Goal on 4th Grade Connecticut Mastery Test 2002-2003 School Year (19)
	All Children		Infants and Toddlers	Preschool Children	School-Age Children			#	%	
	#	% in Formal Care	#	#	#					
Connecticut	14,779	45.9%	4,046	5,078	5,655	75.9%	18.3	18,338	43.9%	42.1%
Coventry	19	52.6%	6	7	6	67.9%	20.1	0	-	43.8%
Cromwell	16	61.9%	4	6	6	85.5%	15.3	16	10.3%	55.3%
Danbury	146	73.5%	48	58	40	70.1%	17.6	390	59.0%	33.7%
Darien	2	-	1	0	1	97.8%	20.8	0	-	72.7%
Deep River	2	-	2	0	0	89.6%	16.3	0	-	35.6%
Derby	61	70.0%	20	16	25	60.4%	18.7	35	36.1%	34.6%
Durham	1	-	0	0	1	see RSD 13	see RSD 13	see RSD 13	see RSD 13	see RSD 13
East Granby	2	-	1	1	0	89.7%	14.5	0	0.0%	53.8%
East Haddam	2	-	0	1	1	75.4%	18.4	3	-	49.6%
East Hampton	13	64.3%	3	7	3	89.4%	19.6	10	5.6%	47.5%
East Hartford	536	44.0%	144	185	207	48.6%	20.4	107	20.5%	19.4%
East Haven	111	56.5%	30	39	42	73.1%	17.9	0	-	23.5%
East Lyme	35	92.7%	12	11	12	85.6%	16.0	0	-	57.5%
East Windsor	0	-	0	0	0	84.8%	20.2	0	-	37.2%
Eastford	0	-	0	0	0	66.7%	15.0	11	100.0%	52.2%
Easton	48	72.6%	13	24	11	100.0%	20.0	0	-	58.9%
Ellington	7	100.0%	1	4	2	80.5%	18.2	0	-	67.2%
Enfield	215	86.6%	58	85	72	71.2%	18.0	38	8.4%	33.2%
Essex	1	-	1	0	0	81.4%	17.2	0	-	35.4%
Fairfield	19	96.0%	5	12	2	92.7%	18.8	294	37.2%	67.1%
Farmington	34	83.7%	6	15	13	90.8%	20.9	0	-	69.5%
Franklin	1	-	0	1	0	78.9%	19.0	0	-	75.0%
Glastonbury	37	89.4%	9	14	14	89.4%	16.9	2	-	69.8%
Goshen	0	-	0	0	0	see RSD 06	see RSD 06	see RSD 06	see RSD 06	see RSD 06
Granby	1	-	0	1	0	90.3%	20.6	0	-	66.5%
Greenwich	23	80.0%	6	12	5	91.7%	19.0	757	100.0%	71.8%
Griswold	24	80.0%	8	12	4	76.8%	16.5	0	-	24.2%
Groton	129	59.6%	34	51	44	69.4%	15.7	103	21.2%	33.5%
Guilford	21	91.3%	4	6	11	91.9%	16.2	7	2.6%	60.5%
Haddam	1	-	0	1	0	see RSD 17	see RSD 17	see RSD 17	see RSD 17	see RSD 17
Hamden	215	47.4%	63	76	76	61.9%	17.4	171	41.6%	33.3%
Hampton	2	-	0	1	1	81.8%	11.5	14	100.0%	52.2%

