



Understanding the Valley Region

A COMMUNITY OF WELL-BEING

A COMMUNITY INDICATORS REPORT PRODUCED BY



DataHaven

Community Health
Needs Assessment
for towns served by



GRIFFIN HEALTH

2019 Valley Community Index

UNDERSTANDING THE VALLEY REGION: 2019 VALLEY COMMUNITY INDEX

Produced by the Valley Community Foundation and DataHaven, October 2019

LEAD AUTHORS

Brian Slattery
Consultant, DataHaven
Mark Abraham
Executive Director, DataHaven
Shaun McGann
Statewide Project Coordinator,
DataHaven
Camille Seaberry
Senior Research Associate,
DataHaven

OTHER CONTRIBUTORS

Josephine Ankrah
Research Coordinator, DataHaven
Kelly Davila
Data Analyst, DataHaven

VALLEY COMMUNITY FOUNDATION STAFF

Sharon Closius, President and CEO
Beth Colette
Valerie Knight-Di Gangi
John Ready
Laura Downs, Morrison Downs
Associates, Project Consultant

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Shelton Economic Development
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Valley Parish Nurse Program
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The WorkPlace, Inc.
Yale-Griffin Prevention
Research Center

Community Volunteers:
Richard Knoll, Jack Walsh
Representatives from the
Valley Council for Health &
Human Services
Representatives from municipal
governments and school districts
throughout the Valley

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Suggested citation: Brian Slattery,
Mark Abraham, Camille Seaberry,
and Shaun McGann. (2019).
Understanding the Valley Region:
2019 Valley Community Index.
Derby, CT: Valley Community
Foundation and DataHaven.

Contents and Key Findings

INTRODUCTION

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- Throughout most of the state and in the Valley, personal well-being has worsened slightly since 2015, with the measure of life satisfaction declining the most.
- Valley adults ages 65 and older score highest of any age group on DataHaven's Personal Wellbeing Index, while adults ages 18 to 34 score lowest.
- Since the early 2000s, the region's residents are increasingly using libraries as centers for programming and community gathering spaces.

A CHANGING VALLEY

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- In 2017, the total population in the Valley was 140,243—on par with Connecticut's largest cities.
- Future population growth in the region is expected to be driven by seniors.
- The Valley is becoming more racially diverse, but this demographic shift is not equal across the region.

COMMUNITY HEALTH IN THE VALLEY

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- Cancers, heart disease, substance abuse, and motor vehicle accidents have impacted the Valley's rate of premature death.
- The rate of non-adequate prenatal care in the Valley rose from 11.3 percent of 2006–2010 births to 16.4 percent of 2011–2015 births.
- Falls are a common cause of nonfatal injury in the Valley and rates of hospital and emergency room encounters are particularly high among older seniors.

EARLY CHILDHOOD & EDUCATION

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- Just 53 percent of Valley three- and four-year-olds were enrolled in preschool in 2017.
- In 2018, the average childcare facility in the Valley charged about \$244 a week to care for infants and toddlers, and about \$225 for preschoolers.
- Performance on statewide standardized tests and high school graduation rates have improved in recent years in the region.

SENIORS

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- Between 2017 and 2035, the Valley's senior population is expected to increase by 34 percent.
- Three out of four adults nationwide want to stay in their homes and communities as they age.
- Seniors who need attentive healthcare in the region face high costs.

ECONOMIC OPPORTUNITY

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- Between 2000 and 2017, the Valley added about 900 jobs.
- Over this time period, wages for Valley jobs declined by 7.4 percent.
- In 2017, there were 71,219 employed Valley residents, but only 47,533 jobs located in the region—a substantial portion of which were held by people residing outside of the Valley.

A Message from the Valley Community Foundation

Knowledge is a powerful tool and the data is clear. Health and well-being are not simply about genetics, but are impacted by factors both within and beyond one's control. Social determinants of health such as diet, smoking, exercise as well as access to a range of services, transportation, employment, public safety, and more, can have a lasting impact on quality of life. The Valley has a long history of being a close-knit, family-centered region. However, disparities among its communities present both challenges and opportunities to collectively address future health and wellness needs. The findings in the 2019 Valley Community Index provide the information to develop strategies for change.

Created in partnership with DataHaven, this report reflects the most recent data collection efforts to examine the social, economic, and physical health of the Valley and continues where the 2016 Community Index report left off. Regional leaders from a range of multi-disciplinary organizations have come together once again to examine what has occurred in the Valley in the last three years. Each section now includes key data points which highlight trends for review. Are we making a difference in the Valley? How and where can we effectively utilize limited resources to have the greatest impact?

To begin to answer these questions, this Index will once again be used to convene community conversations, foster engagement, align current efforts and investments, and collaborate on strategic endeavors to build, sustain, and enhance the quality of life in the Valley. The Index meets Griffin Hospital's IRS requirements in Form 990 Schedule H and Notice 2011-52 that discuss the creation of a Community Health Needs Assessment, which all tax-exempt hospitals complete as a result of the Patient Protection and Affordable Care Act. It also fulfills Naugatuck Valley Health District's requirement for a Community Health Assessment as part of its national accreditation by the Public Health Accreditation Board. The Index serves as a foundation for the Valley Community Health Improvement Plan (Valley CHIP), a requirement for both Griffin Hospital and NVHD.

I want to thank the Valley Community Foundation Board of Directors for reaffirming their commitment to this work. Once again, this report received support from Griffin Health Services and other key funders that understand the role accessible data plays in the overall health and well-being of the region. We are most grateful for their continued partnership. Finally, special thanks also go to the VCF staff, especially Valerie Knight-Di Gangi for her project leadership; Laura Downs for her facilitation and project management expertise; the Community Index Advisory Committee for their direction and input; and to DataHaven for their writing and data mining efforts. As a result of the tireless contributions of so many nonprofit leaders this report clearly demonstrates this region's ongoing dedication to community well-being. I am pleased to present *Understanding the Valley Region, 2019*.



Sharon L. Closius President and CEO, Valley Community Foundation

UNDERSTANDING COMMUNITY WELL-BEING

The DataHaven Community Wellbeing Survey traces its origins to a series of grassroots and locally-based efforts conducted over the past two decades to gather information on well-being and quality of life in Connecticut's diverse neighborhoods. With guidance from DataHaven and an Advisory Council of more than 125 public and private organizations, these area surveys grew substantially each year in size and quality, and became increasingly coordinated. To create a unified statewide survey, DataHaven developed this network into a formal partnership and chose validated questions from national and international surveys to allow comparisons to benchmark data. The survey is now a nationally-recognized program that provides critical, highly-reliable local information not available from any other public data source.

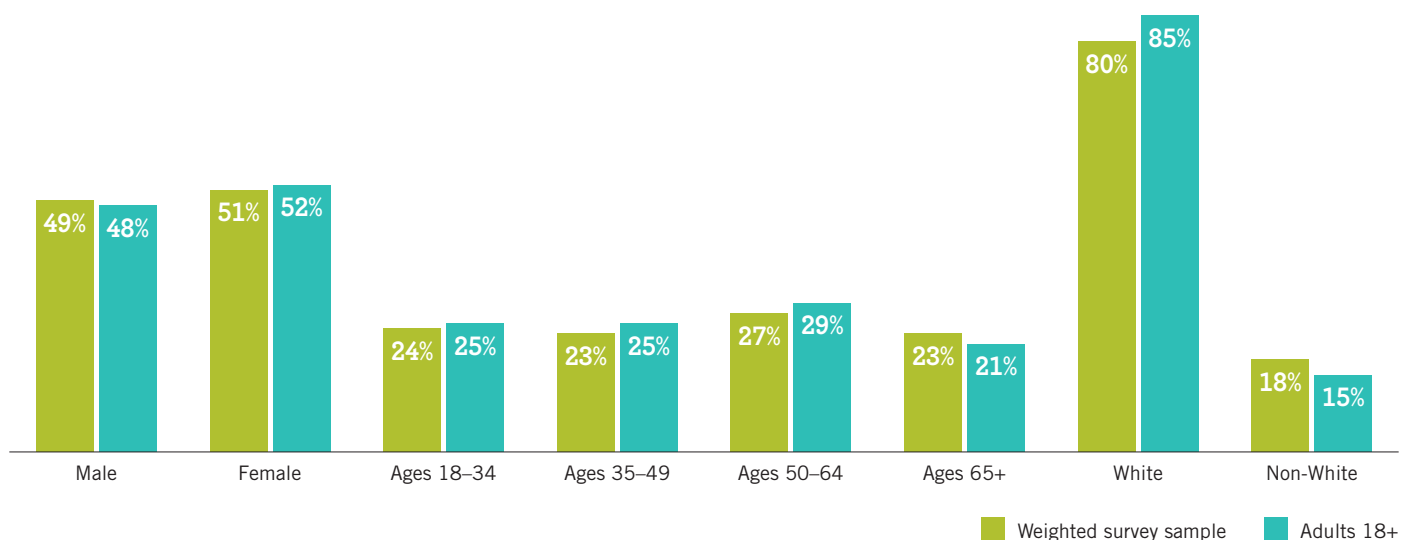
The 2018 Community Wellbeing Survey consisted of live, in-depth interviews with 16,043 adults ages 18 and older statewide, including 1,044 in the Valley Region. The survey assessed topics such as health, employment, and neighborhood resources. Respondents spanned a broad range of ages, ethnicities, and socioeconomic statuses from every Connecticut zip code, and all results are based on weighting survey data by age, gender, reported race, and geography to ensure that they were statistically representative of the population. Data collected at this level reveal local trends in quality of life. The maximum margin of error for the Valley Region sample of 1,044 adults is +/- 3.4% with a 95% confidence interval. This means that in 95 out of every 100 samples of the same size and type, the results obtained from any survey question would never vary by more than plus or minus 3.4 percentage points from the result that we would get if we could interview every single member of the adult population of the Valley.



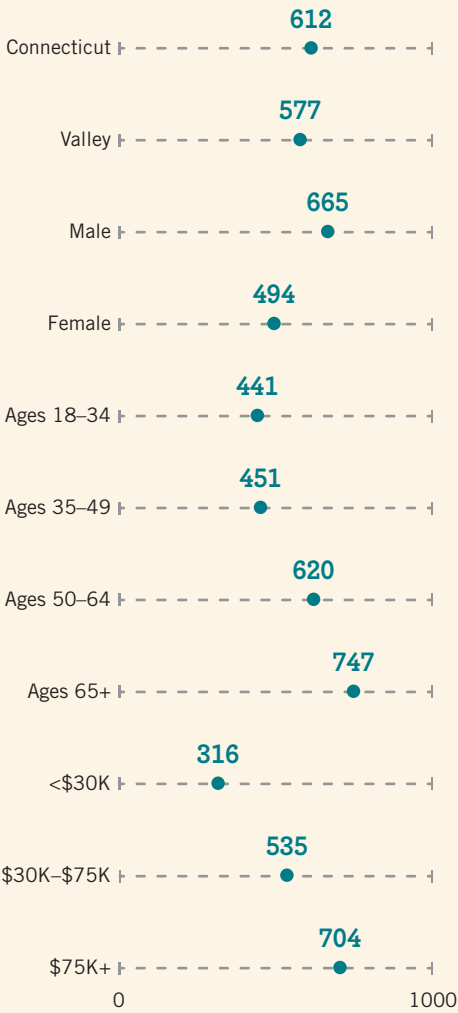
Many factors support personal well-being and happiness, but scientists have identified some of the most important, including: community life and social support, health outcomes, and employment and basic needs.¹

i.01 2018 DataHaven Community Wellbeing Survey sample characteristics

Survey sample characteristics and adult population in the Valley



i.02 Personal Wellbeing Index
2018 DataHaven Community
Wellbeing Survey



PERSONAL WELLBEING INDEX

DataHaven’s Personal Wellbeing Index—consisting of measures of self-reported life satisfaction, happiness, anxiety, and health—reveals inequality by geography, race and ethnicity, and household income level. The DataHaven Community Wellbeing Survey’s questions on health, happiness, anxiety, and life satisfaction help us understand how people evaluate and experience their day-to-day life across multiple dimensions. Designed by a panel of local and national survey research experts, these questions are regularly used to evaluate personal well-being. For this report, we integrate the following four items into a Personal Wellbeing Index score from 0 to 1,000:

- How would you rate your overall health?
- Overall, how satisfied are you with your life nowadays?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

Throughout most of the state and in the Valley, personal well-being has worsened slightly since 2015, with the measure of life satisfaction declining the most. In the Valley, 65 percent of all adults reported being mostly or completely satisfied with life in 2018, compared to 71 percent in 2015.

We often find strong correlations between the Personal Wellbeing Index and other community-level outcomes, suggesting that continuing to improve community health and quality of life in the Valley requires a comprehensive, multi-sector approach.

i.03 Personal Wellbeing Index components by demographic group
Share of adults, 2018 DataHaven Community Wellbeing Survey

	Very good self rated health	Mostly happy	Mostly anxious	Satisfied with life
Connecticut	59%	70%	12%	67%
Valley (2015)	60%	71%	11%	71%
Valley	60%	66%	10%	65%
Male	61%	68%	10%	67%
Female	57%	64%	10%	63%
Ages 18–34	67%	62%	16%	56%
Ages 35–49	62%	64%	9%	62%
Ages 50–64	56%	66%	6%	68%
Ages 65+	50%	71%	10%	71%
<\$30K	47%	59%	13%	49%
\$30K–\$75K	57%	65%	13%	57%
\$75K+	67%	70%	6%	76%



Introduction

The Valley is a community of Connecticut towns located in New Haven and Fairfield Counties. It lies along the Housatonic and Naugatuck Rivers and is connected to city centers along I-95 between New York and New Haven, as well as along Route 8 to Waterbury. The Valley's legacy of agricultural and industrial production arises from its location along two major rivers. Today, the economy of the Valley communities is significantly influenced by the continued development along the Route 8 corridor, which has resulted in both opportunities and challenges. We define the Valley as the seven towns that collaborated to win the All-America City Award in the year 2000: Ansonia, Beacon Falls, Derby, Naugatuck, Oxford, Seymour, and Shelton.

The University of Connecticut Center for Population Research has suggested that each of the state's 169 towns belongs to one of five categories: wealthy, suburban, rural, urban periphery, and urban core. These "Five Connecticut" are determined by population density, income levels, and economic hardship; each category faces unique opportunities and challenges.² In the Valley, Ansonia, Derby, and Naugatuck contain the diverse neighborhoods and manufacturing legacies that are common to urban periphery towns throughout the state. Beacon Falls and Seymour share some of the characteristics of rural towns, while Oxford and Shelton are more typical of higher-income suburban areas. Given this variety, the region is a microcosm of Connecticut as a whole. This report highlights those similarities by comparing the region to the state on key indicators.

The Valley has a common history and identity, but each of its towns has its own unique characteristics. The region's demographics and economy are constantly changing in response to outside forces; these changes affect the region's neighborhoods in different ways. Town centers offer a large share of rental or affordable housing units, which are attractive to younger workers, single adults, and other households that would prefer to rent for economic or lifestyle reasons. In other neighborhoods, newer homes and larger lots continue to attract homeowners with high incomes. The variety of neighborhoods and residents who choose to live there help make the Valley a resilient community with a rich tradition of immigration and migration.

Though community fabric in the Valley is strong, from its farms and forests to its urban cores and thriving business districts, disparities exist between residents and communities within the region. As some people move into new housing developments and apartment complexes, others remain in aging homes. Some have great healthcare while others struggle to obtain basic care. Some live comfortably in the Valley with well-paying jobs while others search for employment or must work two or three jobs just to maintain a basic quality of life. The Valley's older population continues to grow, and many are still working into their seventies and beyond. The younger population, particularly in the Valley's more urbanized areas, is more diverse than ever before.



COMMUNITY LIFE AND ASSETS IN THE VALLEY

Valley residents have access to many public resources, outdoor activities, and arts and cultural opportunities in their communities, which attract visitors from across Connecticut and beyond. The Valley's natural environment is a key community asset, as the region contains numerous green spaces, playgrounds, parklands, rivers, farms and farmers' markets, and community gardens.

Libraries remain important anchor institutions in the region, and transcend their traditional role of simply lending books. While circulation has decreased both in the Valley and statewide since the early 2000s, the region's residents are increasingly using libraries as centers for programming and community gathering spaces; between 2002 and 2018, the total number of programs offered by Valley libraries more than doubled, as did attendance at these programs.³

Valley residents display high-levels of civic engagement; across the three most recent presidential (2016), state (2018), and local (2017) elections, voter turnout in the Valley was above the statewide rates.⁴

i.04 Community Cohesion Share of adults, 2018 DataHaven Community Wellbeing Survey

	Satisfied with area	Police approval	Safe walking at night	Trust neighbors	Positive role models	Receive social support
Connecticut	82%	78%	70%	85%	78%	71%
Valley (2015)	80%	82%	75%	89%	80%	n/a*
Valley	84%	83%	75%	89%	82%	74%
Male	84%	81%	78%	91%	82%	77%
Female	84%	85%	72%	86%	79%	71%
Ages 18–34	79%	82%	72%	82%	72%	70%
Ages 35–49	84%	80%	80%	89%	78%	66%
Ages 50–64	85%	81%	79%	91%	85%	75%
Ages 65+	88%	90%	70%	92%	85%	81%
White	83%	84%	76%	89%	81%	74%
Non-White	87%	77%	72%	86%	79%	71%
<\$30K	79%	77%	63%	80%	71%	60%
\$30K–\$75K	84%	82%	67%	84%	78%	73%
\$75K+	84%	87%	83%	95%	84%	77%

*New survey question.

i.05 Community Assets Share of adults, 2018 DataHaven Community Wellbeing Survey

	Government is responsive	Good place to raise kids	Good condition of parks	Safe sidewalks	Safe biking	Rec facilities available
Connecticut	51%	75%	75%	61%	63%	70%
Valley (2015)	48%	73%	69%	48%	56%	66%
Valley	53%	78%	73%	47%	56%	64%
Male	55%	79%	72%	47%	60%	69%
Female	51%	77%	74%	48%	53%	61%
Ages 18–34	47%	71%	67%	59%	65%	71%
Ages 35–49	45%	77%	69%	48%	57%	65%
Ages 50–64	58%	81%	78%	44%	54%	61%
Ages 65+	63%	82%	77%	39%	50%	60%
White	54%	78%	74%	44%	55%	62%
Non-White	52%	75%	74%	62%	64%	77%
<\$30K	50%	71%	69%	56%	64%	61%
\$30K–\$75K	50%	79%	78%	51%	53%	63%
\$75K+	54%	80%	70%	42%	54%	65%

Additionally, the crime and violent crime rates in the Valley were well below statewide rates in the most recently available 2016–2017 data, decreasing since 2013–2014.⁵

In 2018, Valley adults reported higher levels of community cohesion than the state overall and the majority of Valley residents are satisfied with the community in which they live.⁶ However, between 2015 and 2018, levels of community cohesion changed little in the Valley, though adults reporting they were satisfied with the area in which they live increased by 4 percentage points.⁷ Compared to the state overall in 2018, Valley adults reported higher levels of perceived local government responsiveness and were more likely to think their area was a good place to raise children; however, they were less likely to report high quality community resources (parks, sidewalks, biking infrastructure, and recreation facilities).⁸ Between 2015 and 2018, there was a positive increase across a number of community assets indicators.⁹ Disparities by sex, age, race, and income exist across measures of both community cohesion and community assets.



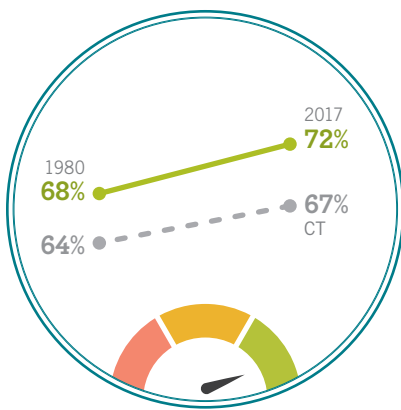
CHAPTER 1

A Changing Valley

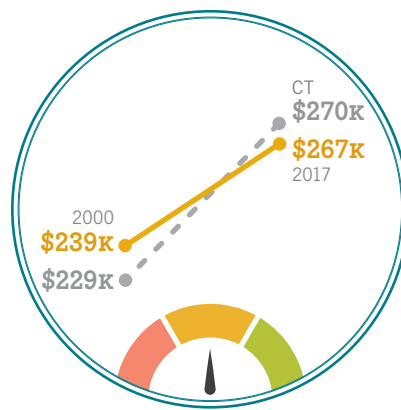
Before we can begin to understand what life is like in the Valley, we need to understand who lives here. In 2017, the total population in the Valley was 140,243. The region's population has grown at a faster rate than the state overall since 1990, and future population growth is expected to be driven by seniors. While the older population continues to expand, younger residents are increasingly diverse—particularly in the region's urban areas; this increase in diversity has been partly driven by immigration from outside the United States (see page 9).

Though the Valley's median income is above the statewide average, there are disparities between towns, and the poverty and low-income rates are on the rise across the region—particularly among children. The Valley's homeownership rate is high overall, but this is not the case for Black and Latino households. Housing costs are unsustainable for many residents, with a quarter of the Valley's renters spending more than half of their income on rent. Additionally, the region's towns with the highest property values and strongest tax bases face fewer difficulties in providing their residents with high quality public goods and resources, which directly impacts quality of life across the Valley.