Town/City Data: Part 4



	Children Receiving Child Care Subsidies 2003 (15)					Kindergarteners with a Preschool Experience 2002-2003 School Year (16)	Average Kindergarten Class Size 2002-2003 School Year (17)	Children Enrolled in Full-Day Kindergarten 2003-2004 School Year (18)		Students Meeting State Performance Goal on 4th Grade Connecticut Mastery Test 2002-2003 School Year (19)
	All Children		Infants and Toddlers	Preschool Children	School-Age Children					
	#	% in Formal Care	#	#	#					
Connecticut	14,779	45.9%	4,046	5,078	5,655	75.9%	18.3	18,338	43.9%	42.1%
Hartford	2,409	27.2%	639	737	1,033	50.8%	18.8	2149	100.0%	9.5%
Hartland	0	-	0	0	0	72.2%	18.0	0	-	56.7%
Harwinton	3	-	2	1	0	see RSD 10	see RSD 10	see RSD 10	see RSD 10	see RSD 10
Hebron	5	85.7%	2	1	2	98.2%	16.4	0	-	60.7%
Kent	0	-	0	0	0	82.8%	14.5	27	93.1%	37.0%
Killingly	80	72.5%	25	37	18	61.7%	12.7	0	-	41.3%
Killingworth	9	93.3%	2	2	5	see RSD 17	see RSD 17	see RSD 17	see RSD 17	see RSD 17
Lebanon	9	50.0%	2	5	2	58.3%	16.8	6	6.8%	42.5%
Ledyard	15	86.4%	5	7	3	78.4%	18.1	0	-	40.1%
Lisbon	3	-	1	0	2	91.1%	15.5	0	-	43.3%
Litchfield	3	-	0	3	0	59.0%	13.8	0	-	57.6%
Lyme	1	-	0	1	0	see RSD 18	see RSD 18	see RSD 18	see RSD 18	see RSD 18
Madison	3	-	0	2	1	94.8%	19.3	0	-	59.4%
Manchester	437	52.4%	105	163	169	60.2%	17.3	205	37.1%	37.1%
Mansfield	5	100.0%	1	3	1	76.2%	17.4	0	-	64.4%
Marlborough	2	-	0	0	2	86.7%	16.6	0	-	53.7%
Meriden	542	40.2%	150	185	207	78.0%	18.7	67	9.1%	36.4%
Middlebury	4	-	1	1	2	see RSD 15	see RSD 15	see RSD 15	see RSD 15	see RSD 15
Middlefield	2	-	1	1	0	see RSD 13	see RSD 13	see RSD 13	see RSD 13	see RSD 13
Middletown	304	59.9%	79	100	125	82.3%	20.3	475	100.0%	39.7%
Milford	80	67.4%	28	20	32	87.7%	16.5	563	100.0%	48.0%
Monroe	4	-	2	1	1	87.4%	19.5	0	-	63.2%
Montville	31	63.4%	6	13	12	71.3%	16.8	5	2.5%	51.9%
Morris	1	-	1	0	0	see RSD 06	see RSD 06	see RSD 06	see RSD 06	see RSD 06
Naugatuck	146	64.0%	31	55	60	67.9%	16.0	0	-	34.1%
New Britain	841	29.8%	234	294	313	47.0%	19.2	385	44.7%	15.5%
New Canaan	0	-	0	0	0	99.3%	19.5	0	-	66.0%
New Fairfield	5	100.0%	2	2	1	77.9%	21.9	0	-	56.9%
New Hartford	5	100.0%	0	4	1	89.5%	15.4	0	-	58.6%
New Haven	1,904	31.9%	488	620	796	71.2%	23.7	1,678	100.0%	15.0%
New London	192	43.1%	52	61	79	55.8%	17.8	249	95.4%	14.6%

Note: RSD (Regional School District) data is displayed at the end of this section.