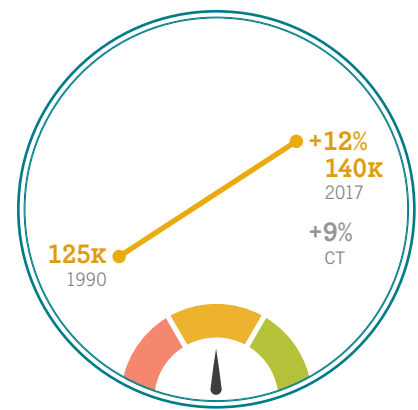
Homeownership rates have increased and are higher than the state overall



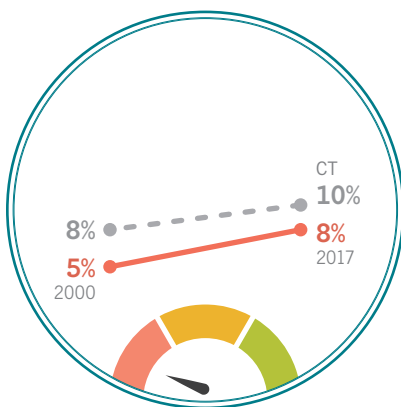
Median home values have grown, and are lower than the state overall



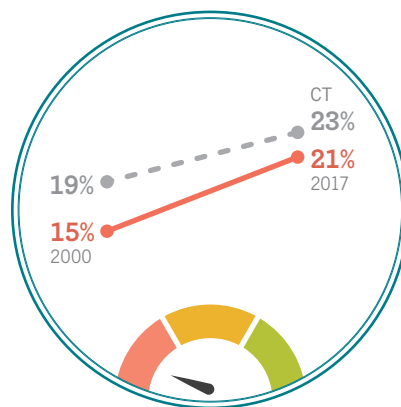
Population in the Valley has grown faster than in Connecticut overall



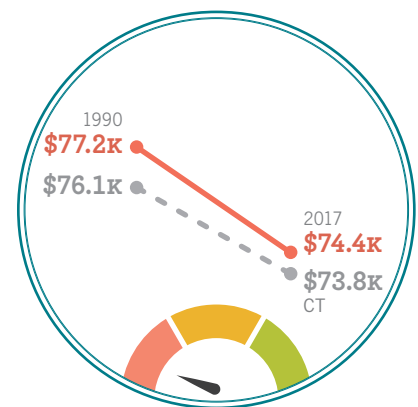
The **poverty rate** in the Valley has increased



The **low-income rate** in the Valley has also increased



Median household income has declined, but is slightly above the state overall



1.01 Population and growth Population in the Valley and towns, 2017

	Population 1990	Population 2017	Population growth	Population density	Median age 2000	Median age 2017	Change in median age
United States	248,709,873	321,004,407	+29%	91	35.3	37.8	+2.5
Connecticut	3,287,116	3,594,478	+9%	742	37.4	40.8	+3.4
Valley	124,701	140,243	+12%	1,221	37.8	42.5	+4.7
Ansonia	18,403	18,953	+3%	3,159	36.8	39.1	+2.3
Beacon Falls	5,083	6,108	+20%	630	36.7	43.7	+7.0
Derby	12,199	12,700	+4%	2,490	37.7	40.9	+3.2
Naugatuck	30,625	31,649	+3%	1,942	35.5	39.2	+3.7
Oxford	8,685	12,972	+49%	397	38.4	44.8	+6.4
Seymour	14,288	16,579	+16%	1,143	38.5	40.8	+2.3
Shelton	35,418	41,282	+17%	1,349	39.8	46.8	+7.0

THE AGING AND DIVERSIFYING VALLEY

Population growth in the Valley has been uneven across age groups. From 1990 to 2015, the number of young children under five years old declined 25 percent, while the number of school-age children ages 5 to 17 rose by 14 percent.¹⁰ The number of young adults ages 18 to 34 dropped by 22 percent, but the number of middle-aged adults between ages 35 and 64 rose by 40 percent.¹¹ The number of younger seniors between ages 65 and 79 rose by 22 percent, and the number of older seniors ages 80 and over rose by 79 percent (see Figure 1.02).¹²

The Valley is becoming more racially diverse, but this demographic shift is not equal across the region. When discussing increasing diversity, this report considers both race and ethnicity. Racial groups discussed include White, Black, and Asian. Ethnicity refers to cultural factors of an individual, based on origin—including nationality, religion, or language. Latino is an ethnicity. In this report, we will refer to racial or ethnic minorities as people who do not identify as non-Latino White. This group includes people who do not identify racially as White, as well as all people who identify ethnically as Latino, regardless of their race.

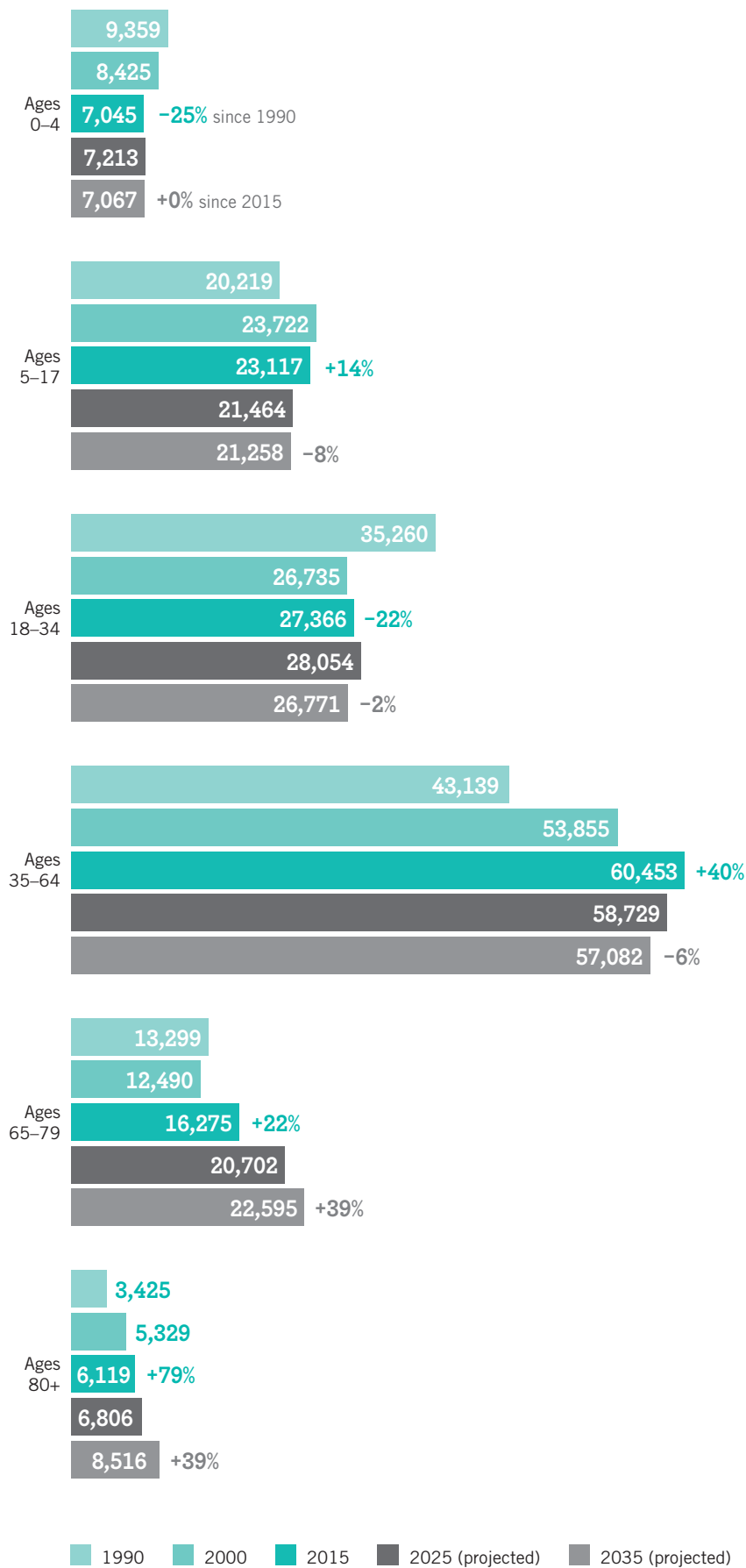
Between 2015 and 2035, the Valley's senior population is projected to increase by 39 percent—nearly twice as fast as the projected growth for seniors statewide.¹³

Between 1990 and 2017, the Valley's non-White population increased from 6 to 22 percent.¹⁴

Between 1990 and 2017, the number of immigrants calling the Valley home grew from 9,086 to 15,868—a 75 percent increase.¹⁵

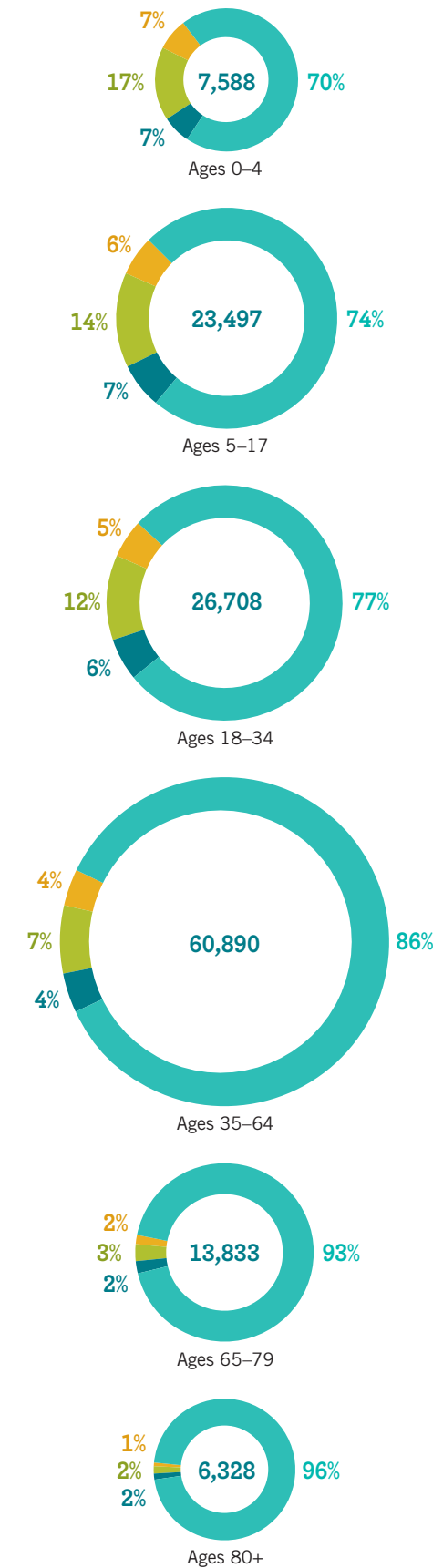
1.02 Population growth in the Valley has been uneven across age groups

Population and change by age group, 1990–2035



1.03 Children and younger adults are more racially diverse

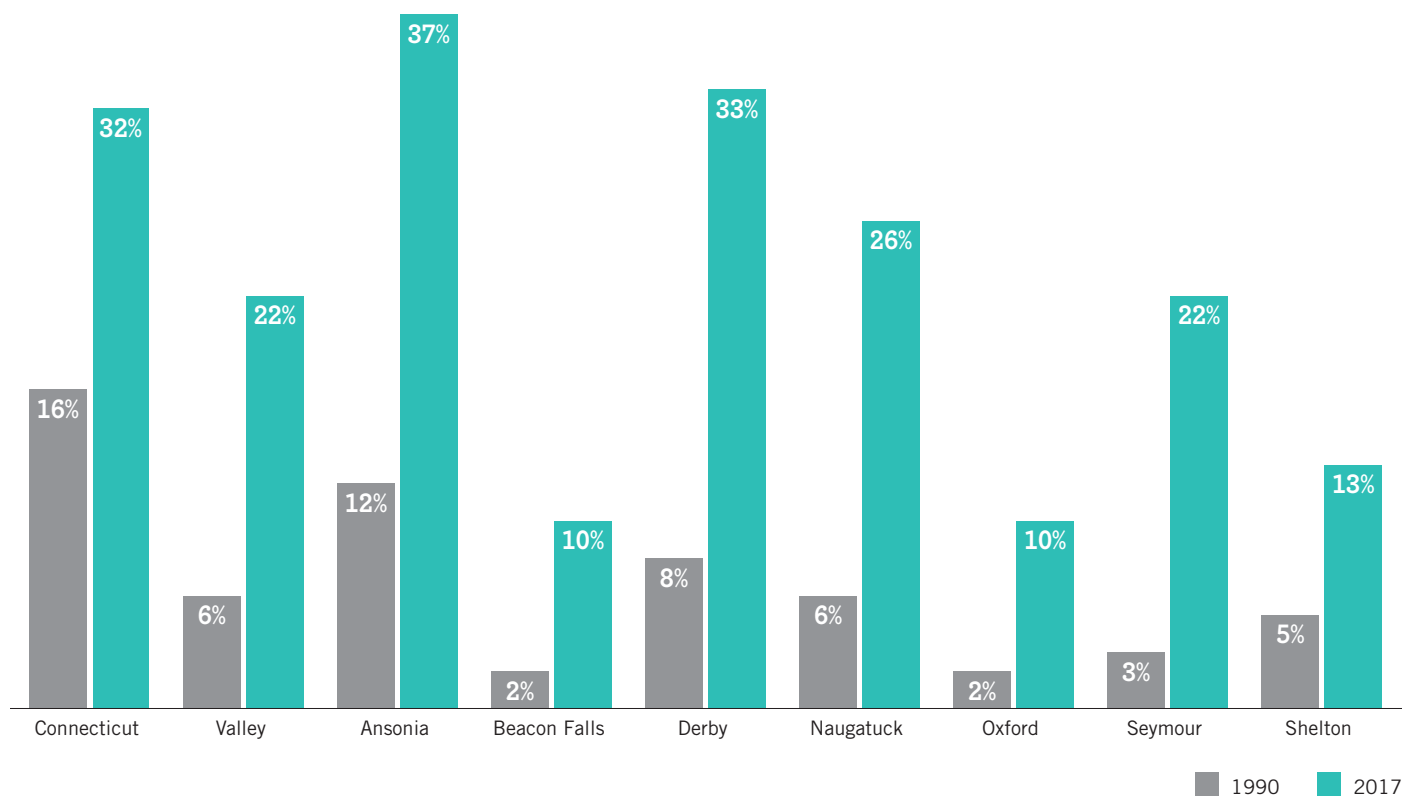
Population by age and race, Valley, 2010



Percentages may not add up to 100% due to rounding.

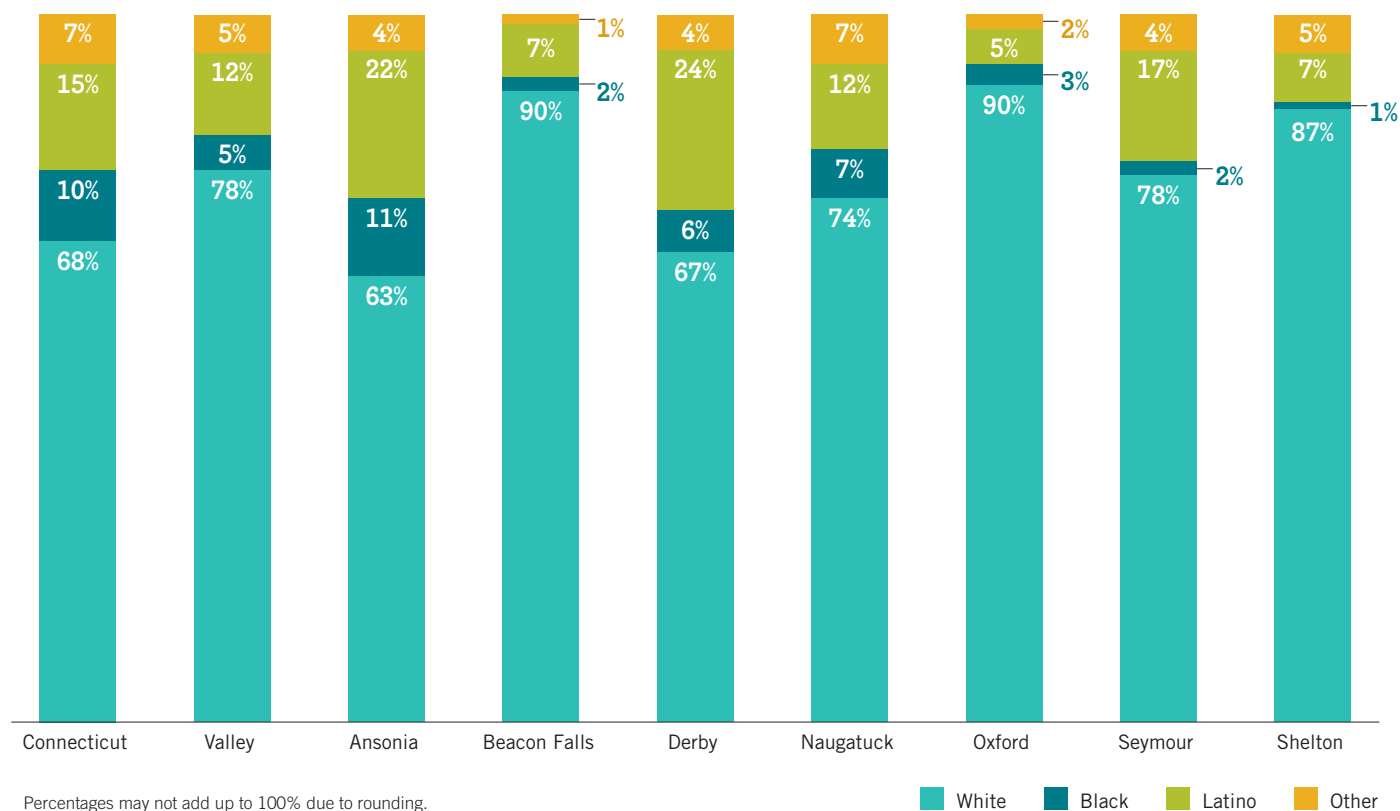
1.04 The Valley is becoming more racially diverse, some places more than others

Non-White share of population, 1990–2017



1.05 Levels of diversity vary by town in the Valley

Population share by race/ethnicity, 2017



Poverty and low-income rates have been increasing across the region between 1990 and 2017, and are highest among households with children.¹⁹

MAKING ENDS MEET

The Valley's median household income in 2017 was \$74,358, slightly higher than the state's median income of \$73,781.¹⁶ This comparison masks a more complicated story, however. Breaking down median income by town reveals a wide range, from Oxford's median income of \$104,316 to \$45,563 in Ansonia.¹⁷ Between 1990 and 2017, the Valley's inflation-adjusted median household income declined by nearly \$3,000, or about 4 percent, a larger decrease than the change seen statewide.¹⁸

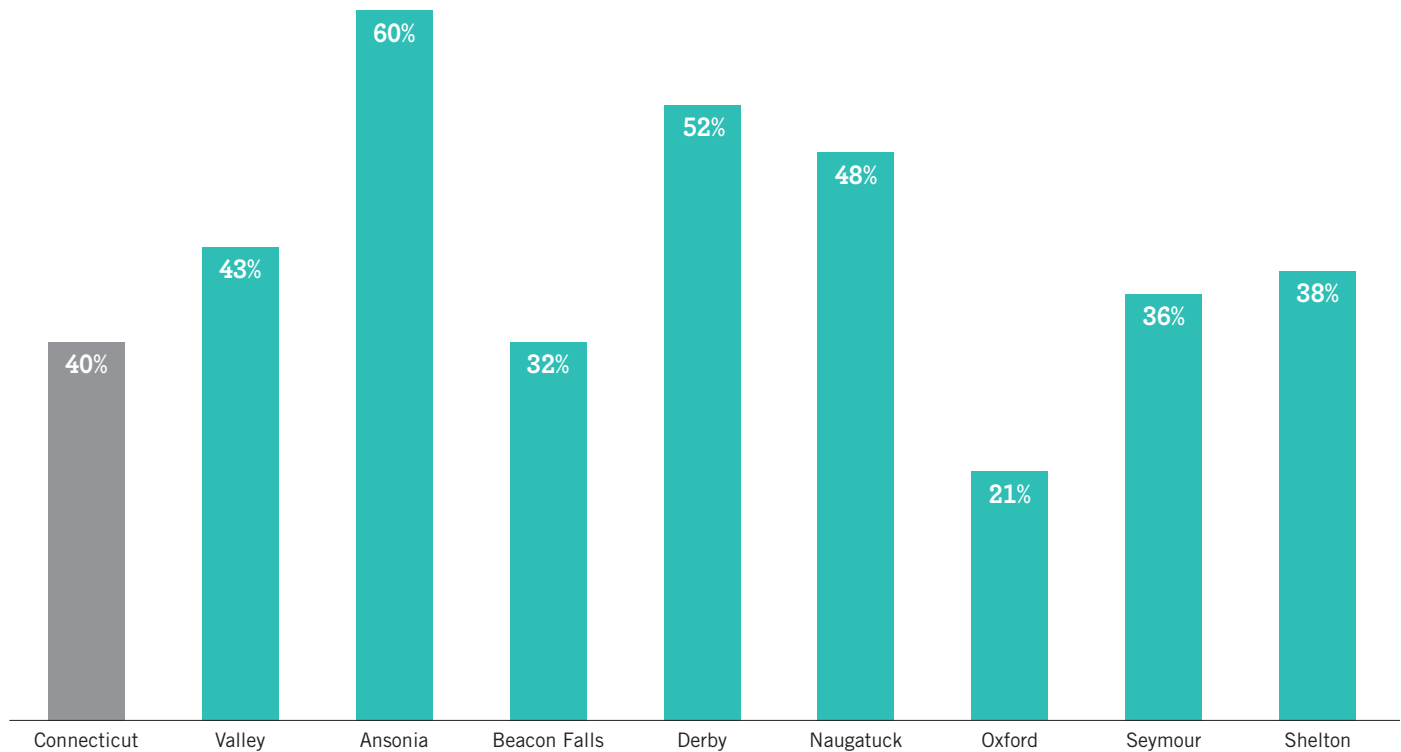
"Poverty" encompasses people who live in households with annual incomes below the federal poverty guideline; under January 2017 guidelines, this was equivalent to \$16,240 per year for a family of two, or \$24,600 for a family of four.²⁰ "Low-income" encompasses people who live in households with annual incomes less than two times the federal poverty guideline.

While the Valley's poverty and low-income rates were 8 and 21 percent, respectively, in 2017 (up from 5 and 15 percent in 2000), many more individuals and families in the region earn above these thresholds but still struggle to make ends meet.²¹ These residents may have jobs and places to live, but money is tight, decisions have to be made every week about which bills to pay, and the prospect of saving money for the future, let alone an emergency, is often not possible.

1.06 Key income indicators By town, 2017

	Households	Median household income	Population in low-income households		Ages 0-5 in low-income households		Ages 0-17 in low-income households	
Connecticut	1,361,755	\$73,781	802,453	23%	72,246	33%	225,715	30%
Valley	52,654	\$74,358	29,249	21%	2,955	35%	8,459	28%
Ansonia	6,981	\$45,563	6,843	36%	615	50%	2,019	47%
Beacon Falls	2,419	\$88,355	547	9%	20	6%	38	3%
Derby	4,919	\$57,432	3,299	27%	591	60%	1,271	45%
Naugatuck	11,765	\$63,452	7,824	25%	1,198	45%	2,415	34%
Oxford	4,463	\$104,316	1,449	11%	30	4%	391	13%
Seymour	6,146	\$75,550	3,183	19%	121	16%	1,030	27%
Shelton	15,961	\$89,250	6,104	15%	380	21%	1,295	17%

1.07 The share of households under the ALICE threshold (Asset Limited, Income Constrained, Employed) varies across the Valley
Share of households under ALICE threshold, 2016



The ALICE Project (Asset Limited, Income Constrained, Employed), a United Way initiative spanning a number of states including Connecticut, utilizes a “household survival budget” based on the actual costs of basic necessities such as housing, childcare, food, transportation, and healthcare for different types of households across Connecticut to establish an ALICE income threshold.²²

The most recent ALICE analyses for the two United Way service areas covering the Valley (Valley United Way and United Way of Naugatuck and Beacon Falls) found that in 2016, 43 percent of the region’s households were considered below the ALICE threshold, suggesting that a significant portion of the population is above the poverty and low-income lines but still struggling to satisfy their basic needs; this figure ranged from 60 percent in Ansonia to 21 percent in Oxford.²³

According to the ALICE report, a yearly household survival budget for a single adult in the Valley in 2016 was at least \$28,896—and for a family with two young children, at least \$80,364, about \$6,000 more than the region’s median household income.²⁴

While the Valley's median household income of \$74,358 may initially appear satisfactory, it is not quite enough for some households to get by.

Considering that in 2016 a family consisting of two adults and two young children in the Valley would need to earn more than \$80,000 to avoid falling below the ALICE threshold, the region's median household income of \$74,358 is less satisfactory than it initially appears. While various studies, agencies, and organizations define economically challenged in different ways, the ALICE report highlights that the Valley's median income is not quite enough for some households to get by. There are Valley households that may be earning an income near the region's median, but that does not necessarily mean that they are slowly saving for the future and for retirement. Rather, they may be barely paying bills from month to month, in a situation where a sudden change—the loss of a job, a prolonged illness—could result in financial disaster.

According to the 2018 DataHaven Community Wellbeing Survey, 34 percent of adults in the Valley said that they were just getting by financially, and a similar share estimated that they had savings to cover two months or less of household expenses if an emergency arose.²⁵ The share of young adults (ages 18 to 34) who only had only two months' worth of savings increased 18 percentage points between 2015 and 2018, from 39 to 57 percent.²⁶ Additionally, food hardship and access to affordable, high-quality fruits and vegetables are issues in the region.

1.08 Financial hardship in the valley

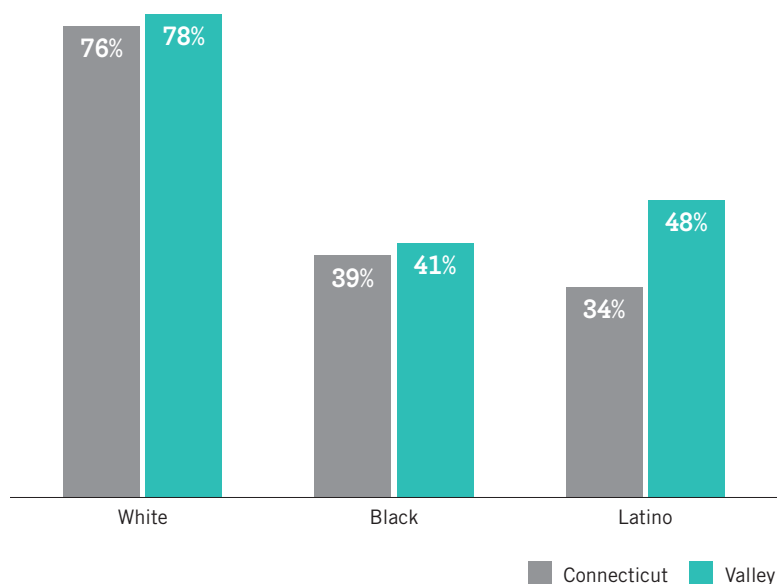
Share of adults, 2018 DataHaven Community Wellbeing Survey

	Just getting by	Less than 2 mos savings	Negative net worth	Food hardship	Utility shutoff threat	Transportation hardship	No bank account
Connecticut	33%	33%	17%	13%	10%	12%	9%
Valley (2015)	36%	32%	n/a*	12%	n/a*	11%	7%
Valley	34%	35%	14%	11%	11%	11%	7%
Male	30%	29%	14%	8%	9%	11%	7%
Female	36%	40%	14%	14%	13%	11%	7%
Ages 18–34	43%	57%	20%	19%	17%	23%	14%
Ages 35–49	37%	36%	11%	12%	13%	11%	7%
Ages 50–64	32%	23%	16%	9%	10%	6%	4%
Ages 65+	24%	25%	7%	3%	3%	6%	4%
White	35%	n/a**	n/a**	12%	n/a**	10%	6%
Non-White	31%	n/a**	n/a**	6%	n/a**	15%	11%
<\$30K	59%	56%	31%	30%	24%	26%	19%
\$30K–\$75K	40%	44%	12%	15%	14%	11%	7%
\$75K+	18%	22%	10%	2%	5%	5%	3%

*New survey question. **Insufficient survey sample size.

1.09 White householders in the Valley are more likely to own their homes than Black and Latino householders

Homeownership rate by race/ethnicity, Valley, 2017



HOMEOWNERSHIP AND HOUSING

Homeownership in the Valley has held relatively steady since 1980, increasing from 68 to 72 percent by 2017.²⁷ There are significant disparities in homeownership between racial and ethnic groups; in 2017, the homeownership rate among White households in the Valley was 78 percent, but only 41 percent and 48 percent for Black and Latino households, respectively.²⁸

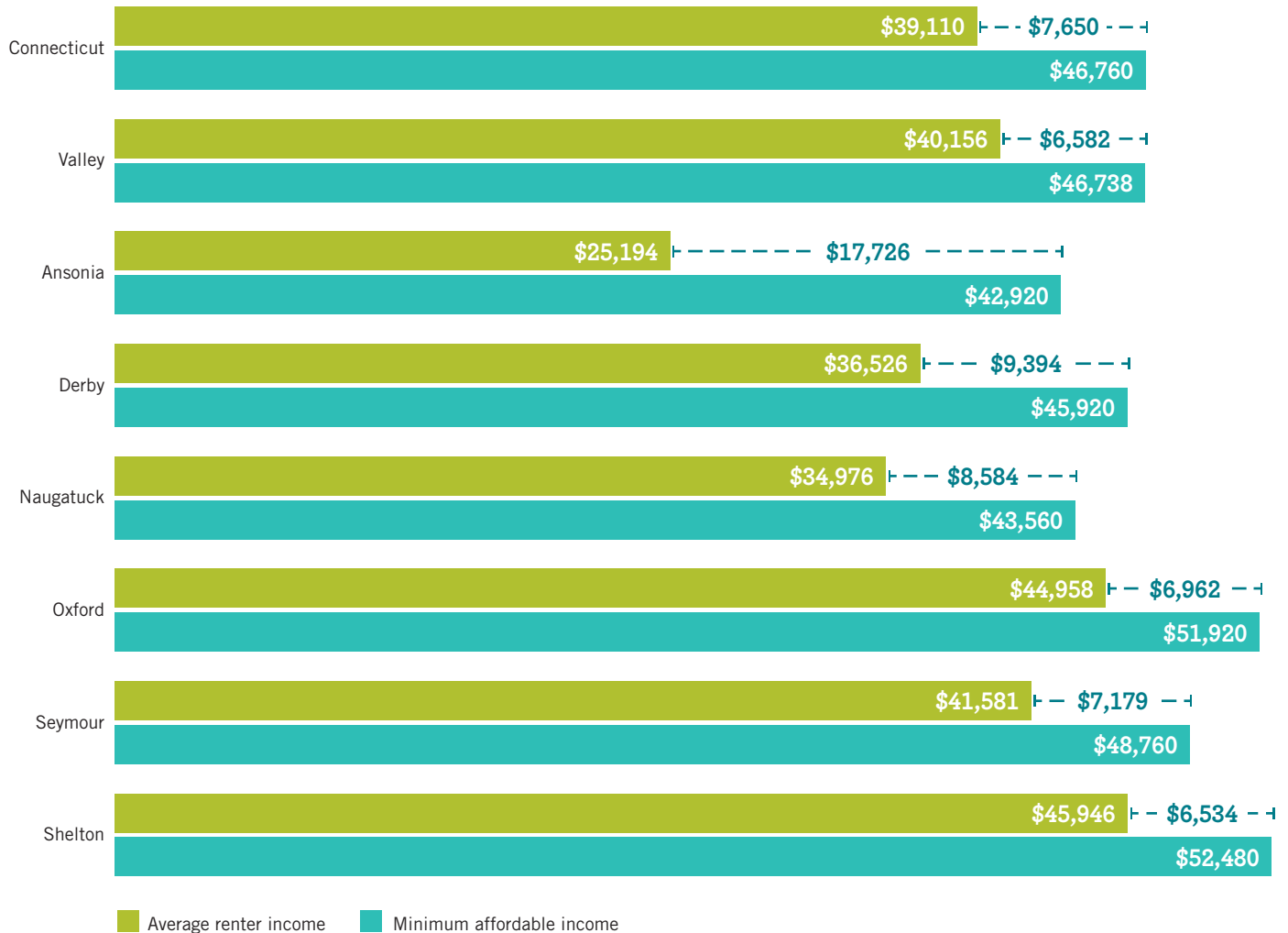
Housing affordability is an issue in the Valley. According to the 2018 DataHaven Community Wellbeing Survey, 7 percent of Valley adults reported not having enough money for housing or shelter at some point in the preceding year.²⁹ According to the U.S. Census Bureau, 36 percent of Valley households were cost-burdened in 2017, meaning they spent more than the recommended 30 percent of their total income on housing costs; 15 percent were severely cost-burdened, spending more than half of their income on housing.³⁰ Overall, renters in the Valley face greater affordability issues; 24 percent of renter households were severely cost-burdened—this figure was highest in Ansonia at 35 percent.³¹

Housing costs in the region are similar to the state overall; the median housing value in the Valley was \$267,425 in 2017, a 12 percent increase from the year 2000 after adjusting for inflation.³² In 2017, the median household income for Valley renter households was \$6,582 less than what would be needed to afford the median rent for a two-bedroom housing unit in the region without being cost-burdened.³³ This rent affordability shortfall varied across the Valley, but was particularly large in Ansonia (see Figure 1.10).³⁴



1.10 The average Valley renter's income is \$6,582 short of affording a 2 bedroom apartment

Median renter household income and minimum household income to afford 2 bedroom housing, 2017 (with shortfall shown)



Based on HUD guideline of housing affordability as housing costs totaling no more than 30% of household income. Insufficient data for Beacon Falls.

In 2018, Ansonia and Derby were the only towns in the region with rates of 2-1-1 shelter requests far above the Valley average; the rate in Ansonia was about 3 times greater than that of the Valley overall, while the rate in Derby was nearly 2.5 times greater.³⁸

Rising homeownership costs, high rents, and declining incomes can lead to housing insecurity and homelessness. While data on homelessness is difficult to collect and track, calls to 2-1-1 Connecticut (a United Way program meant to connect residents to health and community services) are a useful proxy.³⁵ Statewide, housing and shelter requests are the most common category of calls to 2-1-1, and within this category, the majority of calls include shelter requests, defined as “temporary housing solutions for adults, children, and families experiencing homelessness, violence, abuse, illness, weather extremes, or other crisis events or emergencies.”³⁶

During 2014, there were 399 requests for shelter originating within the Valley, representing a rate of 286 calls per 100,000 residents; in comparison, during 2018, there were 511 requests for shelter, representing a rate of 364 calls per 100,000 residents (a 28 percent increase).³⁷

MUNICIPAL FISCAL HEALTH

Valley residents rely on their local governments to provide a wide array of public goods—from infrastructure maintenance to library programming and public safety. The fiscal health of local governments in the region directly impacts their ability to invest in programs and services for the communities they serve. In Connecticut, local government revenue is generated mostly through property taxes, and thus, wealthier towns with more valuable real estate are able to draw on stronger tax bases. Research has confirmed that disparities in towns' municipal gap—the difference between a town's costs of providing public services and its resources available to pay for such services—are driven primarily by differences in revenue-raising capacity.³⁹

In the Valley, Oxford and Shelton were the only towns where the costs of providing key public services were not higher than their economic resources to do so; they also were the towns with the strongest equalized net grand lists per capita (an estimate of the market value of all taxable property per resident) by a large margin.⁴⁰ Compared to the state overall, towns in the Valley generally have lower equalized net grand lists per capita (with the exception of Oxford and Shelton)—a trend that has held steady both leading up to and following the Great Recession.⁴¹

Most new housing units are being constructed in Oxford and Shelton, the Valley towns with the highest housing values. In 2016 and 2017, of the 315 new housing unit construction permits issued in the region, 76 percent were in one of these two towns.⁴² Overall, the majority of housing units in the Valley were still single family in 2017 (71 percent).⁴³

Between 2001 and 2004, only 1 percent of new housing unit permits issued in the Valley were multi-family; this figure increased to 34 percent between 2014 and 2017.⁴⁴

1.11 Measures of municipal fiscal health and housing in Valley towns

	Municipal gap per capita, 2012	Equalized Net Grand List per capita, 2017	Median home value, 2017	Share new housing permits, 2016–2017
Valley	n/a	\$114,041	\$267,425	315 total
Ansonia	–\$734	\$73,182	\$208,700	2%
Beacon Falls	–\$65	\$109,458	\$235,100	14%
Derby	–\$632	\$81,631	\$194,600	2%
Naugatuck	–\$506	\$73,412	\$179,900	3%
Oxford	\$142	\$158,520	\$354,500	40%
Seymour	–\$331	\$102,974	\$243,400	3%
Shelton	\$128	\$164,447	\$341,500	35%

BROWNFIELD REDEVELOPMENT

There is no doubt that redevelopment of brownfields—sites that may be contaminated from prior industrial use—are important investments for the Valley.

Largely located along the accessible riverfront and walkable downtowns from Naugatuck to Shelton, reclamation of these areas provides many different options for land use throughout the Valley. Deploying current infrastructure to serve densely-packed town centers where business and residents coexist can potentially reconnect the use of these areas in a traditional downtown arrangement.

As of the spring of 2019, about 90 acres of brownfields had been redeveloped across the Valley, and about two-thirds of those areas were occupied.⁴⁵

CHAPTER 2

Community Health in the Valley

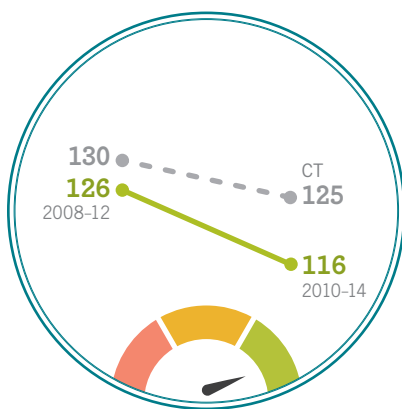
The Valley is a healthy place to call home, and its residents demonstrate higher levels of self-reported health than peers statewide and nationally. However, barriers to achieve and maintain one's overall health and wellness, such as access to reliable transportation, paid medical leave, education, sustainable and healthy food options, and adequate childcare exist and can have long lasting effects throughout one's life.

Understanding and addressing these social determinants of health, and which populations are disproportionately impacted by them, is critical to continuing to improve community health across the Valley.

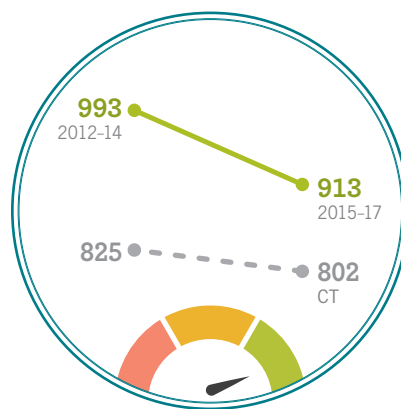
The conditions that shape the health a person experiences throughout their life are known as the social determinants of health.

Premature death rates are years of potential life lost before age 75 per 100,000 residents.

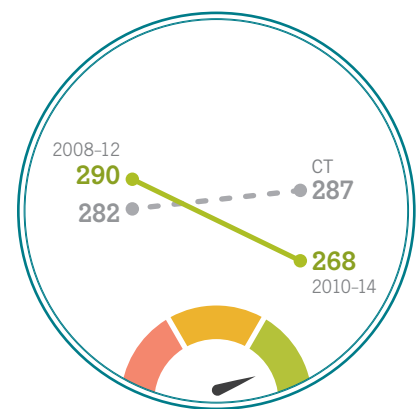
The premature death rate for **breast cancer** has declined at a faster rate than the state overall



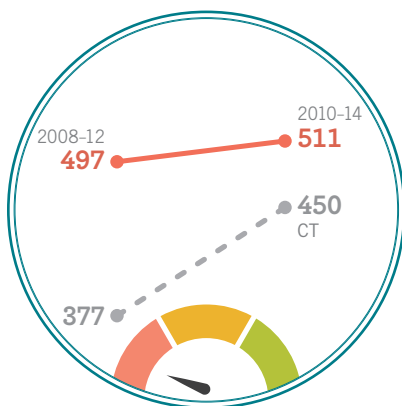
The premature death rate for **heart disease** has declined but remains above the state overall



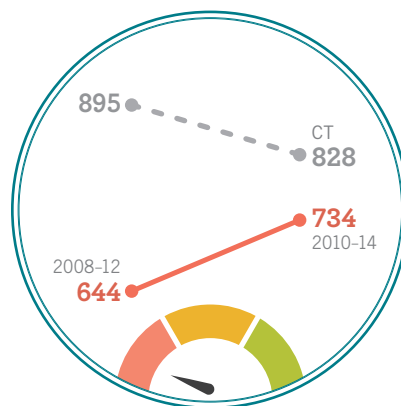
The premature death rate for **suicide** has declined and is now lower than the state overall



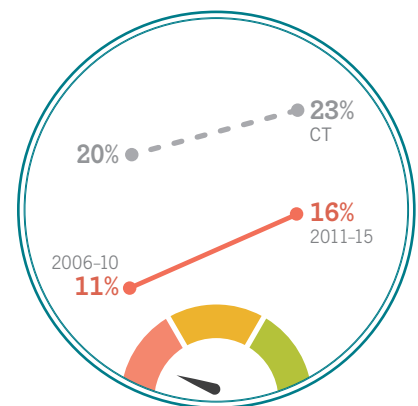
The premature death rate for **drug overdoses** has increased and is higher than the state overall



The premature death rate for **fetal/infant death** has increased, but remains below the state overall



The rate of **non-adequate prenatal care** has increased, but is lower than the state overall



CONNECTING HEALTH AND WEALTH

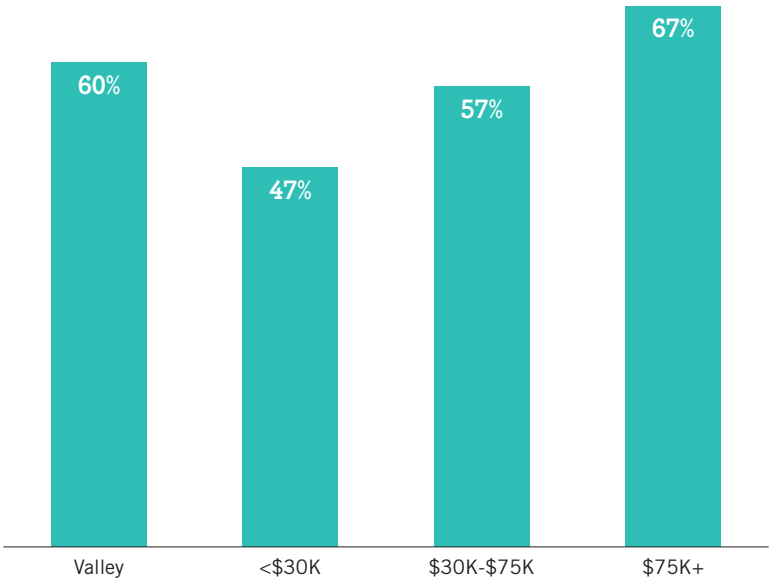
According to the 2018 DataHaven Community Wellbeing Survey, 60 percent of the Valley’s adults reported being in very good health—a figure similar to the statewide average (59 percent)⁴⁶ and well above the most recent national rate (51 percent).⁴⁷ This measure of self-rated health is widely used, as it is one of the most reliable ways to predict a population’s quality of life and lifespan, and is a component of this report’s Personal Well-Being Index (see page 4).⁴⁸ While the U.S. is financially prosperous overall, its income-related health differences are among the highest of all middle- or high-income nations in the world. The country is fairly unique in the extent to which its wealthier residents (i.e., those earning \$100,000 or more annually) are so much more likely than more middle-income residents to obtain the critical resources they need to stay healthy.⁴⁹ Income-related differences in health are also evident in the Valley.