	Children Receiving Child Care Subsidies 2003 (15)					Kindergarteners with a Preschool Experience 2002-2003 School Year (16)	Average Kindergarten Class Size 2002-2003 School Year (17)	Children Enrolled in Full-Day Kindergarten 2003-2004 School Year (18)		Students Meeting State Performance Goal on 4th Grade Connecticut Mastery Test 2002-2003 School Year (19)
	All Children		Infants and Toddlers	Preschool Children	School-Age Children			#	%	
	#	% in Formal Care	#	#	#					
Connecticut	14,779	45.9%	4,046	5,078	5,655	75.9%	18.3	18,338	43.9%	42.1%
New Milford	51	87.9%	9	24	18	62.8%	19.0	3	-	43.9%
Newington	42	60.0%	7	21	14	78.0%	18.7	279	98.2%	49.2%
Newtown	6	33.3%	0	6	0	73.6%	20.0	0	-	66.9%
Norfolk	0	-	0	0	0	100.0%	21.0	0	-	36.4%
North Branford	12	84.6%	4	6	2	90.6%	20.3	0	-	37.6%
North Canaan	4	-	0	0	4	64.9%	18.5	32	100.0%	38.6%
North Haven	19	63.6%	4	9	6	89.0%	18.7	286	100.0%	54.1%
North Stonington	5	100.0%	1	3	1	77.0%	15.3	0	-	46.3%
Norwalk	236	62.5%	78	77	81	88.4%	19.9	879	100.0%	30.8%
Norwich	221	65.3%	66	82	73	79.2%	15.6	0	-	31.9%
Old Lyme	2	-	2	0	0	see RSD 18	see RSD 18	see RSD 18	see RSD 18	see RSD 18
Old Saybrook	18	65.2%	7	7	4	77.5%	16.0	134	100.0%	62.8%
Orange	1	-	0	1	0	94.4%	19.8	0	-	52.2%
Oxford	2	-	1	1	0	91.9%	15.0	0	-	45.2%
Plainfield	43	70.8%	11	19	13	69.2%	18.7	0	-	38.8%
Plainville	35	69.4%	8	11	16	80.3%	14.7	3	-	45.9%
Plymouth	26	48.1%	4	8	14	84.1%	14.3	0	-	34.4%
Pomfret	7	100.0%	2	0	5	90.4%	17.3	0	-	56.4%
Portland	11	78.6%	2	1	8	85.7%	17.5	1	-	45.3%
Preston	4	-	2	1	1	81.1%	18.5	0	-	35.8%
Prospect	5	9.1%	0	2	3	see RSD 16	see RSD 16	see RSD 16	see RSD 16	see RSD 16
Putnam	23	75.9%	10	9	4	64.2%	15.8	95	100.0%	32.9%
Redding	1	-	0	1	0	91.8%	22.3	0	-	55.0%
Ridgefield	3	-	0	2	1	89.7%	17.3	7	2.0%	67.7%
Rocky Hill	11	87.5%	2	7	2	73.6%	17.0	0	-	50.3%
Roxbury	0	-	0	0	0	see RSD 12	see RSD 12	see RSD 12	see RSD 12	see RSD 12
Salem	2	-	1	1	0	87.3%	13.5	0	-	27.3%
Salisbury	6	100.0%	0	2	4	59.4%	10.7	0	-	53.8%
Scotland	0	-	0	0	0	71.4%	14.0	28	100.0%	26.3%
Seymour	26	90.0%	9	0	7	78.8%	21.8	17	9.6%	45.5%
Sharon	1	-	1	0	0	59.1%	11.0	0	-	46.7%
Shelton	25	90.0%	8	13	4	86.7%	18.4	3	-	50.5%

Town/City Data: Part 4



	Children Receiving Child Care Subsidies 2003 (15)					Kindergarteners with a Preschool Experience 2002-2003 School Year (16)	Average Kindergarten Class Size 2002-2003 School Year (17)	Children Enrolled in Full-Day Kindergarten 2003-2004 School Year (18)		Students Meeting State Performance Goal on 4th Grade Connecticut Mastery Test 2002-2003 School Year (19)
	All Children		Infants and Toddlers	Preschool Children	School-Age Children			#	%	
	#	% in Formal Care	#	#	#					
Connecticut	14,779	45.9%	4,046	5,078	5,655	75.9%	18.3	18,338	43.9%	42.1%
Sherman	0	-	0	0	0	92.5%	17.7	0	-	47.5%
Simsbury	15	100.0%	3	0	6	95.7%	20.6	0	-	77.0%
Somers	13	100.0%	3	7	3	92.7%	16.0	0	-	36.3%
South Windsor	22	75.0%	5	11	6	88.7%	19.6	0	-	58.9%
Southbury	2	-	1	1	0	see RSD 15	see RSD 15	see RSD 15	see RSD 15	see RSD 15
Southington	95	52.1%	16	32	47	80.0%	16.8	8	1.8%	45.7%
Sprague	7	71.4%	2	3	2	55.6%	18.0	0	-	37.8%
Stafford	32	73.5%	7	11	14	91.4%	14.8	0	-	31.0%
Stamford	160	65.4%	47	61	52	76.0%	19.3	1,270	100.0%	39.3%
Sterling	3	-	1	2	0	81.6%	12.7	17	35.4%	36.0%
Stonington	19	87.0%	5	13	1	68.5%	19.1	0	-	45.5%
Stratford	116	53.2%	41	36	39	65.8%	17.3	245	43.8%	32.5%
Suffield	17	92.3%	5	8	4	87.8%	18.4	0	-	64.8%
Thomaston	17	84.2%	5	4	8	68.9%	21.4	87	87.9%	32.1%
Thompson	10	90.0%	1	6	3	84.6%	14.9	50	52.6%	59.0%
Tolland	9	91.7%	2	4	3	58.4%	20.3	0	-	54.1%
Torrington	159	74.6%	38	59	62	75.4%	17.7	0	-	37.9%
Trumbull	7	57.1%	3	0	4	86.8%	17.8	0	-	61.8%
Union	0	-	0	0	0	75.0%	8.0	0	-	57.1%
Vernon	153	56.5%	47	52	54	74.7%	16.7	271	100.0%	47.2%
Voluntown	0	-	0	0	0	88.9%	13.5	0	-	35.7%
Wallingford	115	78.7%	24	50	41	90.0%	17.2	0	-	45.3%
Warren	0	-	0	0	0	see RSD 06	see RSD 06	see RSD 06	see RSD 06	see RSD 06
Washington	2	-	0	1	1	see RSD 12	see RSD 12	see RSD 12	see RSD 12	see RSD 12
Waterbury	1,291	35.6%	350	416	525	49.3%	18.8	1713	100.0%	16.8%
Waterford	20	84.0%	7	8	5	75.4%	16.6	2	-	52.1%
Watertown	34	65.8%	9	14	11	74.8%	17.3	92	39.7%	44.7%
West Hartford	101	56.3%	32	33	36	85.3%	19.2	773	100.0%	64.2%
West Haven	378	47.4%	109	121	148	68.6%	20.3	390	65.5%	38.6%
Westbrook	18	95.0%	4	8	6	83.5%	19.0	0	-	49.3%
Weston	1	-	1	0	0	97.5%	20.4	191	100.0%	69.3%