Income and employment status often drive differences in access to healthcare, such as getting preventive screenings as recommended, affording medications, and the ability to purchase other goods and services, including adequate housing. These differences can compound over generations, as children living in higher-income households are more likely to succeed in school and obtain jobs with greater potential for advancement.

Factors such as racial or gender-based discrimination, a limited understanding of basic health information and services, family social history, excessive debt, and variations in the quality of the built environment—all of which can underlie income differences—also play a role in disparate health outcomes.

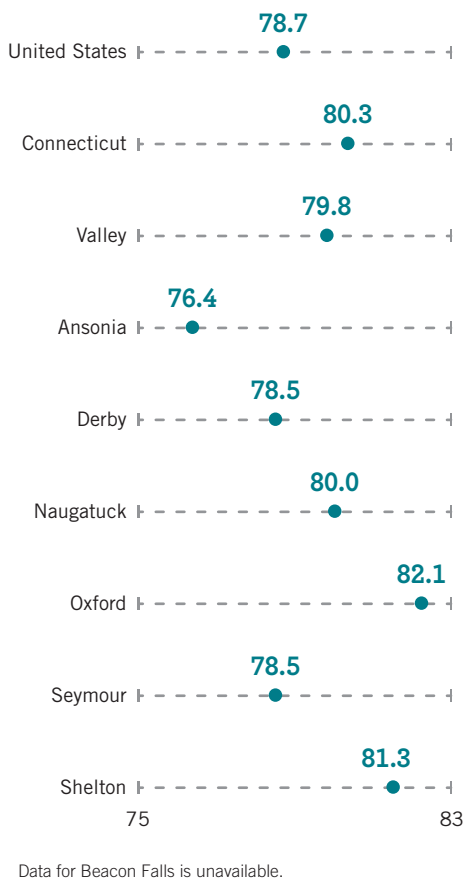
The United States is fairly unique in the extent to which its wealthier residents (those earning \$100,000 or more annually) are more likely than more middle-income residents to obtain the critical resources they need to stay healthy.

2.01 Wealthier Valley adults have higher self-rated health
Share of adults reporting self-rated health as excellent or very good, 2018 Datahaven Community Wellbeing Survey



2.02 Average life expectancy varies by town across the Valley

Estimated life expectancy in years, 2010–2015



THE VALLEY'S 10-YEAR DIFFERENCE IN LIFE EXPECTANCY

The Valley's average life expectancy of 79.8 years is about one year longer than the national average, and similar to that of the average Connecticut neighborhood.⁵⁰ Additionally, there are disparities from town to town in the region, and even within towns. For example, in some areas of Ansonia, life expectancy is as low as 74.2 years, compared to 83.9 in areas of Shelton.⁵¹

The Valley's variations in life expectancy can be explained by looking at differences in the rates of premature death within the population—calculated based on the number of years of potential life lost by residents before they reach their 75th birthdays (YPLL-75). Lung cancer, heart disease, motor vehicle crashes, and drug-related deaths affect the region's life expectancy.

LEADING CAUSES OF PREMATURE DEATH

Between 2010 and 2014 (the most recent 5-year dataset available), the Valley's premature death rate was above the statewide rate. Cancers were the most common causes of premature death in the Valley; the premature death rate due to cancer was 17 percent higher in the region than in Connecticut overall. Lung cancer was a major contributor to this elevated rate in the Valley and was the most likely cause of cancer-related premature death for residents. The rate of premature death from lung cancer in the Valley was 37 percent above the statewide rate. To put this in perspective, 48 Valley residents died from lung cancer before they reached their 75th birthday on average every year, and each person who died had their lifespan shortened by an average of 11 years.

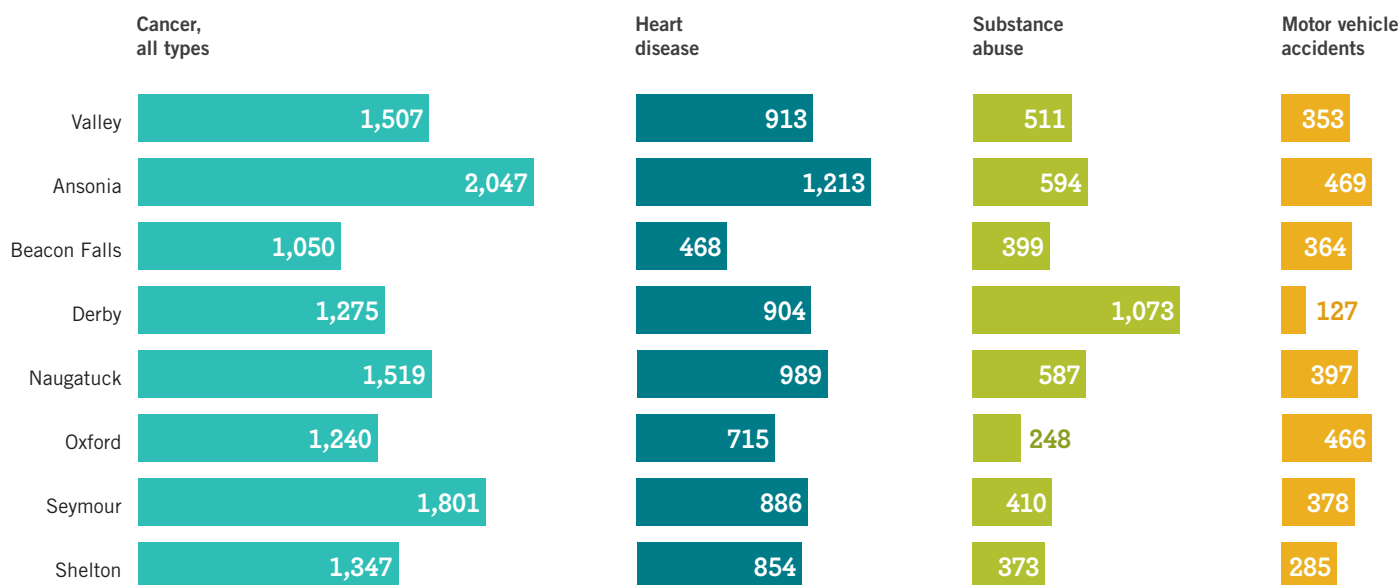
2.03 Premature death rates in the Valley

Years of potential life lost before age 75 (YPLL-75) per 100,000 residents, per year, by leading causes, 2008–2012 and 2010–2014

Cause	2008–2012 rate	2010–2014 rate	Valley trend	Statewide comparison, 2010–2014 rate
Cancer, all types	1,556	1,507	–3%	1,284
Lung Cancer	417	408	–2%	297
Breast Cancer	126	116	–8%	125
Heart Disease	993	913	–8%	802
Fetal/Infant Death	644	734	+14%	828
Substance Abuse	497	511	+3%	450
Motor Vehicle Accidents	359	353	–2%	259
Suicide	290	268	–8%	287
Firearm Injuries	166	176	+6%	193

2.04 Cancer, heart disease, drugs, and motor vehicle crashes impact Valley residents' lifespans the most, and vary by town

Years of potential life lost before age 75 (YPLL-75) per 100,000 residents per year by selected causes, 2010–2014



While lung cancer was responsible for half the difference in the premature death rates between the Valley and state overall, heart disease (14 percent higher in the Valley), drug-related deaths (14 percent higher in the Valley), and motor vehicle crashes (36 percent higher in the Valley) also played a role in this gap. It is important to point out that the impact of the opioid crisis is not yet entirely reflected within the most currently-available statewide dataset used in this section. Due to the availability of opioids such as fentanyl, drug-related deaths have skyrocketed in recent years, meaning from 2015 to 2018, opioid overdoses were roughly tied with heart disease as the second leading cause of premature death in the Valley.⁵² For the other leading causes of premature death displayed in Figure 2.03, the rate in the Valley was similar to the state overall.

Between 2010 and 2014, rates of premature death due to cancers, heart disease, drugs, and motor vehicles crashes were higher in the Valley than statewide.

From 2015 to 2018, opioid overdoses were roughly tied with heart disease as the second leading cause of premature death in the Valley.

2.05 Birth outcomes

DataHaven analysis of CTDPH vital statistics data, 2006–2010 and 2011–2015

	2006–2010			2011–2015			Percent change		
	Total births	Low birth weight	Non-adequate care	Total births	Low birth weight	Non-adequate care	Total births	Low birth weight	Non-adequate care
Connecticut	200,357	8%	20%	181,687	8%	23%	–9%	–3%	+14%
Valley	7,292	8%	11%	6,575	8%	16%	–10%	+3%	+45%
Ansonia	1,198	8%	12%	1,039	9%	18%	–13%	+14%	+49%
Beacon Falls	303	7%	7%	206	10%	14%	–32%	+40%	+106%
Derby	748	8%	12%	667	8%	19%	–11%	–3%	+62%
Naugatuck	1,863	8%	11%	1,782	8%	14%	–4%	+3%	+28%
Oxford	595	7%	9%	464	5%	12%	–22%	–22%	+38%
Seymour	821	7%	10%	794	8%	14%	–3%	+18%	+36%
Shelton	1,764	7%	14%	1,623	7%	20%	–8%	–7%	+48%

The rate of non-adequate prenatal care in the Valley increased 45 percent, compared to a 14 percent increase statewide.⁵⁸

INFANT HEALTH OUTCOMES

A person's infant health outcomes—beginning with proper maternal health—greatly impact that person's health later in life. In 2015, the rate of infant mortality in the Valley was 6.1 deaths per 1,000 live births, which was similar to the state average of 5.6 deaths per 1,000 live births.⁵³ The two most significant causes of infant mortality are birth defects and conditions related to preterm birth or low birthweight. Birth defects have many causes, some of which are unknown, but risk factors during pregnancy may include a lack of folic acid, alcohol use, smoking, obesity, and uncontrolled diabetes.⁵⁴ Similarly, the causes of premature birth and low birthweight are complex, but some are related to health inequities, such as a lack of adequate prenatal care, poor nutrition, and factors that exacerbate the risk of chronic diseases.

The rate of low birthweight babies—defined as the percentage of infants born that weigh fewer than roughly five and a half pounds—rose by 3 percent in the Valley over the past decade, despite falling by 3 percent statewide.⁵⁵ The rate of low birthweight babies in the Valley was higher among Black and Latina mothers than White mothers.⁵⁶

The rate of non-adequate prenatal care in the Valley—meaning that the mother went to fewer than 80 percent of the expected prenatal care visits or did not start the visits until her second trimester—rose from 11.3 percent of 2006–2010 births to 16.4 percent of 2011–2015 births.⁵⁷

ENVIRONMENTAL HAZARDS

While lead is toxic to everyone, lead poisoning is of particular concern to children under the age of six due to rapid physical and cognitive development in early childhood. Health problems related to lead are a constant concern in areas with older housing stock that may contain lead paint. As such, regulations that aim to limit children's exposure have been tightened. Even at relatively low levels, lead poisoning can cause behavioral changes and cognitive impairment in children. As of May 2013, the state's reference level is 5 micrograms of lead per deciliter of blood ($\mu\text{g/dL}$); a child under six years old with a level higher than that is classified as lead poisoned. In 2016, there were 54 children under age six in the Valley who had blood lead concentrations higher than the updated reference, representing 2 percent of the children tested in the region—compared to 2.7 percent statewide.⁵⁹ Forty-one percent of the Valley's cases were among children living in Ansonia (22 cases), which had a 4.4 percent rate of lead poisoning.⁶⁰ Nearly half of Ansonia's housing units were built before 1950, and older homes are more likely to contain lead-based paint.⁶¹ It is critical that children between the ages of 9 months and 2-years-old receive a lead screening. As of 2016, the share of children within this age group that had been screened in the Valley (72 percent) slightly trailed the rate statewide (74 percent).⁶² While the Valley overall experienced a small increase in the rate of child lead screenings between 2013 and 2016, Ansonia, Derby, and Seymour all experienced decreases.

Children are also at increased risk of asthma exacerbations due to environmental factors, including, but not limited to, cockroaches, mold, and traffic pollution.⁶³ Childhood asthma affects children's quality of life and performance in school, and can be fatal if left untreated.

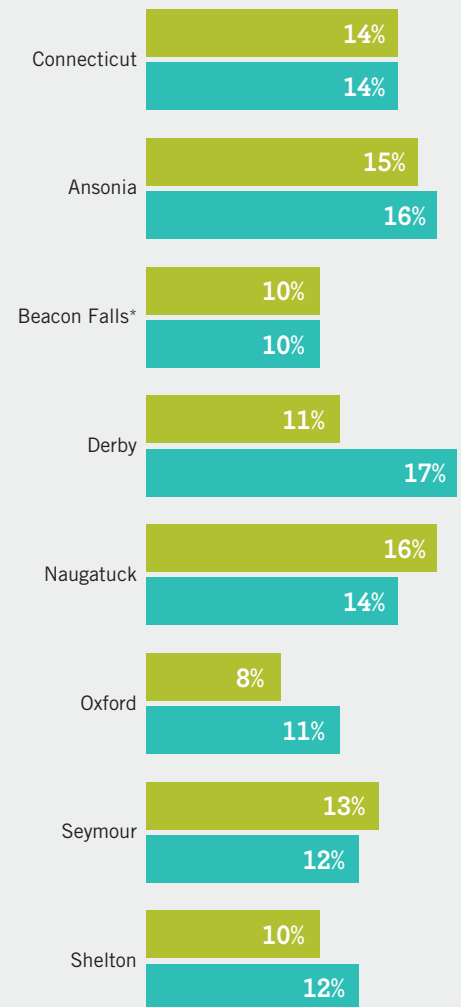
2.06 Lead poisonings and screenings

CTDPH childhood lead poisoning surveillance, 2013–2016

	Age 9mos to 2yrs who had lead screening		Under age 6 with elevated blood lead	
	2013	2016	2013	2016
Connecticut	71%	74%	3.0%	2.7%
Valley	69%	72%	2.4%	2.0%
Ansonia	72%	71%	4.1%	4.4%
Beacon Falls	59%	69%	2.4%	0.0%
Derby	70%	63%	3.2%	2.5%
Naugatuck	55%	66%	3.0%	1.3%
Oxford	70%	84%	1.7%	0.6%
Seymour	80%	70%	1.2%	2.4%
Shelton	76%	79%	0.8%	1.2%

2.07 Asthma prevalence by public school district

CTDPH school-based asthma surveillance, 2009–2011 and 2012–2014



* Data is for Regional School District 16, also serving Prospect

2009–2011
2012–2014

According to the Connecticut Department of Public Health's School-Based Asthma Surveillance Report, levels of childhood asthma were generally lower in Valley public schools than statewide; however, Ansonia and Derby school districts were above the statewide rate.⁶⁴

Chronic diseases such as diabetes, heart disease, chronic obstructive pulmonary disease, and asthma are among the most common causes for hospitalization and emergency room encounters.

CHRONIC DISEASE AND HEALTH RISK FACTORS

According to the U.S. Centers for Disease Control and Prevention (CDC), six out of every ten adults in the U.S. live with a chronic disease, and four out of every ten have two or more related chronic conditions.⁶⁵ These conditions include heart disease, cancer, chronic lung disease, chronic kidney disease, stroke, Alzheimer's, and diabetes. Ninety percent of healthcare expenditures go towards the treatment of chronic and mental health conditions.⁶⁶ In 2010, chronic diseases comprised seven of the top ten causes of mortality in the U.S., accounting for over 65 percent of all deaths.⁶⁷ Disproportionately more clinical visits to physicians' offices and hospitals occur for patients who are in the oldest age groups and those who are more prone to experiencing chronic diseases.⁶⁸

In the Valley, chronic diseases such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD), and asthma have consistently ranked among the most common causes for hospitalization and emergency room encounters. Hospital encounter rates in the Valley due to these conditions were lower than the statewide averages from 2015 to 2017, and displayed similar or relatively smaller increases from the 2012–2014 period. Hospital encounter rates for these chronic diseases do differ town by town, with Ansonia, Derby, and Naugatuck consistently demonstrating rates above the Valley overall.⁶⁹

2.08 Rates of hospitalizations and emergency department visits in the Valley

Age-adjusted and relative age-adjusted rates, per 10,000 residents, by leading causes, 2012–2014 and 2015–2017

Cause	2012–2014 rate	2015–2017 rate	Valley trend	Statewide comparison, 2015–2017 rate
Mental Disorder	421	505	+20%	694
Diabetes	427	466	+9%	639
Falls	344	317	–8%	328
Asthma	215	278	+30%	486
Childhood Asthma	236	276	+17%	439
Depressive Disorder	244	238	–3%	326
Heart Disease	206	232	+12%	240
COPD	182	228	+25%	262
Substance Abuse	142	156	+10%	178
Motor Vehicle Accidents	132	122	–8%	113
Dental	77	54	–30%	58
Homicide and Assault	31	26	–15%	35

2.09 Variation in rates of hospital encounters Chronic disease, age-adjusted rate of hospitalizations and emergency department encounters (per 10,000 residents), 2012–2014 to 2015–2017





2.10 Access to healthcare

Share of adults, Valley, 2018 DataHaven Community Wellbeing Survey

	Didn't get care	Postponed care
Connecticut	9%	23%
Valley (2015)	6%	24%
Valley	7%	23%
Male	7%	21%
Female	8%	25%
Ages 18–34	12%	28%
Ages 35–49	8%	28%
Ages 50–64	5%	26%
Ages 65+	5%	11%
White	7%	23%
Non-White	12%	26%
<\$30K	11%	20%
\$30K–\$75K	10%	25%
\$75K+	5%	25%

ACCESS TO HEALTHCARE

In 2018, the DataHaven Community Wellbeing Survey found the percentage of uninsured adults in the Valley (2 percent) was similar to that of Connecticut overall (5 percent), and lower than national averages.⁷⁰ Having health insurance, however, does not guarantee timely or high-quality medical care. According to the 2018 Community Wellbeing Survey, 10 percent of Valley adults reported lacking a “medical home,” meaning that they did not have any person or place that they considered to be their personal doctor, who they see on an ongoing basis.⁷¹ Others reported having postponed necessary medical care within the past year or having failed to get care altogether.⁷²

Attaining and maintaining good health requires not only access to high quality medical services, but also engagement in daily behaviors that promote health. Broader issues of income, education, employment, and racial and gender discrimination can pose obstacles to living a healthy lifestyle. Barriers exist to accessing affordable, nutritious food.

2.11 Health risk factors

Share of adults with risk factors, Valley, 2018 DataHaven Community Wellbeing Survey

	Has health insurance	Dental visit in past year	Food hardship	Obesity	Diabetes	Smoking	Current asthma
Connecticut	95%	74%	13%	29%	10%	14%	11%
Valley (2015)	94%	73%	12%	28%	10%	17%	13%
Valley	98%	74%	11%	32%	10%	17%	11%
Male	96%	71%	8%	30%	12%	16%	n/a**
Female	98%	77%	14%	34%	8%	16%	n/a**
Ages 18–34	95%	67%	19%	22%	1%	20%	n/a**
Ages 35–49	97%	69%	12%	36%	4%	22%	n/a**
Ages 50–64	97%	82%	9%	41%	17%	18%	n/a**
Ages 65+	98%	78%	3%	29%	17%	8%	n/a**
White	97%	74%	12%	32%	10%	n/a	n/a**
Non-White	95%	73%	6%	30%	9%	n/a	n/a**
<\$30K	95%	61%	30%	32%	14%	22%	n/a**
\$30K–\$75K	96%	67%	15%	36%	9%	19%	n/a**
\$75K+	99%	84%	2%	31%	8%	13%	n/a**

**Insufficient survey sample size.

Lacking affordable medical care may play a role in residents relying on the emergency room. According to the 2018 Community Wellbeing Survey, 24 percent of Valley adults reported receiving care in a hospital emergency room at least once; for those earning less than \$30,000 per year, this figure was 34 percent.⁷³

Cost also impacts Valley residents' ability to get the medicines they need. According to the 2018 Community Wellbeing Survey, 12 percent of adults earning less than \$30,000 a year reported not getting prescription medicines they needed because they could not afford it, compared to 7 percent in the region overall and just 4 percent earning over \$75,000 a year.⁷⁴

According to the 2018 DataHaven Community Wellbeing Survey, 23 percent of Valley adults reported postponing needed medical care at least one time in the last year.



Vaping—inhalating and exhaling vapor produced by an e-cigarette or similar, electronic device—is becoming more common, particularly among young adults.

ORAL HEALTH

Good oral health helps prevent infections, heart disease, stroke, adverse birth outcomes, and other serious conditions, and has other impacts on quality of life.⁷⁵ According to the CDC, over 40 percent of U.S. adults experience mouth pain each year, causing many people to miss work for emergency dental care. In Connecticut, about 16 percent of elementary school-age children have untreated tooth decay.⁷⁶

Emergency room encounters related to preventable dental conditions are considered an incidence proxy, or representation, of the lack of timely and adequate oral healthcare. Seeking acute care at a hospital for a severe tooth infection, for example, may not address the underlying need for preventive dental care. Overall, the Valley had similar rates of emergency room encounters and hospitalizations for preventable dental conditions to the state average—though rates in Ansonia were higher.⁷⁷ The number of emergency room and hospital encounters for this issue declined in the Valley from 2012–2014 to 2015–2017.⁷⁸

According to the 2018 Community Wellbeing Survey, 26 percent of Valley adults said they had not been to the dentist in the past year. This rate was substantially higher among younger adults (33 percent) and adults earning less than \$30,000 per year (39 percent).⁷⁹

SMOKING AND VAPING

Cigarette smoking is one notable risk factor for cancer, causing an estimated 48.5 percent of all deaths from 12 major types of cancer combined.⁸⁰ It is a contributing factor in up to 90 percent of lung cancer deaths, as smokers are 15 to 30 times more likely to die of lung cancer than non-smokers,⁸¹ as well as half of bladder cancer deaths. Beyond being a cancer risk factor, smoking and secondhand smoke have been linked to many other health issues including infant health, asthma, and stroke. While smoking rates have fallen during the past two decades, the rate in the Valley remained steady between 2015 and 2018 and is currently 17 percent, above the statewide rate (14 percent).⁸² The rate is higher among adults earning less than \$30,000 per year (22 percent).⁸³

According to the 2018 DataHaven Community Wellbeing Survey, 10 percent of adults in the Valley reported using e-cigarettes or vaping more than once a month, above the statewide rate of 8 percent. Among adults ages 18 to 34, 47 percent had tried e-cigarettes as of 2018.⁸⁴



OBESITY

In Connecticut, more than a quarter of adults have a body mass index that classifies them as obese. Connecticut's obesity rate has increased dramatically since 1990, when it was estimated to be only 10 percent.⁸⁵ According to the DataHaven Community Wellbeing Survey, between 2015 and 2018, the prevalence of obesity among Valley adults rose from 28 percent to 32 percent, compared to a rise from 26 percent to 29 percent statewide;⁸⁶ the Behavioral Risk Factor Surveillance System recorded a statewide increase from 25 percent in 2015 to 27 percent in 2017.⁸⁷ Additionally, while 55 percent of Valley adults report exercising at least three days per week, the share who report that they did not get exercise even once during a typical week increased slightly, from 17 percent to 20 percent, between 2015 and 2018.⁸⁸

Childhood obesity is also a major concern, though Connecticut's estimated 11.9 percent obesity rate among youth ages 10 to 17 is lower than the U.S. rate of 15.8 percent.⁸⁹ Local, state, and national rates are calculated based on self-reported or parent- and caregiver-reported height and weight, and likely underestimate the actual obesity rate by a few percentage points.

Between 2015 and 2018, the prevalence of obesity among Valley adults rose from 28 percent to 32 percent, compared to a rise from 26 percent to 29 percent statewide.

In 2016, only 43 percent of U.S. adults with any mental health disorder received treatment; nationwide, less than 11 percent of adults with a substance use disorder received treatment.

2.12 Recent feelings of anxiousness or depression Share of adults, Valley, 2018
DataHaven Community Wellbeing Survey

	Anxious	Depressed
Connecticut	12%	9%
Valley (2015)	11%	9%
Valley	10%	9%
Male	10%	8%
Female	10%	11%
Ages 18–34	16%	19%
Ages 35–49	9%	7%
Ages 50–64	6%	6%
Ages 65+	10%	8%
White	11%	10%
Non-White	7%	8%
<\$30K	13%	17%
\$30K–\$75K	13%	11%
\$75K+	6%	5%

BEHAVIORAL HEALTH

Behavioral health disorders include both mental illness and substance use disorders.⁹⁰ According to the Substance Abuse and Mental Health Services Administration, behavioral health disorders affect nearly one in five Americans—yet behavioral healthcare needs often go unmet.⁹¹ In 2016, only 43 percent of the 44.7 million adults nationwide with any mental health disorder received treatment, and less than 11 percent of adults with a substance use disorder received treatment.⁹² Behavioral health is a growing concern both nationwide and within Connecticut, and some behavioral health disorders are trending upward in the Valley.

DEPRESSION AND MENTAL HEALTH

Depression is rooted within many different social, medical, and environmental factors, including substance use, traumatic experiences, and social isolation. Depression is a risk factor or cause of many other health problems, including chronic pain, insomnia, and conditions that are exacerbated when patients have difficulty accessing medical care or taking medications according to the instructions of healthcare providers.⁹³

Depression and other mental disorders are significant factors in Valley residents' decisions to seek or receive care within the state's hospitals and emergency rooms. Statewide and within the region, hospital encounters for mental disorders rose considerably between the 2012–2014 period and the 2015–2017 period.⁹⁴ Hospital encounters for depressive disorder slightly decreased in the Valley between these periods, despite increasing statewide.⁹⁵ Overall, the Valley's encounter rate for both mental and depressive disorders is below the statewide rate.⁹⁶

According to the 2018 DataHaven Community Wellbeing Survey, 10 percent of Valley adults reported being mostly or completely anxious, and 9 percent reported feeling down, depressed, or hopeless more than half of the days during the past two weeks, rates that were similar to the statewide average and have changed little since the 2015 survey.⁹⁷ Younger adults and those with low incomes were more likely to report feeling anxious and depressed.⁹⁸

ADVERSE CHILDHOOD EXPERIENCES

According to the Connecticut Department of Public Health, adverse childhood experiences (ACEs) can affect a child's social, emotional, and cognitive development; their adoption of risky behavior later in life; and their chances of disease and even early death. Three of five adults across the state reported having had at least one ACE—ranging from an incarcerated household member or sexual abuse to the more prevalent household drinking problems, divorced parents, and emotional abuse. Two-thirds of those who had had at least one ACE had multiple ACEs.⁹⁹

Funded by the Connecticut Department of Children and Families (DCF) and accessed by calling 2-1-1, Mobile Crisis Intervention Services is a mobile intervention service for children and adolescents experiencing a behavioral or mental health need or crisis. Statewide, calls increased 11 percent between the 2017 and 2018 fiscal years; as of 2016 the most common primary diagnosis at intake was depressive disorder (32 percent), though anxiety disorder (11 percent) and trauma disorders (8 percent) were also common.¹⁰¹ During the 2018 fiscal year, there were 571 calls from Valley towns: Ansonia (94), Beacon Falls (29), Derby (87), Naugatuck (187), Oxford (53), Seymour (48), and Shelton (73).¹⁰²

INTENTIONAL INJURIES AND SUBSTANCE ABUSE

Intentional injuries, such as those related to violence (domestic violence and otherwise) and suicide attempts, are troubling. Within the Valley, hospital encounters related to violence from 2015 to 2017 were below the statewide rate and declining, but disparities exist between towns. The rate in Ansonia stands out, while Derby's rate mirrors the statewide rate—the remaining Valley towns exhibit rates well below the state.¹⁰³ Hospital encounters related to suicide and self-harm in the Valley were well below the state overall.¹⁰⁴

Some in the region struggle with alcohol, marijuana, and opioid use disorders. In 2018, 5 percent of Valley adults reported drinking heavily (more than four drinks at a time for women or five drinks for men) at least six times in the past month.¹⁰⁵ Six percent of adults—including 9 percent of those ages 18 to 34—reported using marijuana more than 10 times during any given month.¹⁰⁶ Drinking too much can dramatically change mood and behavior, and long-term alcohol use can damage organs including the heart and liver, increasing the risk of cancers and other diseases.¹⁰⁷ Like alcohol, marijuana is associated with depression and anxiety, though it is not yet known whether this is a causal relationship.¹⁰⁸

Drinking too much can dramatically change mood and behavior, and long-term alcohol use can damage organs including the heart and liver, increasing the risk of cancers and other diseases.

Between 2015 and 2018, the Valley averaged 30.1 drug overdose deaths per 100,000 residents per year, above the state's rate of 24.2 per 100,000; filtered for just opiate- and opioid-related deaths, these rates become 28.8 and 22.8, respectively.

THE OPIOID CRISIS

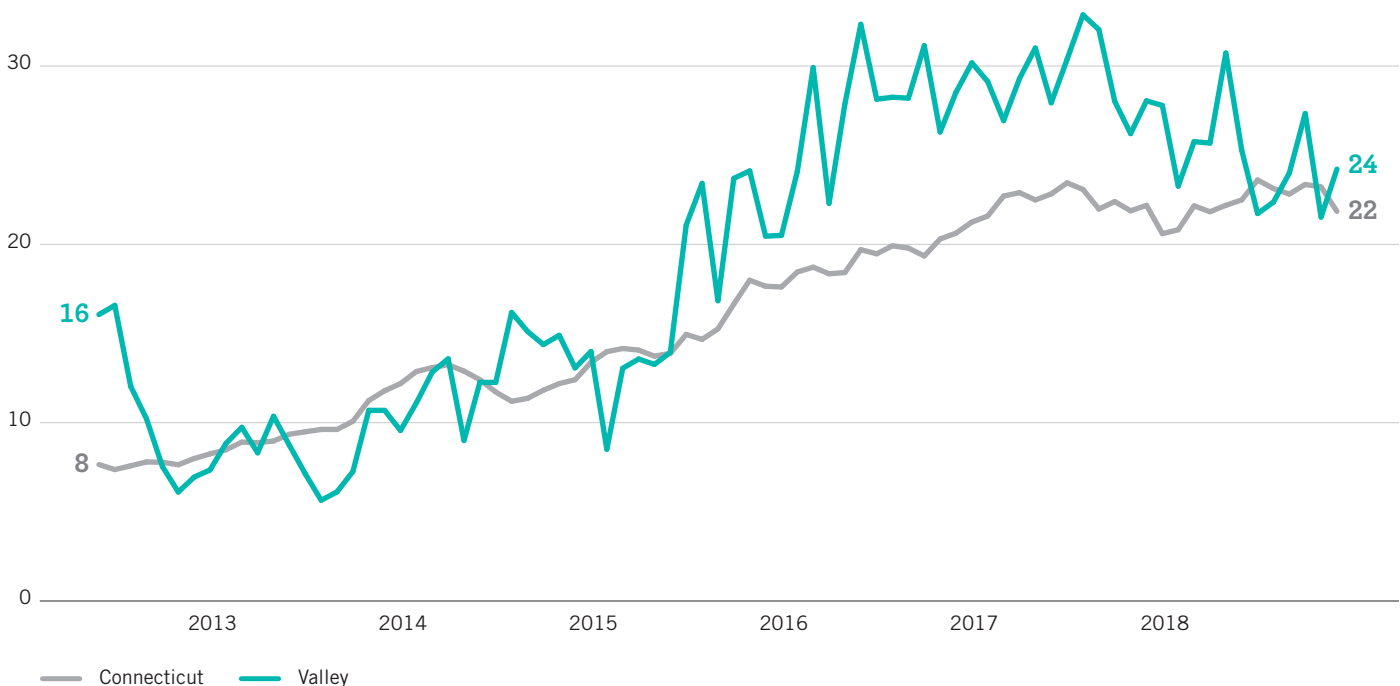
The opioid crisis has made headlines across the country, with some of the highest overdose death rates occurring in the northeast U.S. From 2015 to 2017 Connecticut's drug overdose death rate ranked 11th among all states in the country, and several nearby states—including New Hampshire, Massachusetts, and Rhode Island—fell within the top 10 each of those three years.¹⁰⁹ Thousands of Americans die of opioid overdoses each month, including an average of 67 Connecticut residents per month from 2015 to 2018. Between 2015 and 2018, the Valley averaged 30.1 drug overdose deaths per 100,000 residents per year, above the state's rate of 24.2 per 100,000; filtered for just opiate- and opioid-related deaths, these rates become 28.8 and 22.8, respectively (see Figure 2.14).¹¹⁰

The full effect of the opioid crisis is not yet captured in the comprehensive 2010–2014 premature mortality data used earlier in this chapter, though drug-related deaths are a leading cause of premature death in the Valley. In the span of just a few years, the number of deaths in the Valley from drug overdoses more than doubled, from 20 deaths in 2014 to 48 deaths in 2016; this increase was driven mostly by a steep rise in opiate- and opioid-related deaths.¹¹¹ The median age for fatal overdoses for Valley resident is 41, about half the region's average life expectancy.¹¹²

The Centers for Disease Control and Prevention characterizes the epidemic as multilayered with three distinct waves.¹¹³ Prescription opioids were the main drivers of the first wave (1990s); heroin was

2.13 Overdose death rates have skyrocketed in recent years

Age-adjusted monthly rate of drug overdose deaths per 1 million residents, 6 month moving average, 2012–2018



2.14 Overdose deaths by substance

Total count and annualized age-adjusted overdose death rate per 100K residents by presence of opiates or opioids, Valley, 2015–2018

	Any substance count	Any substance rate	Opiate/opioid count	Opiate/opioid rate
Connecticut	3,423	24.2	3,202	22.8
Valley	161	30.1	152	28.8

largely responsible for the rise in 2010; and synthetic opioids, such as fentanyl, have driven the current wave, which began in 2013.¹¹⁴ These patterns hold true in the Valley, where the death rate from drug overdoses has followed the upward trend seen throughout the state and country—though between 2015 and 2018, it generally remained above the statewide average.¹¹⁵ The Valley is also experiencing an increasing presence of fentanyl in its fatal overdoses. The substance was detected in 4 out of the Valley’s 34 overdose deaths (12 percent) in 2012 and 2013, but in 51 of the 85 deaths (60 percent) in 2017 and 2018.¹¹⁶

As is the case elsewhere in the state, men make up much larger shares of Valley drug overdose deaths than women: since 2012, women have accounted for more than a third of the region’s overdose deaths in a given year one time.¹¹⁷ Rates for White residents are higher as well.¹¹⁸

For every person who dies of an opioid overdose, many more seek treatment, often multiple times. Between the 2014 and 2018 fiscal years Valley residents were admitted to opioid treatment programs a total of 6,054 times, averaging 1,211 admissions per year, or 863 admissions per 100,000 residents per year.¹²⁰ Ansonia, Derby, and Naugatuck had opioid treatment admissions rates above the Valley average.¹²¹ The majority of these admissions were to programs funded by the state Department of Mental Health and Addiction Services. People are often admitted to programs multiple times within one year.

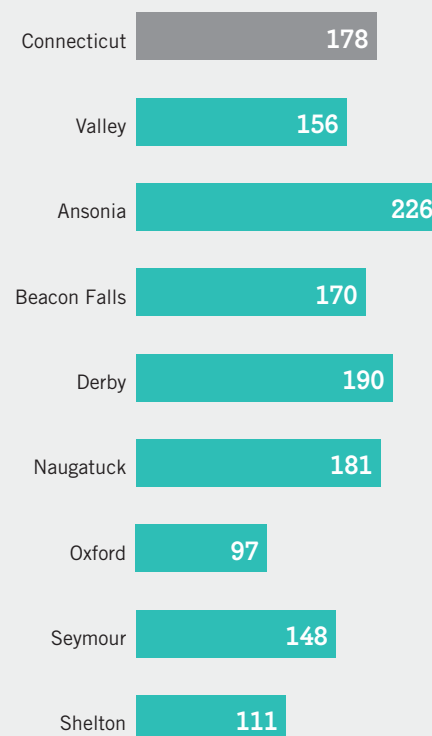
Many residents also seek or receive care for substance use disorders at area hospitals and emergency rooms, and this number is increasing both in the Valley and statewide.¹²² Compared to Connecticut as a whole, the Valley has lower rates of hospital and emergency room encounters for substance use, a category that includes diagnoses related to use of opioids and other drugs.¹²³ Across the state, rates of drug-related hospital encounters are higher for males than females, as well as for adults ages 20 to 64.¹²⁴

The reach of the opioid crisis goes beyond just people who have struggled with addiction themselves, as many adults in the Valley know someone who has struggled with abuse of or addiction to prescription painkillers, heroin, or other opiates. According to the 2018 DataHaven Community Wellbeing Survey, 33 percent of Valley adults reported personally knowing someone who struggled with misuse or addiction to heroin or other opiates; 24 percent knew someone who died from an opioid overdose.¹²⁵

Between 2015 and 2018, White residents’ age-adjusted overdose death rate was 37 per 100,000 residents per year, higher than Black residents’ rate of 12.3 or Latino residents’ rate of 9.7.¹¹⁹

2.15 Rates of hospital encounters for substance abuse

Age-adjusted rate of hospitalizations and emergency department encounters (per 10,000 residents), 2015–2017



According to the CDC, one in four adults older than 64 will fall each year, and 20 percent of falls will induce a serious injury such as a hip fracture or traumatic brain injury.

INJURIES

Intentional and unintentional injuries, including drug overdoses, falls, assaults, and suicide, are the leading causes of death in the U.S. for people between the ages of 1 and 44. They also have major consequences on quality of life, as there are 13 hospitalizations and 129 emergency room encounters for every death.¹²⁶ Injuries—as well as the physical and mental tolls they can take—can have a negative impact on productivity and quality of life. Data on hospital and emergency room encounters help illustrate the extent of this burden within the Valley.

Falls are a common cause of non-fatal injury in both the U.S. and the Valley. Rates of hospital and emergency room encounters are particularly high among older seniors. According to the CDC, one in four adults older than 64 will fall each year, and 20 percent of falls will induce a serious injury such as a hip fracture or traumatic brain injury, which can be debilitating and sometimes life threatening.¹²⁷ Extensive and costly treatment may often be required, with greater burden on older adults for whom costs average \$30,000 per fall, making them among the 20 most expensive medical conditions.¹²⁸

Fall prevention strategies, physical rehabilitation, and close assessments of risk factors offer effective mechanisms for reducing the burden of these types of encounters.¹²⁹ The rate of hospital encounters due to falls in the Valley was about the same as the state overall between 2015 and 2017, and has declined since the period from 2012 to 2014.¹³⁰ Rates are highest in Ansonia and Derby, which also have the oldest housing stock in the region (see Chapter 4 for more information regarding elevated fall risks for seniors living in older housing).¹³¹



The burden of injuries related to motor vehicle crashes is also considerable. The World Health Organization (WHO) reports that in 2013, among high-income countries, the U.S. experienced the highest rates of road traffic deaths and second highest in crash deaths related to alcohol.¹³² Motor vehicle crashes can be prevented through interventions that improve seat belt use, create safer streets for pedestrians and cyclists, and enhance the enforcement of traffic safety laws, especially among youth who are at risk.¹³³

In the Valley, motor vehicle crashes are a key contributor to the region’s elevated rate of premature mortality in comparison to the state (see Figure 2.03). Though decreasing, the rate of motor vehicle crash-related hospital encounters in the Valley is above that of the state as a whole, and is highest among Ansonia residents.¹³⁴ While most types of hospital and emergency room encounters are far more prevalent among older adults than they are among children and youth, motor vehicle crashes are among the hospital encounter types that are more likely to affect children and youth (ages 0 to 19) than older adults.¹³⁵

INFECTIOUS DISEASES

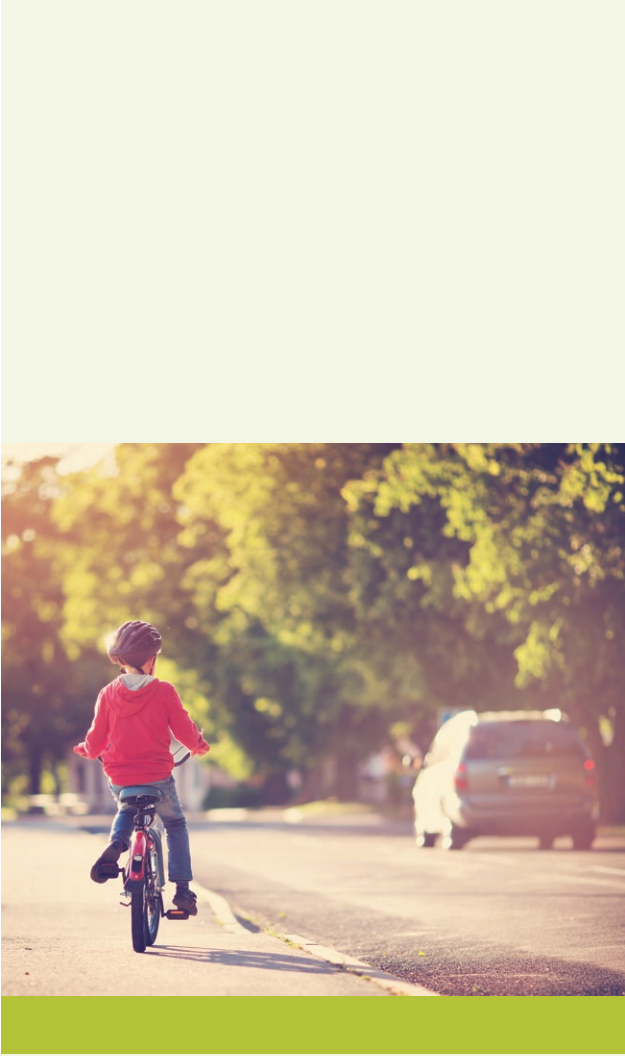
Lyme Disease is Connecticut’s most commonly reported tick-borne disease and tracked by local health departments. Lyme Disease is an infection transmitted through the bite of an infected tick and is easily avoidable by preventing tick bites.

Sexually Transmitted Diseases (STDs), also known as sexually transmitted infections or STIs, are some of the most common infections found statewide and continue to be a public health problem. Although the number of cases is relatively small, they continue to rise throughout the Valley towns. Education and testing are important keys to preventing infection transmission.

2.16 Infectious diseases
Cases reported to Naugatuck Valley Health District (NVHD), selected diseases, 2014–2018*

	2014–15	2015–16	2016–17	2017–18
Chlamydia	274	373	462	361
Syphilis	14	9	54	47
Gonorrhea	46	42	32	64
Lyme	61	31	103	151
Hepatitis C	250	208	262	250

*NVHD does not include Oxford.



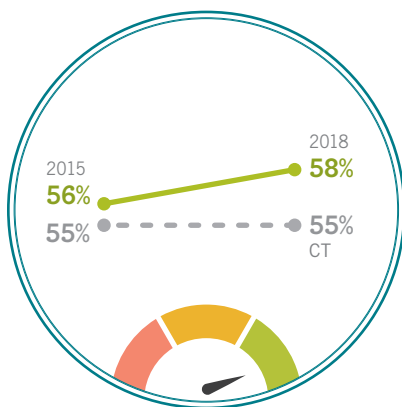
CHAPTER 3

Early Childhood & Education

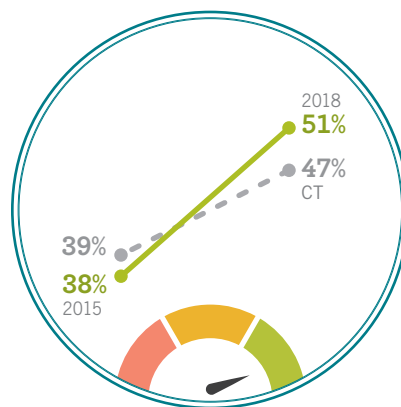
Our brains grow most rapidly and dramatically during the earliest years of life from prenatal to age 5. Children's early experiences and environments are the most critical elements in promoting the development of lifelong health and success. However, between 2000 and 2017, the preschool enrollment rate in the Valley declined, and there is a significant shortage in affordable childcare options for infants and toddlers.