Note: RSD (Regional School District) data is displayed at the end of this section.



	Children Receiving Child Care Subsidies 2003 (15)					Kindergarteners with a Preschool Experience 2002-2003 School Year (16)	Average Kindergarten Class Size 2002-2003 School Year (17)	Children Enrolled in Full-Day Kindergarten 2003-2004 School Year (18)		Students Meeting State Performance Goal on 4th Grade Connecticut Mastery Test 2002-2003 School Year (19)		
	All Children		Infants and Toddlers	Preschool Children	School-Age Children			%	Avg. # of Students		#	%
	#	% in Formal Care	#	#	#							
Connecticut	14,779	45.9%	4,046	5,078	5,655	75.9%	18.3	18,338	43.9%	42.1%		
Westport	4	-	3	0	1	98.2%	19.3	0	-	72.5%		
Wethersfield	52	53.0%	14	19	19	78.0%	20.6	0	-	57.4%		
Willington	8	66.7%	5	3	0	92.2%	12.8	7	16.7%	29.2%		
Wilton	4	-	1	1	2	99.7%	19.6	0	-	68.4%		
Winchester	48	64.3%	21	15	12	79.7%	17.6	125	100.0%	38.1%		
Windham	195	39.2%	63	59	73	69.8%	18.2	274	100.0%	17.3%		
Windsor	146	65.0%	33	53	60	78.3%	16.3	90	42.7%	41.8%		
Windsor Locks	38	63.0%	3	19	16	72.9%	16.1	125	88.0%	47.3%		
Wolcott	12	35.7%	0	4	8	81.9%	18.4	189	100.0%	48.8%		
Woodbridge	1	-	0	1	0	85.0%	20.0	113	100.0%	52.3%		
Woodbury	2	-	2	0	0	see RSD 14	see RSD 14	see RSD 14	see RSD 14	see RSD 14		
Woodstock	3	-	1	1	1	74.3%	17.5	59	74.7%	45.2%		