Valley public school districts overall have experienced an uptick in academic performance and high school graduation rates, and are performing ahead of the state on both metrics. However, the number of students from economically-challenged households is growing, as captured by the increasing rate of students eligible for free or reduced price meals (FRPM). Students of color and high-needs students in the region face challenges, such as lower rates of passing standardized tests and graduating from high school, and higher rates of chronic absenteeism and school discipline. Robust adult education programs in the region provide additional continuing education opportunities, and utilization of these programs is increasing.

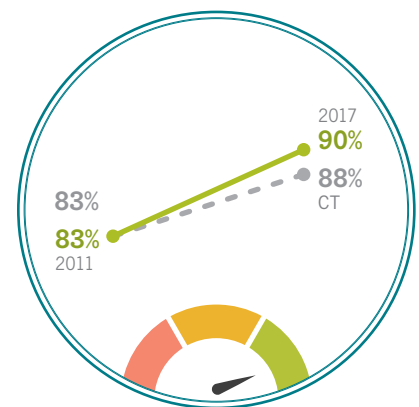
More Valley students are passing state tests in English/language arts



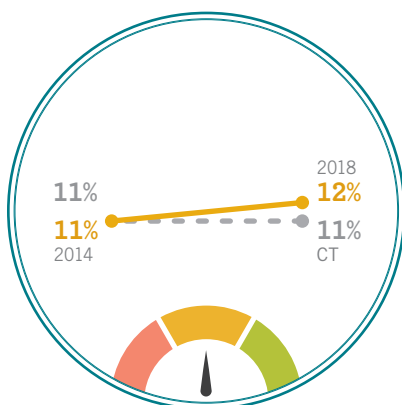
Pass rates have also risen substantially for state tests in math



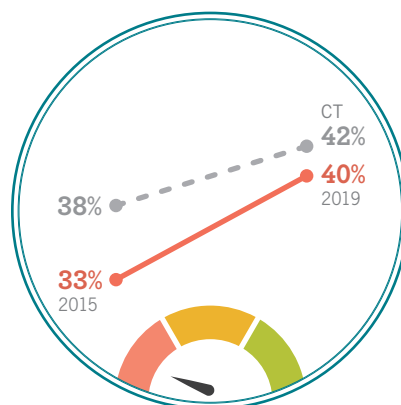
Four-year high school graduation rates are up, outpacing rates statewide



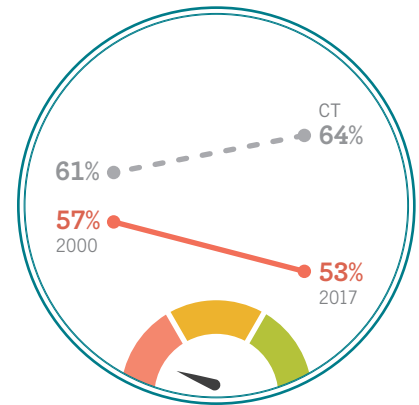
The rate of chronic absenteeism is stable and in line with the state



A growing number of students qualify for free and reduced price meals



Preschool enrollment has declined and is below the state overall



THE FIRST FIVE YEARS

According to a 2017 Connecticut Voices for Children report, the state expanded its funding for childcare services from 2005 to 2016. Since 2006, nearly 80 percent of four-year-olds in the state were enrolled in preschool, even though the need for care for infants and toddlers still surpassed the available capacity. However, those advances were threatened in 2017, when the state reduced funding for childcare services. This Connecticut Voices for Children report also noted that community wealth strongly predicts whether children go to preschool and the level of their academic performance later on, suggesting that greater attention should be paid to the economic barriers that prevent many children from accessing high-quality early childhood education.¹³⁶

From 2000 to 2017, the preschool enrollment rate in the Valley declined from 57 to 53 percent.¹³⁷

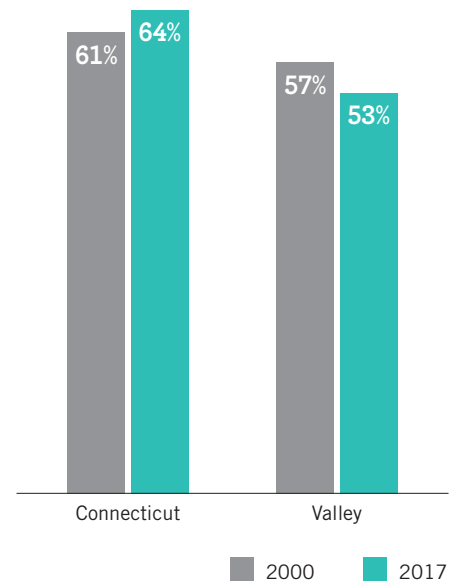
In 2018, the Valley had 113 Office of Early Childhood-regulated providers offering childcare for infants and toddlers, including childcare centers, family day cares, and nursery schools.¹³⁸ In total, 597 infants and toddlers in the Valley were enrolled in these childcare programs, leaving 73 vacant childcare openings.¹³⁹ However, with a total capacity of 670 childcare slots in the region and a total of 4,050 infants and toddlers under age 3, it is clear there is a severe shortage in early childcare options.¹⁴⁰

A family's inability to afford childcare may help explain the vacancies in the Valley's regulated childcare programs and the region's lagging preschool enrollment rate. Based on estimates according to the United Way ALICE Project, the minimum weekly childcare cost for a young family—a household with two adults, one infant, and one preschooler—ranges from about \$395 to \$425 in the Valley.¹⁴¹ In 2018, the average childcare facility in the Valley charged about \$244 a week to care for infants and toddlers, and about \$225 for preschoolers.¹⁴² According to these figures, the young family described above would spend \$469 per week or \$24,388 per year on childcare—33 percent of the Valley's median household income.¹⁴³

These high costs have clear implications for the Valley's working families struggling to make ends meet (see Chapter 1). According to the 2018 DataHaven Community Wellbeing Survey, of adults statewide living with children below kindergarten-age, 57 percent reported that it is either somewhat or very difficult to find high-quality, affordable childcare.¹⁴⁴ In the Valley, childcare is both a great financial burden and a great necessity, as it prepares children for the future and enables parents to work. Young children who miss out on high-quality early learning experiences and opportunities start their education on unequal footing.

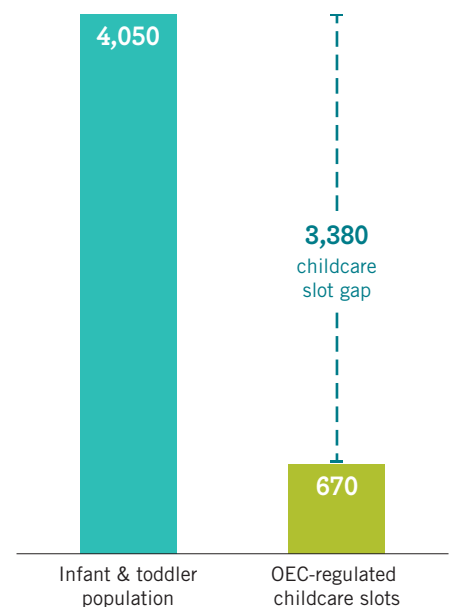
3.01 Preschool enrollment in the Valley lags behind the statewide rate

Share of three- and four-year-olds enrolled in preschool, 2000–2017



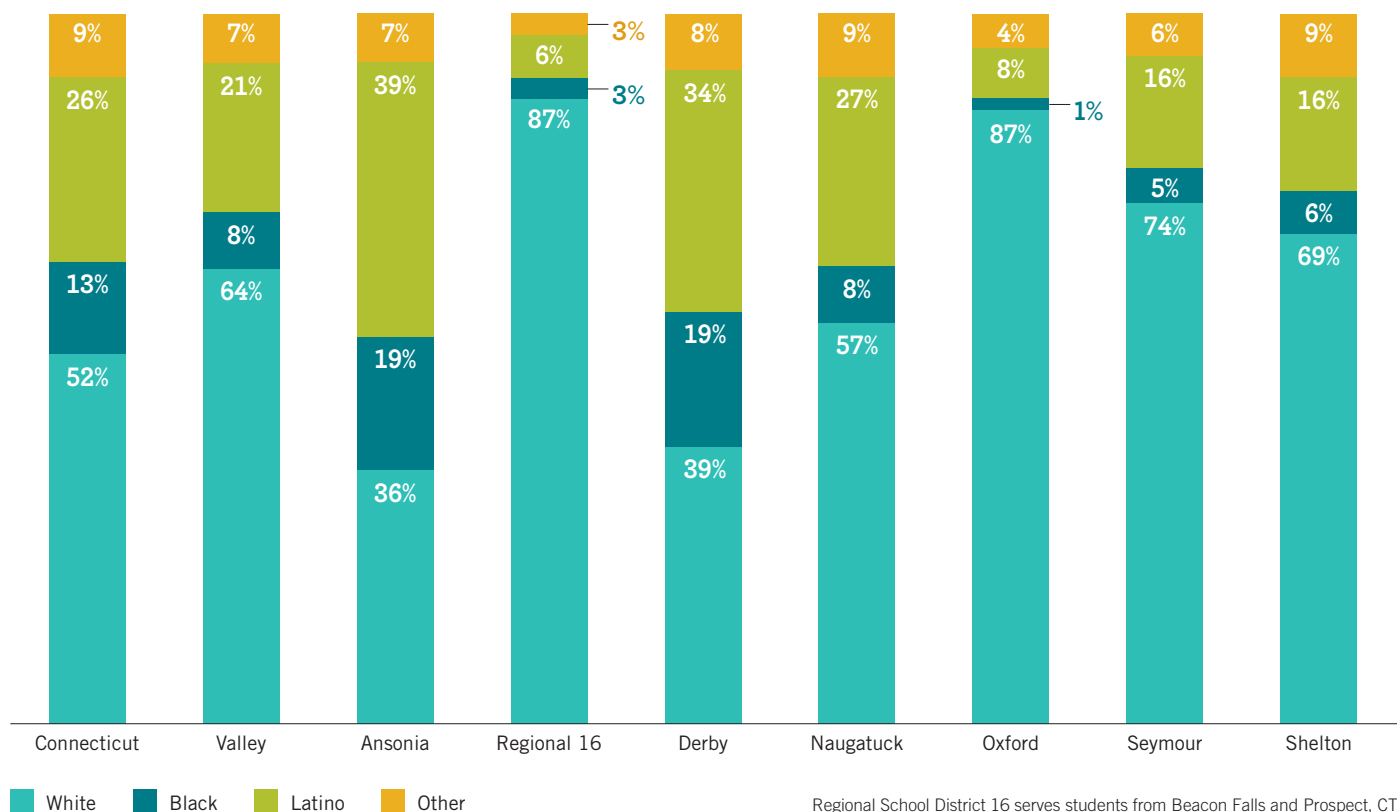
3.02 There is a shortage of infant and toddler childcare options in the Valley

Childcare capacity for infants and toddlers under age 3, 2018



3.03 Student diversity is highest in Ansonia, Derby, and Naugatuck school districts

Share of K–12 students by race/ethnicity, 2018–2019



STUDENT BODY DEMOGRAPHICS

The Valley is home to 18,776 public school students from preschool to 12th grade, including 463 in pre-kindergarten programs, 12,735 kindergarten to eighth grade students, and 5,578 high school students.¹⁴⁵ The region consists of seven public school districts: Ansonia, Regional 16 (serving students from both Beacon Falls and Prospect), Derby, Naugatuck, Oxford, Seymour, and Shelton.

HIGH-NEEDS STUDENTS

Students who take special education classes, who qualify for free or reduced-price meals (FRPM) at school based on having family incomes that are less than 185 percent of the federal poverty line, or who are English language learners (ELL) are considered to be “high-needs” students.¹⁴⁶ Students may have more than one of these designations. Growing child poverty and low-income rates across the Valley are reflected in the student body (see Chapter 1); between the 2014–2015 and 2018–2019 school years, the share of FRPM-eligible students in Valley public schools increased 7 percentage points.¹⁴⁷

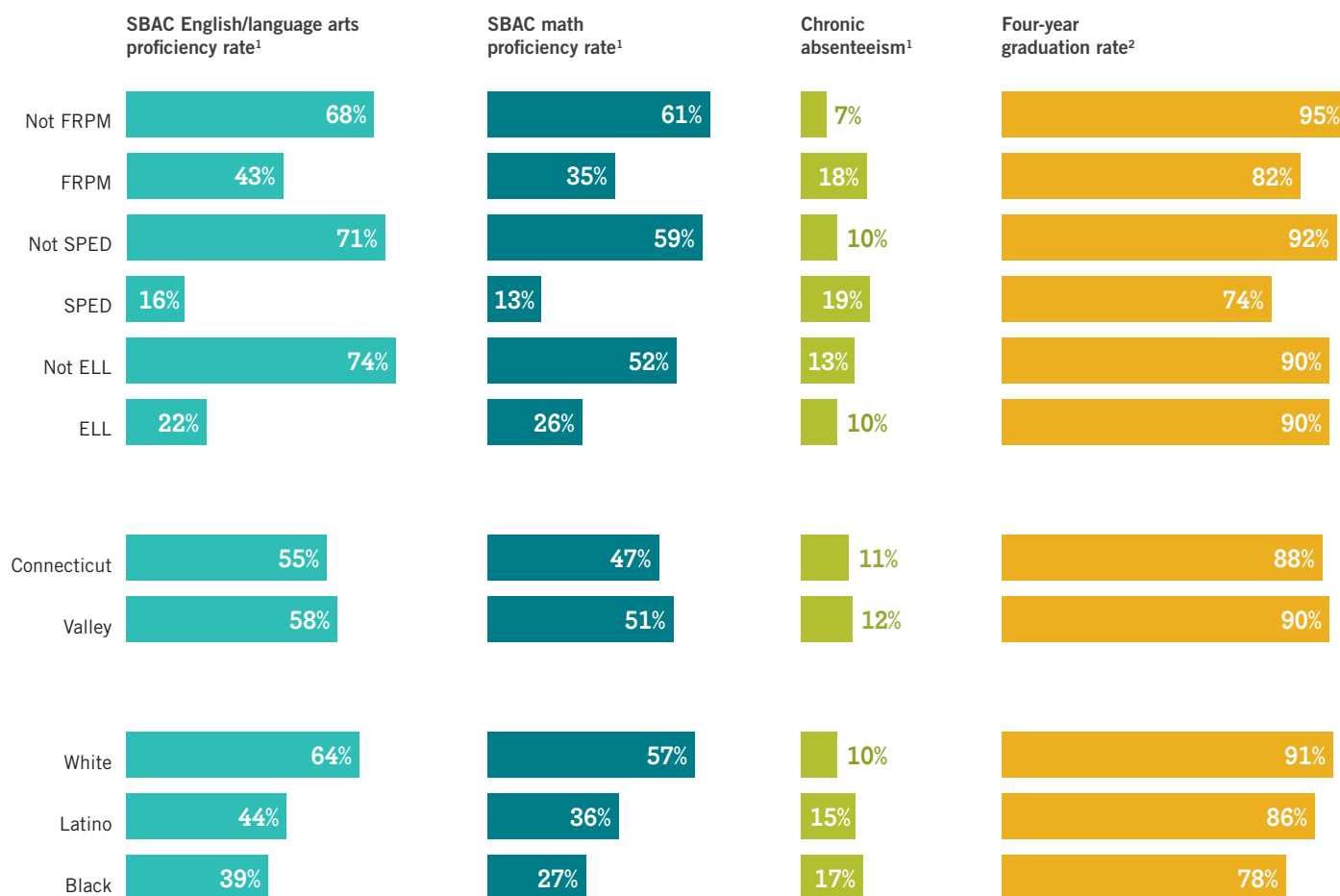
3.04 High-needs students Valley public school districts, 2018–2019

	Total enrollment	Special education students (SPED)		ELL students		FRPM-eligible students	
Connecticut	530,612	81,758	15%	40,441	8%	223,498	42%
Valley	18,776	2,924	16%	774	4%	7,531	40%
Ansonia	2,324	485	21%	104	5%	1,398	60%
Regional 16	2,134	275	13%	32	2%	434	20%
Derby	1,308	239	18%	40	3%	937	72%
Naugatuck	4,320	705	16%	263	6%	2,320	54%
Oxford	1,799	206	12%	35	2%	246	14%
Seymour	2,178	326	15%	67	3%	809	37%
Shelton	4,713	688	15%	233	5%	1,387	29%

Regional School District 16 serves students from Beacon Falls and Prospect, CT.

3.05 There are achievement gaps for Black, Latino, and high-needs students in the Valley

Share of public K–12 students meeting achievement measures



1. School year 2017–2018 2. Class of 2017
The Smarter Balanced Assessment Consortium (SBAC) is the state's major standardized test.

In 2018 in Valley public school districts, Black students were suspended or expelled at a rate almost 3 times greater than White students, and special education students were suspended or expelled 2.5 times as often as students who were not in special education.¹⁵⁸

ACADEMIC PERFORMANCE AND ATTENDANCE

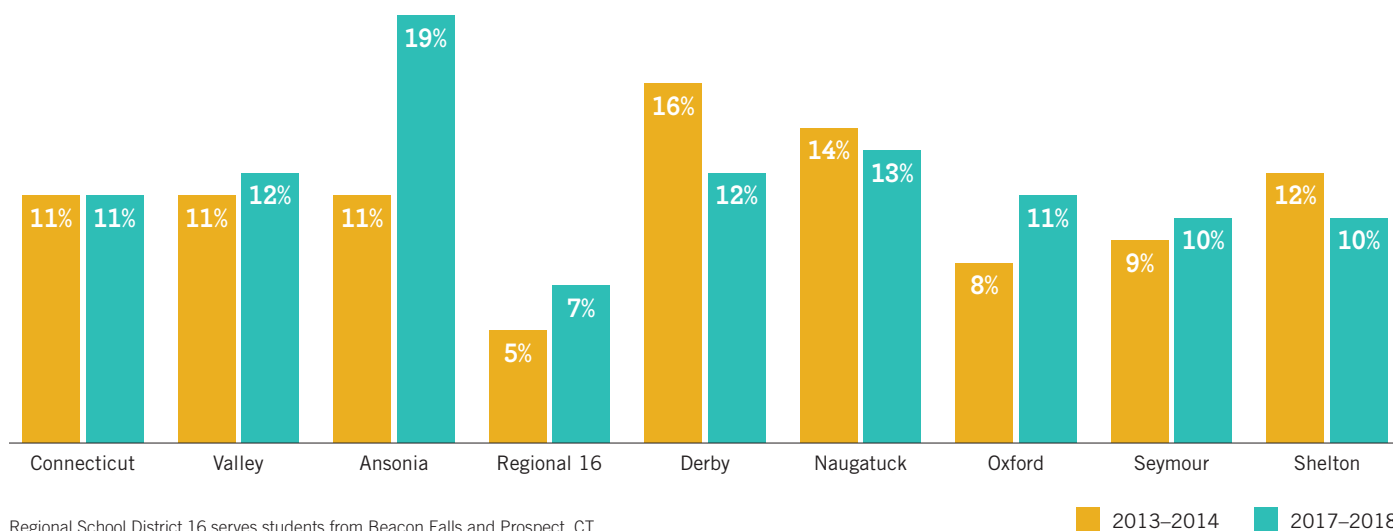
Performance on standardized tests and school attendance predict how likely students are to succeed in school and graduate. On the state's major standardized test, the Smarter Balanced Assessment Consortium (SBAC), scores rated as meeting (level 3) or exceeding (level 4) grade-level goals are considered passing. Between the 2014–2015 and 2017–2018 school years, students in Valley public schools increased their pass rates in both English/language arts (ELA) and math.¹⁴⁸ However, there is an academic achievement gap for Black, Latino, and high-needs students throughout the Valley on these standardized tests.

A major risk factor for students' academic success is chronic absenteeism, or missing more than 10 percent of the days in a school year for which a student is enrolled for any reason. A national study found that over half of chronically-absent kindergarteners became chronically-absent first graders.¹⁴⁹ There are a number of factors that may contribute to chronic absenteeism, such as asthma and other chronic diseases, substance use, and poverty; neighborhood-level issues like access to transportation and safe routes to school;¹⁵⁰ and school-level factors such as school climate and bullying.¹⁵¹

Academic disadvantages can result from chronic absenteeism, and the latter is driven in part by in-school and out-of-school suspensions. Students who are suspended or expelled from school are more likely to have negative perceptions of school¹⁵² and to have lower GPAs.¹⁵³ They are also more likely to be involved with the juvenile justice system.¹⁵⁴ Black and Latino students—particularly boys—are expelled or suspended far more frequently than White students,¹⁵⁵ as early as preschool.¹⁵⁶ Even when the confounding effects of socioeconomic status are controlled for, Black students are still disciplined more frequently than their White counterparts.¹⁵⁷

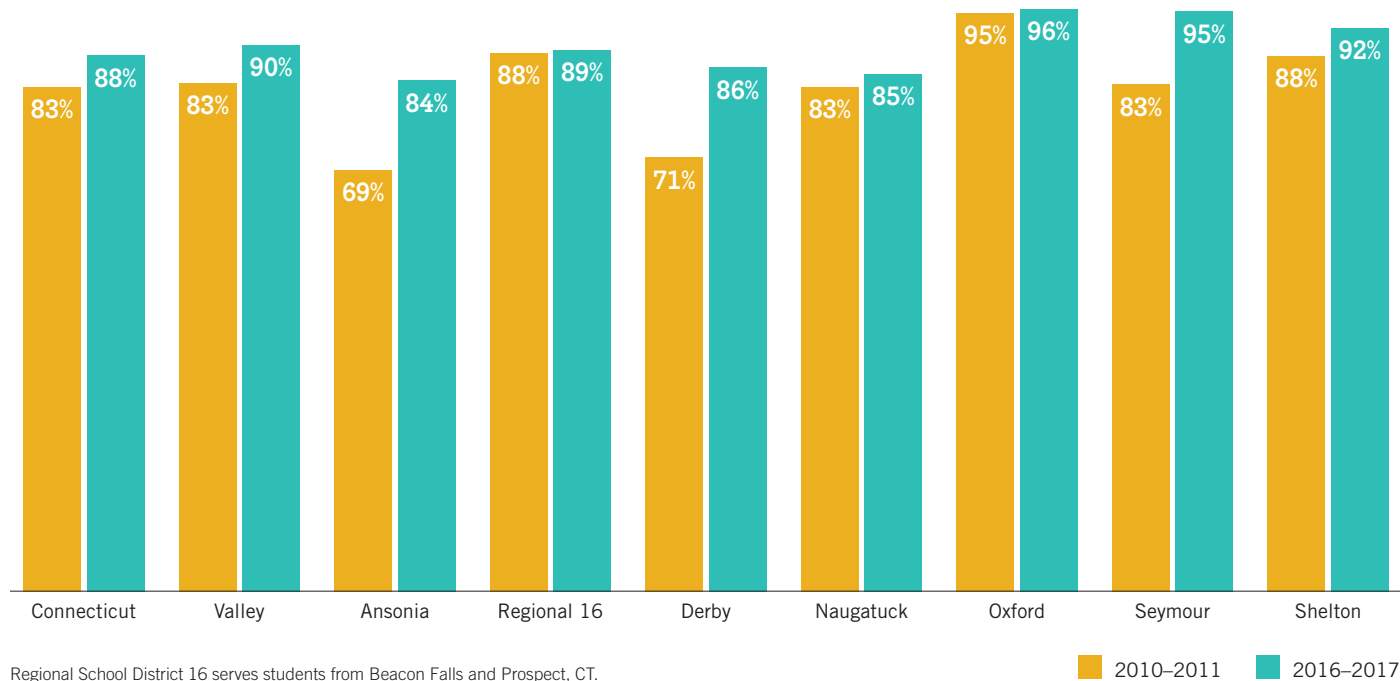
3.06 The overall rate of chronic absenteeism in the Valley has held steady, but varies by town

Chronic absenteeism, public K–12 students, 2013–2014 and 2017–2018



3.07 The Valley's high school graduation rate has improved

Four-year high school graduation rate for public school students, classes of 2011 and 2017



GRADUATION RATES

Four-year high school graduation rates in the Valley have increased in recent years; 90 percent of the class of 2017 graduated on time, compared to 83 percent of the class of 2011—reflecting a statewide uptick of about the same magnitude.¹⁵⁹

Though the four-year high school graduation rates in the Valley are high, similar to standardized test scores and chronic absenteeism, there are underlying disparities. FRPM-eligible students, Black students, and special education students experienced lower graduation rates than Valley students overall.¹⁶⁰

Each school district in the Valley experienced increased graduation rates between 2011 and 2017, with Ansonia, Derby, and Seymour demonstrating the greatest increases.¹⁶¹



3.08 Six years after graduating high school, 47% of Valley public school students have a college degree

Number and share of students enrolling in, persisting in, and graduating from college, of Valley high school graduates

	Graduated high school ¹	Enrolled in college within 1 yr ¹	Enrollment rate ¹	Persisted ¹	Persistence rate ¹	Earned degree in 6 yrs ²	Attainment rate ²	With 4 yr degree ²	With 2 yr degree ²
Connecticut	37,708	27,697	73%	24,540	89%	18,706	49%	16,400	2,306
Valley	1,168	810	69%	715	88%	633	47%	528	105
Ansonia	133	77	58%	61	79%	68	42%	56	12
Regional 16	174	131	75%	119	91%	101	51%	83	18
Derby	99	54	55%	39	72%	28	33%	24	4
Naugatuck	289	183	63%	164	90%	132	41%	107	25
Seymour	125	97	78%	87	90%	98	53%	80	18
Shelton	348	268	77%	245	91%	206	52%	178	28

1. Class of 2014 2. Class of 2010

Data for Oxford is unavailable. Regional School District 16 serves students from Beacon Falls and Prospect, CT.

Only 47 percent of a given Valley high school class have a college degree six years after graduating high school—similar to the state rate of 49 percent.

POST-SECONDARY OUTCOMES

While 69 percent of high school graduates in the Valley enroll in a two- or four-year college within a year of graduating from high school, and 88 percent of those students re-enroll for a second consecutive year (also known as persistence rate), only 47 percent of a given Valley high school class have a college degree six years after graduating high school—similar to the state rate of 49 percent (also known as attainment rate).¹⁶² For the class of 2010, the college degree attainment rate was particularly low in Derby at 33 percent.¹⁶³

In the Valley in 2017, 5 percent of the population between 16 and 19 years old were considered “opportunity youth” (or “disconnected youth”)—defined as young adults neither in school nor working—similar to the rate statewide.¹⁶⁴

According to the 2018 Community Wellbeing Survey, 92 percent of Valley adults believed it was almost certain or very likely that youth in their community would graduate high school, while 53 percent believed it was almost certain or very likely that youth in their community would find a job with opportunities for advancement—similar to perceptions statewide.¹⁶⁵

ADULT EDUCATION

There are several adult education programs that serve the Valley Region school districts, including the Valley Regional adult education program in Shelton (also serving Ansonia, Derby, and Seymour), the Naugatuck adult education program (also serving Oxford and parts of Wolcott), and the Waterbury adult education program (also serving Regional District 16 and parts of Wolcott).¹⁶⁶ In 2018, the Shelton and Naugatuck programs had 586 total students constituting 1,717 total class enrollments; both total students and total class enrollments increased from 2015, 4 percent and 18 percent, respectively.¹⁶⁷ Students enrolled in adult education classes range in age from 16 to over 60, and the most popular program in 2018 was English as a second language (ESL). According to the 2018 Community Wellbeing Survey, statewide, 23 percent of working adults felt they needed either more education or more training to get ahead in their jobs or careers.¹⁶⁸

EDUCATION AND OPPORTUNITY

The relationship between education and economic opportunity later in life is apparent. The quality of a child's education is highly correlated with upward mobility,¹⁶⁹ but a person's economic future is also dependent on circumstances of their youth. The place a child grows up, their race, and their family's income will greatly impact whether that child will move up the socioeconomic ladder. For example, considering low-income children in New Haven County as a whole, the probability that a low-income White child will reach the top 20 percent of households by income (19 percent) is more than twice that of a Latino child (8 percent) and more than four times that of a Black child (4.5 percent).¹⁷⁰

As a result of factors beyond their control, these children are subject to the effects of differential access to quality education, post-secondary and employment opportunities, and wealth-building opportunities. Those with better access tend to have correspondingly better overall health and higher quality of life than people with limited access to those opportunities.

In New Haven County, the probability of a low-income White child growing up to be within the top 20 percent of households by income is more than twice that of a Latino child and more than four times that of a Black child.

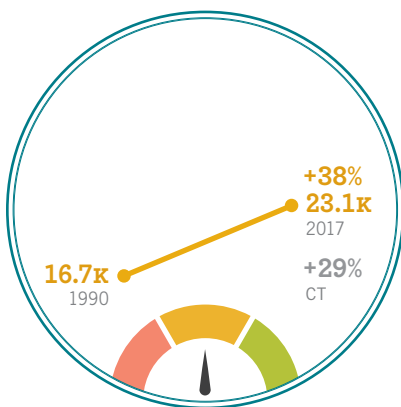
Seniors

Across the country, the senior population is growing. By 2035, one out of three American households are projected to be headed by someone age 65 or older, and the 80 or older population is projected to more than double between 2015 and 2035.¹⁷¹ The Valley will be greatly impacted by this trend, and projections point to the region's senior population increasing more sharply than that of the state overall. As is the case across the U.S., the Valley's growing population of seniors are breaking away from traditional perceptions of aging by working longer and sometimes caring for even older parents.

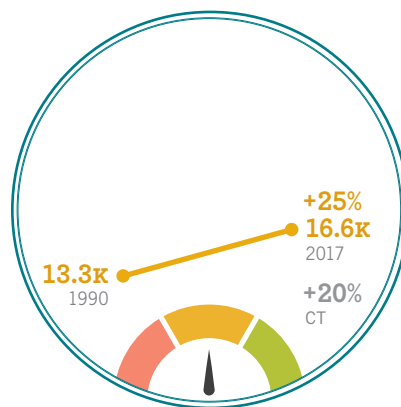
With their deep roots in the Valley, seniors are assets to community life and serve as a rich source of community history. Seniors are also an integral piece of the Valley's economy and social fabric, but the growth of this population segment presents challenges that the region must be prepared to address. There are unique issues seniors face related to housing, transportation, healthcare, and social engagement. The future of the Valley depends in part on anticipating and addressing seniors' changing needs and lifestyles.

The Valley's senior population has grown and is projected to continue to increase faster than the state's

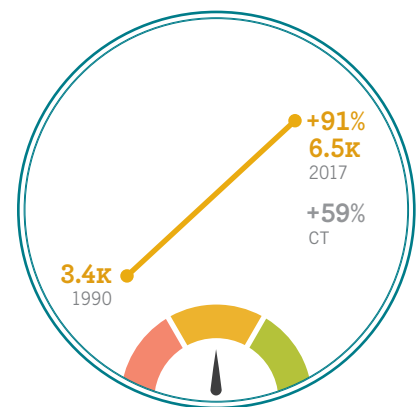
Total senior population (ages 65+)
1990–2017



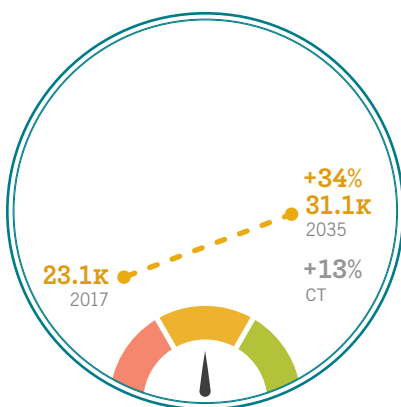
Younger senior population (ages 65-79)
1990–2017



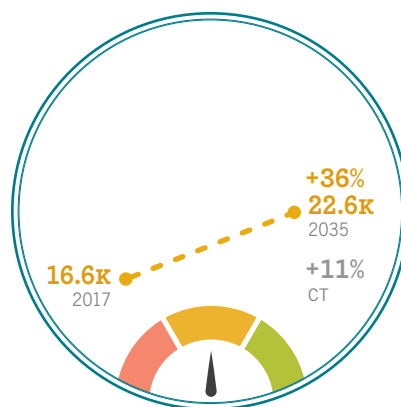
Older senior population (ages 80+)
1990–2017



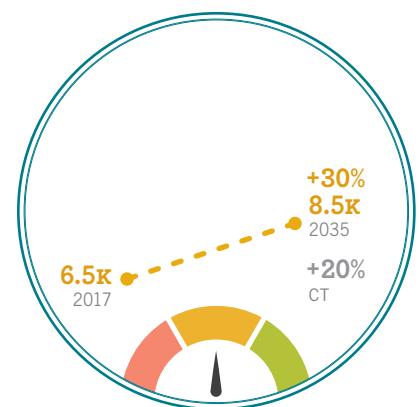
Total senior population (ages 65+)
2017–2035 projection



Younger senior population (ages 65-79)
2017–2035 projection

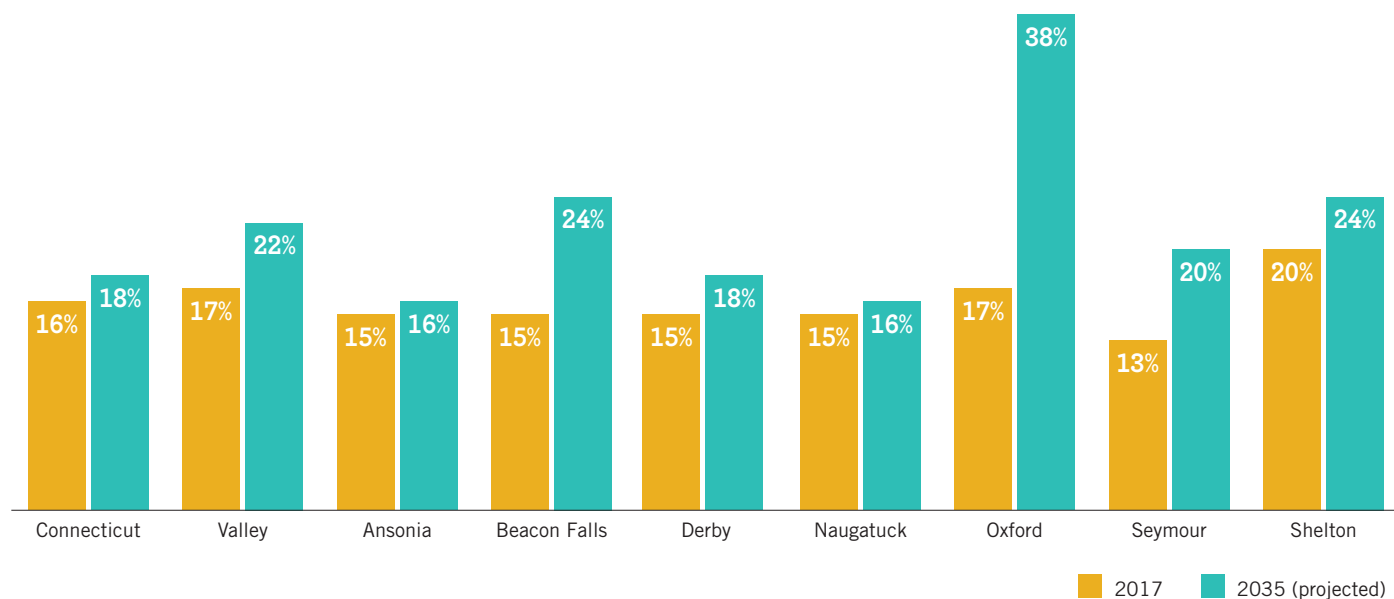


Older senior population (ages 80+)
2017–2035 projection



4.01 Senior population varies between Valley towns, as does projected growth

Share of senior population ages 65+, 2017–2035



SENIOR EMPLOYMENT AND FINANCIAL WELL-BEING

Older adults are remaining in the workforce longer. Nationwide in 1990, about 12 percent of the population ages 65 years and older was in the labor force; however, by 2010, this figure had increased to 16 percent.¹⁷² In the Valley in 2017, 21 percent of adults ages 65 and older were in the labor force, compared to 17 percent in 2010.¹⁷³ Among the reasons for continued labor force participation among seniors are the need to keep working for financial reasons and the ability to keep working due to increased lifespan.¹⁷⁴ Senior workers are an asset to regional economies, increasing tax revenue, stimulating growth through consumer spending, and providing additional talent and expertise during periods of low unemployment.¹⁷⁵

In 2017, the poverty and low-income rates among Valley seniors, 6 percent and 21 percent, were similar to rates in the Valley overall (see Chapter 1).¹⁷⁶ Between 2000 and 2017, the low-income rate among Valley seniors decreased by 3 percentage points; over the same period, the low-income rate among the Valley population overall increased by 6 percentage points.¹⁷⁷ As the senior population continues to increase, so too will the number of seniors in the region living in households below the poverty and low-income levels.¹⁷⁸

Between 2000 and 2017, the low-income rate among Valley seniors decreased by 3 percentage points; over the same period, the low-income rate among the Valley population overall increased by 6 percentage points.



Three out of four adults nationwide want to stay in their homes and communities as they age.

AGING IN PLACE

Most Valley seniors are homeowners. In 2017, 80 percent of seniors in the region owned their homes, compared to 72 percent of the overall adult population.¹⁷⁹ A 2018 AARP survey found that 3 out of 4 adults nationwide want to stay in their homes and communities as they age, also known as “aging in place,”¹⁸⁰ but nationwide and in the Valley, many older adults have concerns about whether their current homes are conducive to this.

According to the 2018 Community Wellbeing Survey, 67 percent of Valley seniors reported living in the same place for at least 20 years; however, 20 percent of older adults over the age of 55 did not think their homes had the physical features to be a suitable and convenient place to age.¹⁷¹ This may be particularly true for those living in older homes with more than one story, which can put seniors at a higher risk for falls. As of 2017, 26 percent of the Valley’s housing units were built before 1950, but this figure was particularly high in Ansonia (46 percent).¹⁸² Older homes are likely to have physical features like narrow stairs, doorways, and hallways, which can obstruct mobility or increase fall risks for seniors. Falls and other health complications are particularly dangerous for seniors that live by themselves; in 2017, 27 percent of Valley seniors lived alone, more than twice the rate for the Valley’s overall population.¹⁸³

According to the 2018 Community Wellbeing Survey, the vast majority of Valley seniors, 89 percent, drive themselves as their primary mode of transportation.¹⁸⁴ While only 6 percent of seniors ages 65 and older reported staying home in the last year when they needed or wanted to go someplace due to a lack of reliable transportation,¹⁸⁵ it is likely that this issue has a greater impact on older seniors. Nationwide, over 50 percent of seniors ages 85 and older do not drive a car.¹⁸⁶ Reliable transportation access is important for seniors who must leave the home to fulfill basic needs like healthcare, grocery shopping, banking, and social interaction.

SENIOR HEALTHCARE

Given that seniors are eligible for Medicare starting at 65, almost every senior in the Valley has health insurance; only 2 percent of those 65 and older are without it, and 95 percent have a personal doctor.¹⁸⁷ However, 22 percent of seniors had not been to the dentist in more than a year.¹⁸⁸ As the likelihood of chronic disease is higher among the older population, senior access to healthcare remains a concern.

Seniors who need attentive healthcare face high costs. According to Genworth's Cost of Care Survey, in New Haven County in 2018 the annual median costs for homemaker services and home health aides were \$51,480 and \$56,628, respectively.¹⁸⁹ However, these figures are from a baseline of 44 hours of home healthcare per week; 24 hours of care, seven days per week (or 168 total hours per week) would increase these costs to \$196,560 and \$216,216. Annual median costs for adult day healthcare (\$24,050) and assisted living facilities (\$41,220) were lower than the aforementioned home healthcare options, while nursing home care was also expensive at a median annual cost of \$145,635 for a semi-private room and \$160,053 for a private room.¹⁹⁰ In recent years, the costs of home healthcare and adult day healthcare are growing in New Haven County; in 2018 the 5-year annual cost for homemaker services increased by 2 percent, while costs increased 3 percent for home health aides and adult day healthcare. Costs remained the same or decreased for assisted living facilities and nursing home care.¹⁹¹

Cost concerns and personal preferences lead many seniors to seek informal care from family members, particularly their children.¹⁹² According to a 2017 report, between 1995 and 2010 nationwide, 10 percent of adults ages 60 to 69, and 12 percent of adults ages 70 and older provided care to parents. The same report found that the average number of hours of care provided by older adults caring for parents was significant: 76 hours per month among caregivers ages 60 to 69, and 95 hours per month among caregivers ages 70 and older.¹⁹³ Additionally, spousal caregiving duties often fall on the shoulders of seniors.