Regional School District Data, Notes & Sources



Regional School District (RSD) Data	Enrollment in Preschool Special Education (Ages 3 to 5) 2003-2004 School Year (9)	Kindergarteners with a Preschool Experience 2002-2003 School Year (16)	Average Kindergarten Class Size 2002-2003 School Year (17)	Children Enrolled in Full-Day Kindergarten 2003-2004 School Year (18)		Students Meeting State Performance Goal on 4th Grade Connecticut Mastery Test 2002-2003 School Year (19)
Note: Some data in the previous chart stem from school district data. In most cases, one town/city is located within each school district. However, the following school districts serving elementary-age children encompass several municipalities and thus, these data are presented here separately by Regional School District.	#	%	Avg. # of Students	#	%	%
Regional School District 06 (Goshen, Morris, and Warren)	18	89.0%	14.6	0	-	62.0%
Regional School District 10 (Burlington and Harwinton)	24	85.7%	15.8	0	-	68.9%
Regional School District 12 (Bridgewater, Roxbury, and Washington)	25	88.2%	12.7	0	-	59.5%
Regional School District 13 (Durham and Middlefield)	26	62.8%	16.4	0	-	49.7%
Regional School District 14 (Bethlehem and Woodbury)	30	86.4%	17.1	0	-	59.3%
Regional School District 15 (Middlebury and Southbury)	63	81.0%	17.7	9	2.9%	61.5%
Regional School District 16 (Beacon Falls and Prospect)	46	85.0%	14.7	0	-	47.9%
Regional School District 17 (Haddam and Killingworth)	32	90.8%	17.5	0	-	43.3%
Regional School District 18 (Lyme and Old Lyme)	35	87.4%	13.6	97	100.0%	45.4%

Notes:

- Rates and percentages are not calculated for towns/cities with fewer than 5 occurrences, due to the high degree of variability associated with small numbers.
- * For confidentiality reasons, numbers and rates for towns/cities with 10 or fewer cases of child abuse/neglect are not reported.

Sources:

- | | | |
|--|--|--|
| (1) US Census Bureau 2000, Summary File 1 | (7) Connecticut Department of Public Health, Childhood Lead Poisoning Prevention Program, 2000-2002 | (14) Child Care Infoline Provider Database, June 2003 |
| (2) Connecticut Department of Public Health, Provisional Registration Reports (Table 4) and unpublished data, 1999-2001 | (8) Connecticut Birth to Three System, FY2003 | (15) Connecticut Department of Social Services, 2003 |
| (3) Connecticut Department of Public Health, Registration Reports (Table 2A), 1997-2001 (data for 1999-2001 is provisional) | (9) Connecticut Department of Education, Preliminary Data, School Year 2003-2004 | (16) Connecticut Department of Education, Strategic School Profiles, 2002-2003 School Year |
| (4) Connecticut Department of Public Health, Provisional Registration Reports (Table 4) and unpublished data, 1999-2001 | (10) Connecticut Department of Public Health, Provisional Registration Reports (Table 3) and unpublished data, 1999-2001 | (17) Connecticut Department of Education, Strategic School Profiles, 2002-2003 School Year |
| (5) Connecticut Department of Public Health, Provisional Registration Reports (Table 4) and unpublished data, 1999-2001 | (11) Connecticut Department of Children and Families, 2003 and CT Association for Human Services, 2004 | (18) Connecticut Department of Education, 2003-2004 School Year |
| (6) Connecticut Department of Social Services and CT Covering Kids and Families, HUSKY A Enrollment by Town, July 2003-June 2004 | (12) US Census Bureau 2000, Table P87 | (19) Connecticut Department of Education, Strategic School Profiles, 2002-2003 School Year |
| | (13) Connecticut Department of Social Services, October 2003 | (20) US Census Bureau 2000, based on 1999 income, Table PCT39 |





STEPPING STONE ONE: Health and Child Development

Maternal Health

Percentages for the Smoking During Pregnancy indicator are calculated by taking the number of births to smokers in one year and dividing that number by the total number of births for which smoking status is determined in that year.

Likewise, annual percentages for the Late or No Prenatal Care indicator are calculated by taking the number of births to women receiving late or no prenatal care in one year and dividing that number by the total number of births for which the status of prenatal care is known in that year. The town chart, which displays three-year averages, reports both the number and percent of births to mothers receiving late or no prenatal care over a three-year period (1999 to 2001). The denominator for the three-year average percentages is the total number of births from 1999 to 2001 for which the status of prenatal care is known.

Infant Mortality

Infant mortality is expressed as a rate – the number of infant deaths per 1,000 live births. Annual infant mortality rates are calculated by taking the number of infant deaths in one year and dividing that number by the total number of live births in that year, then multiplying by 1,000. The town chart, which displays five-year averages, reports both the total number of infant deaths and the infant mortality rate over a five-year period (1997 to 2001). The five-year average rate is calculated by summing the number of infant deaths over five years (1997 to 2001) and dividing the sum by the total number of live births over those five years, then multiplying by 1,000.

Births to Teen Mothers

Annual percentages for Births to Teen Mothers are calculated by taking the number of births to teens (ages 15 to 19) in one year and dividing that number by the total number of births for which the age of the mother is known in that year. Data for three-year average percentages is generated by summing the number of births to teens (ages 15 to 19) over a three-year period (1999 to 2001) and dividing that sum by the total number of births over those three years for which the mother's age is known.

Low Birthweight Infants

Annual percentages for Low Birthweight Infants are calculated by taking the number of infants born at low birthweight in one year and dividing that number by the total number of births in that year for which the birthweight is known. Data for three-year average percentages is calculated by summing the number of infants born at low birthweight over a three-year time period (1999 to 2001) and dividing that sum by the total number of births for which birthweight is known during the same three-year period.

Access to Health Insurance and Preventive Care

For methodological details on On-Time Well-Child Visits, see “EPSDT On-Time Visit Rates: First Quarter 2001” at www.childrenshealthcouncil.org.

Lead Poisoning

Percentages for lead screening rates are calculated by summing the number of 1 and 2 year olds screened over three years (2000 to 2002) and dividing that sum by the estimated total number of 1 and 2 year old children over the three-year period. Three-year population estimates were derived by multiplying the US Census 2000 figure by three.

Strong Families

Percentages for Maternal Education are calculated as a three-year average by summing the annual number of births to women without a high school diploma over three years (1999 to 2001) and dividing that sum by the total number of births for which educational status is known over that same three-year period.

STEPPING STONE TWO: Safety and Child Welfare

Children in Foster Care

Percentages on young children in foster care by race/ethnicity exclude children for whom race/ethnicity is categorized as “unknown” or “unable to determine.”



Child Abuse and Neglect

To generate substantiated child abuse/neglect rates in the town chart, the number of substantiated children under age 18 is divided by the total number of children under 18, then multiplied by 1,000. Total population estimates for the denominators are calculated by applying the percentage of the population under 18 as determined by the US Census 2000 and applying that percentage to the Connecticut Department of Public Health's population estimate for the year 2002.

Child Deaths

Child Deaths is expressed as a rate – deaths per 100,000 children. The child death rate is presented as a three-year average. The rate is calculated by summing the number of child deaths between 1999 and 2001 for each age group and dividing that sum by the total number of children in each age group over that same time period, then multiplying by 100,000. Population totals for the denominator were derived from US Census 2000 estimates and multiplied by three to calculate three-year totals.

STEPPING STONE THREE: Economic Stability

Children in Poverty

Percentages for young children in poverty are calculated by dividing the number of children under age 6 in poverty by the total number of children under age 6 for whom poverty status is determined. Data for both the numerator and denominator is from the US Census 2000.

STEPPING STONE FOUR: Early Care and Education

Supply of Regulated Early Care and Education

The data source for this indicator and the Supply of Quality Early Care and Education indicator is a dataset obtained from Child Care Infoline reporting on the licensed or regulated programs in their resource and referral database as of June 2003. The University of Connecticut Center for Economic Analysis prepared the data and assisted the Child Health and Development Institute in the analysis.

The number of regulated slots reflects only the intended enrollment capacity of each program. Note that this figure may be smaller than the maximum number of slots a program is authorized to provide according to licensing regulations. Intended enrollment calculations are based on provider responses to a fall 2002 Child Care Infoline survey. In calculating the ratio of available slots per 100 children, US Census 2000 data on the total number of children in the relevant age group were used.

Family child care and center-based care rates cannot be added together in an age category, because the denominators used in these calculations are different, reflecting age ranges in licensing. For family child care, infants and toddlers are under age 2 and preschoolers are 2, 3, and 4 year olds. For center-based care the ranges are under age 3 and 3 and 4 years respectively.

Supply of Quality Early Care and Education

Percentages for this indicator are calculated by dividing the number of quality programs or slots by the total number of regulated programs or slots. The term "regulated" encompasses both licensed child care and license-exempt school programs.

Kindergarten Children with a Preschool Experience

Percent calculations are derived using the total number of kindergarten children as the denominator.

STEPPING STONE FIVE: Ready Schools

Children in Full-Day Kindergarten

For percent calculations, only those school districts offering kindergarten programs were included in the denominator (158 districts). The analysis excludes charter schools, regional education centers and other schools without an Education Reference Group (ERG) designation. All of these children received full-day kindergarten.



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