Nationwide, 41 percent of younger seniors ages 65 to 79 have at least one self-care, household activity, or mobility disability, but for older seniors ages 80 and older, this figure rises to nearly 71 percent.¹⁹⁴



CHAPTER 5

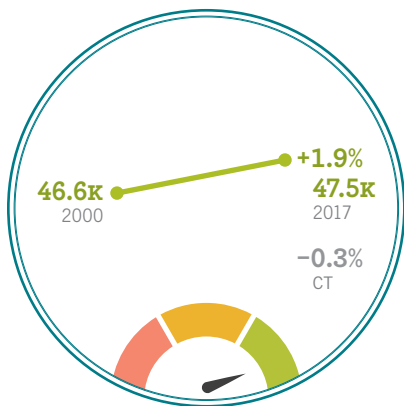
Economic Opportunity

A strong local economy and diverse, accessible regional economic opportunities for residents are crucial for individual and community-wide economic security, as well as overall well-being. The Valley is part of a combined metropolitan area of Fairfield and New Haven Counties and most working residents commute to jobs outside the region, making access to reliable transportation critical to the success of the Valley's workforce. As is the case statewide, job opportunities in the regional economy are shifting towards the service sector, and wages for these industries have been stagnant or declining since the early 2000s. Education remains a critical stepping stone towards high-quality jobs, and the share of Valley adults with at least a bachelor's degree has increased since 2000, but still lags behind the state overall. The recent release of the 2018-19 Comprehensive Economic Development Strategy (CEDS) for the Naugatuck Valley corridor—consisting of 20 communities in the larger region—displays a continued commitment to a regional approach to ensuring a growing and vibrant economy.¹⁹⁵

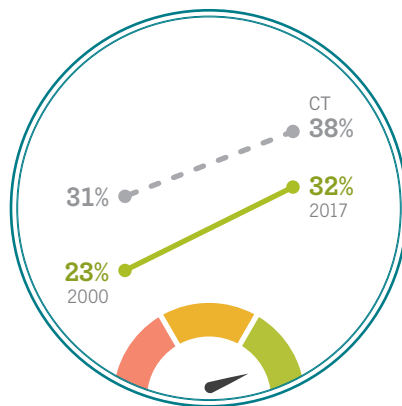
JOBS AND JOBS ACCESS

Living in the Valley, residents have access to two major Connecticut job markets in Fairfield and New Haven Counties. Between 2000 and 2017, the number of jobs in these counties ebbed and flowed in line with the larger economic climate, decreasing after the Great Recession and then bouncing back in the following years.¹⁹⁶ While the total number of jobs in Fairfield and New Haven Counties in 2017 was similar to the number in 2000, they have shifted dramatically toward a service economy.¹⁹⁷ As the region's senior population grows, healthcare and social assistance workers will likely continue to be in high demand. The Connecticut Department of Labor's most recent 2016 forecast estimates that statewide, the health care and social assistance sector will grow by an additional 11 percent by 2026.¹⁹⁸

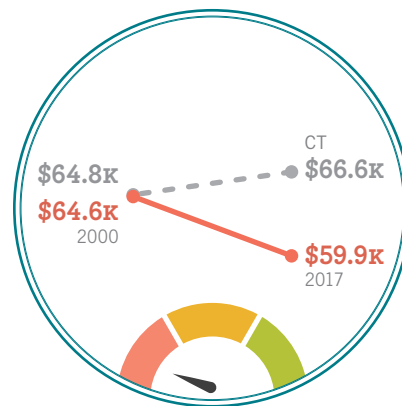
The number of **jobs in the Valley** is growing, faster than the state overall



The share of Valley adults with a **Bachelor's degree or higher** has increased

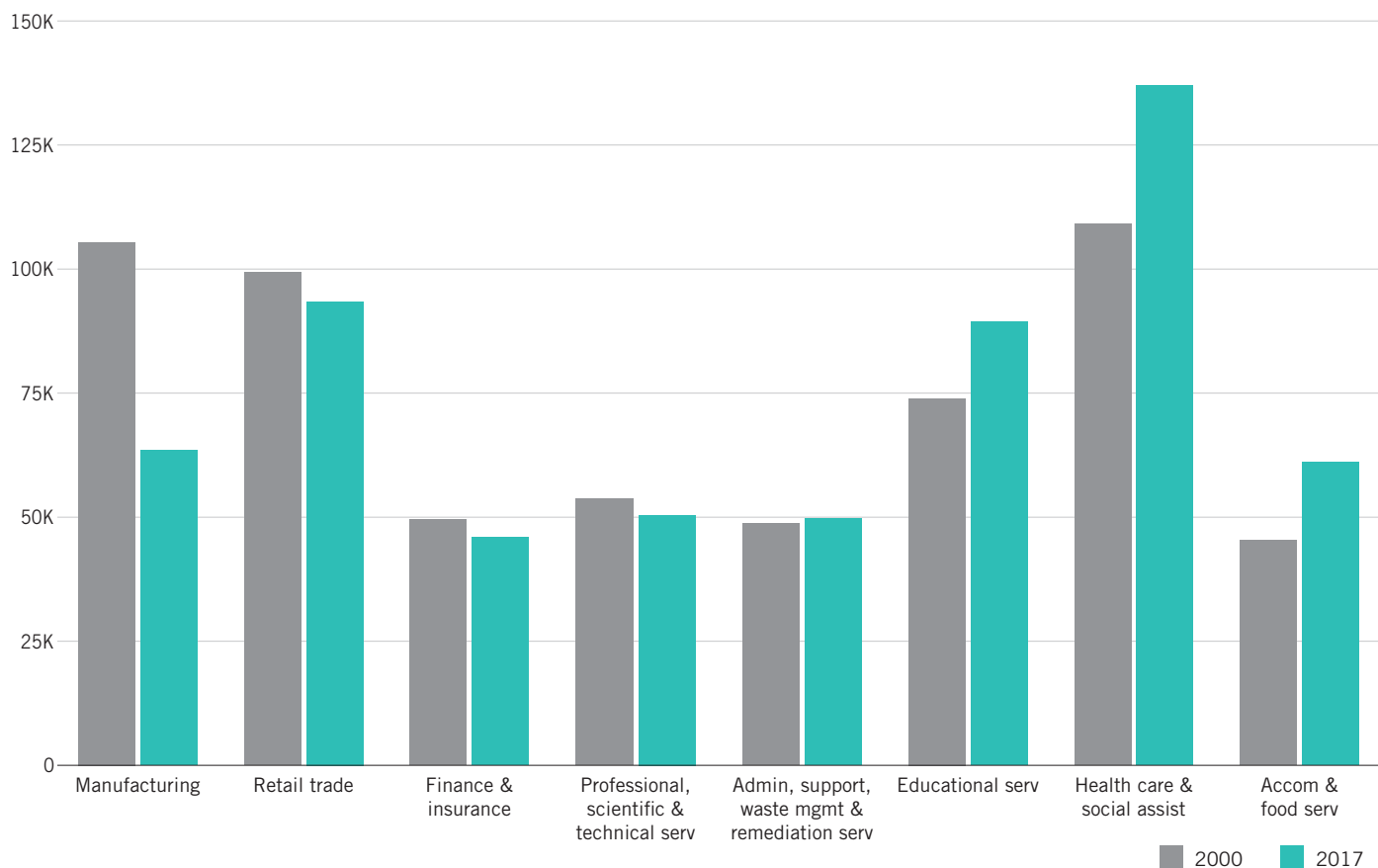


Annual wages for Valley jobs have declined and are lower than the state



5.01 Fairfield and New Haven Counties' manufacturing sectors have declined, while health care and social assistance jobs soar

Number of jobs by sector, Fairfield and New Haven Counties, 2000–2017



In 2017, the average wage in Fairfield and New Haven Counties was \$72,828. In the fast-growing service sectors, wages were generally lower, and have been largely stagnant or declining since 2000. Meanwhile, wages in some high-paying sectors, like finance and insurance, have continued to climb. Between 2000 and 2017, average annual wages in the finance and insurance sector increased 19 percent to \$222,434. Wages in the retail trade sector fell by 26 percent over the same period, reaching \$36,096 in 2017, while wages in the accommodation and food services sector declined 5 percent to \$22,892. Wages in the quickly-growing health care and social assistance sector were largely stagnant; the average wage in this sector was \$52,868 in 2017, a gain of about \$500 since 2000.¹⁹⁹

Jobs in the region have shifted towards the service economy.



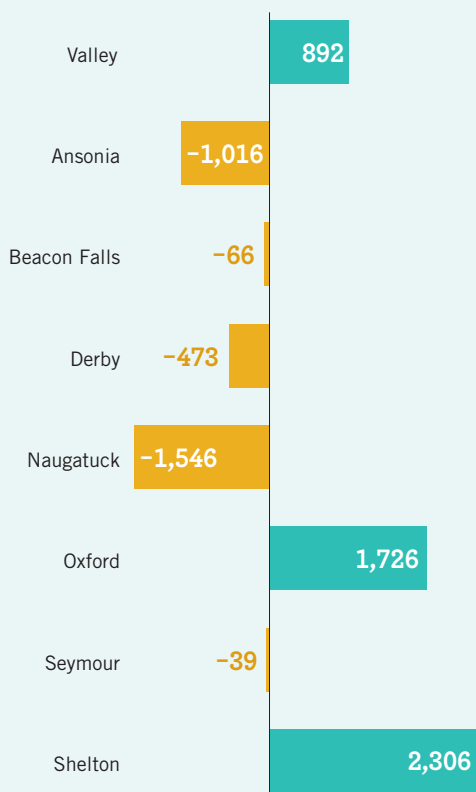
5.02 Job and wage growth in the Valley

Number of jobs by town, 2000–2017, and annual average wage by town, 2000–2017, in 2017 dollars

	Jobs 2000	Jobs 2017	Job growth 2000–2017	Average wage 2000	Average wage 2017	Wage growth 2000–2017
Connecticut	1,674,802	1,669,921	−0.3%	\$64,794	\$66,647	2.9%
Valley	46,641	47,533	1.9%	\$64,648	\$59,851	−7.4%
Ansonia	4,344	3,328	−23.4%	\$42,957	\$40,414	−5.9%
Beacon Falls	969	903	−6.8%	\$48,006	\$60,965	27.0%
Derby	5,091	4,618	−9.3%	\$38,184	\$44,235	15.8%
Naugatuck	8,611	7,065	−18.0%	\$47,173	\$46,630	−1.2%
Oxford	1,802	3,528	95.8%	\$52,259	\$58,707	12.3%
Seymour	4,356	4,317	−0.9%	\$49,123	\$47,662	−3.0%
Shelton	21,468	23,774	10.7%	\$87,264	\$71,875	−17.6%

5.03 Job growth in the Valley is concentrated in Oxford and Shelton

Net job growth, 2000–2017

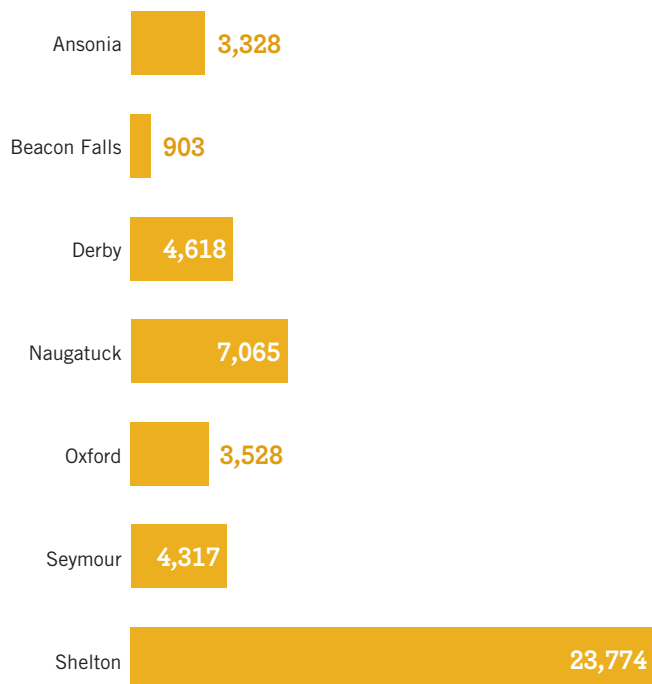


The Valley's average unemployment rate of 8 percent from 2013 to 2017 was similar to the statewide and national rates (both 7 percent).²⁰⁰ Though jobs located in the Valley are not exclusively held by Valley residents, they are nonetheless integral to the region's economic health, contributing to the local tax base. Shelton contained half of the Valley's jobs in 2017.²⁰¹

Though the Valley's median household income in 2017 of \$74,358 was above that of the state overall (see Chapter 1), wages for jobs located in the Valley have declined, reflecting the larger regional trend of an economy shifting towards service sectors. The inflation-adjusted annual average wage for Valley jobs declined by almost \$4,800 between 2000 and 2017, from \$64,648 to \$59,851, and was almost \$6,800 below the statewide annual average in 2017.²⁰² A 2016 workforce development plan demonstrated that residents of Southwest Connecticut may be responding to the shifting economy by increasingly taking on additional side-jobs beyond their primary occupation to supplement income.²⁰³

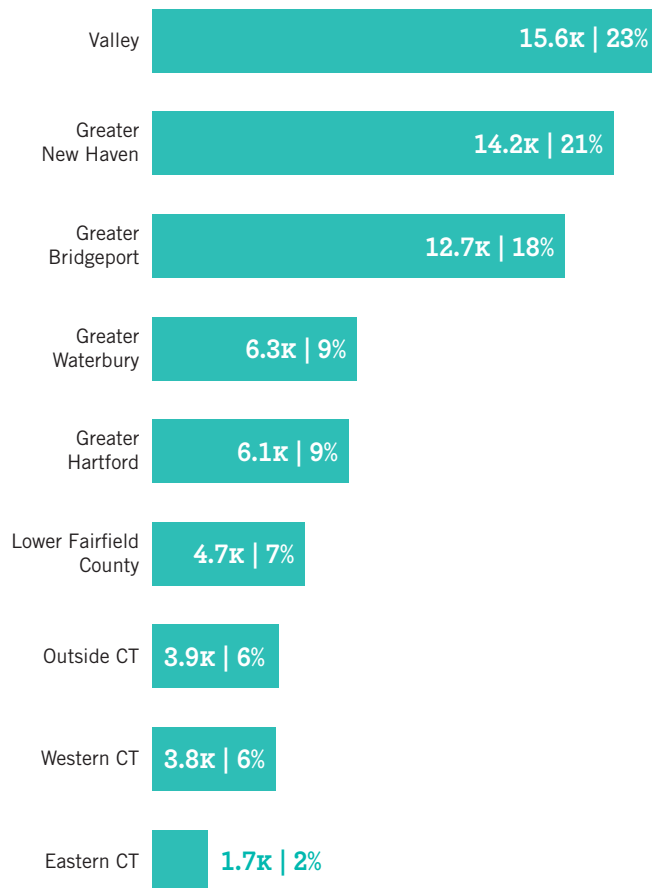
5.04 Where jobs are located in the Valley

Job count by town, 2017



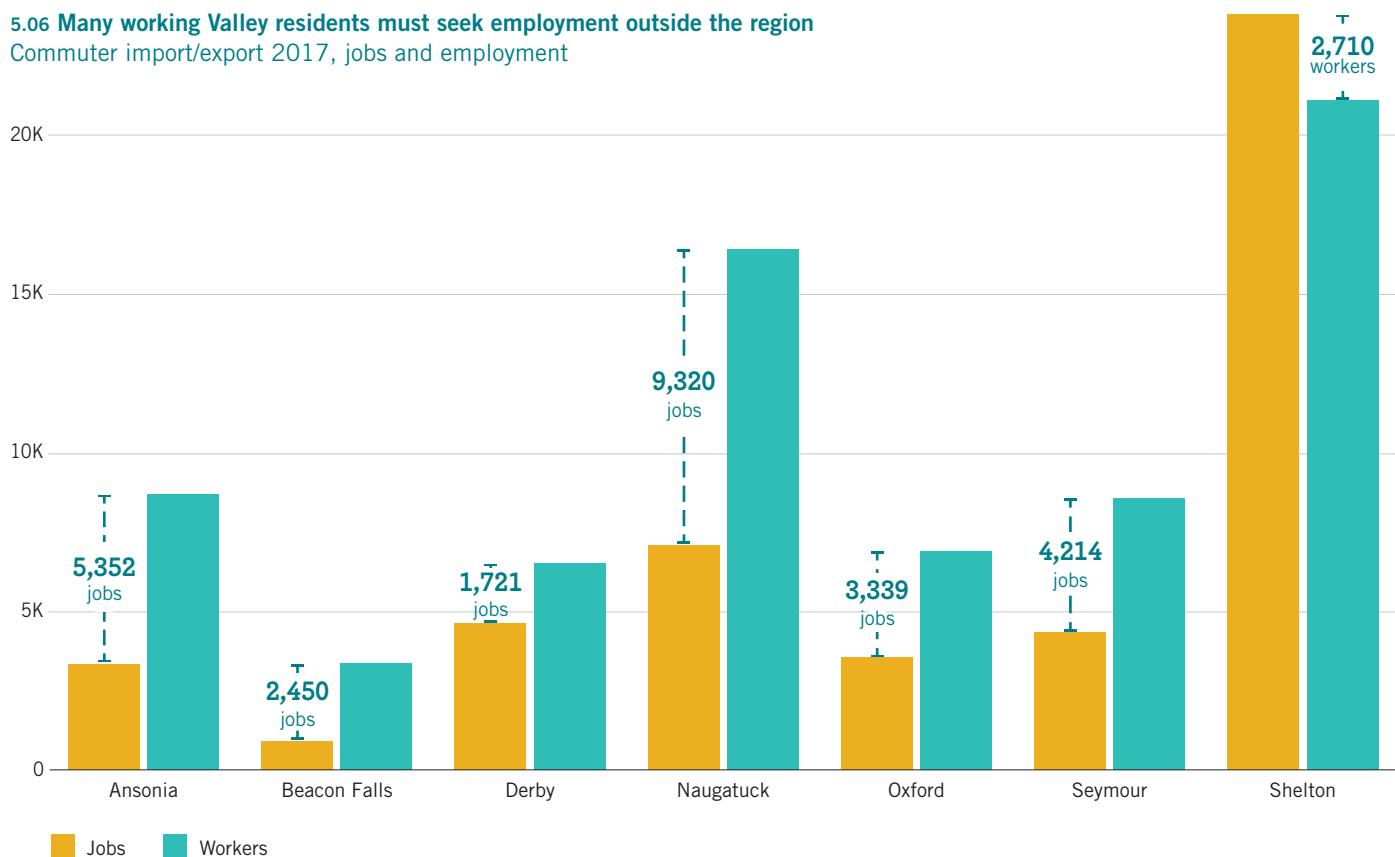
5.05 Less than a quarter of employed Valley residents work within the region

Where Valley residents work, 2015



5.06 Many working Valley residents must seek employment outside the region

Commuter import/export 2017, jobs and employment



TRANSIT INVESTMENT AS AN ECONOMIC DRIVER

As of 2019, the Naugatuck Valley Council of Governments has undertaken a study of options to reduce congestion and increase mobility throughout Route 8 and the Waterbury Branch Rail Line corridors. This critical study outlines opportunities to improve on the current transit and commuter rail services in the Corridor, and to invest in Transit Oriented Development (TOD) in the region's cities and towns.

Mobility improvements would be a major boon to the region's many commuters, while TOD investment can help the Naugatuck Valley achieve both economic competitiveness and economic equity.²⁰⁷

TRANSPORTATION AND JOB LOCATIONS

Transportation is an important factor in Valley residents' ability to access quality jobs. Based on the most recently available data, only 23 percent of workers residing in the Valley in 2015 actually held jobs located within the region, while the remainder commuted to towns outside the region.²⁰⁴ In 2017, there were 71,219 employed Valley residents, but only 47,533 jobs located in the region—a substantial portion of which were held by people residing outside the Valley.²⁰⁵ Even if every job located in the Valley was occupied by a Valley resident, the region would still be nearly 24,000 jobs short of providing employment to the total number of working residents. Access to reliable transportation is critical for Valley residents, as many must seek job opportunities outside the region.

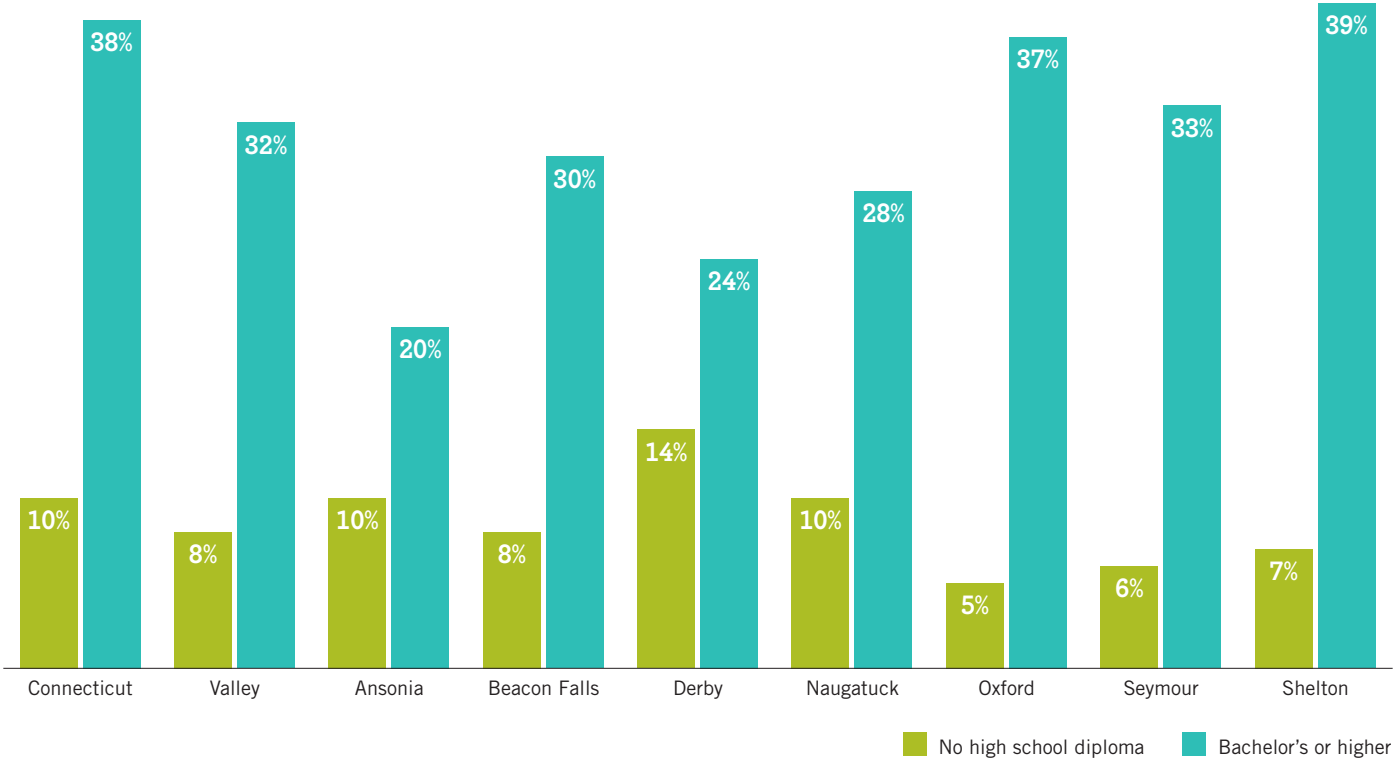
According to the 2018 Community Wellbeing Survey, for most Valley adults, driving alone is the primary mode of transportation.²⁰⁶ However, greater shares of lower-income adults in the Valley reported using other modes of transportation than higher-income adults.

5.07 Transportation in the Valley

Share of adults, 2018 DataHaven Community Wellbeing Survey

	Access to car often	Primary means of transportation other than driving alone
Connecticut	88%	18%
Valley (2015)	91%	9%
Valley	93%	12%
Male	94%	9%
Female	92%	13%
Ages 18–34	92%	19%
Ages 35–49	94%	9%
Ages 50–64	93%	10%
Ages 65+	95%	10%
White	94%	10%
Non-White	90%	19%
<\$30K	83%	25%
\$30K–\$75K	94%	12%
\$75K+	97%	8%

5.08 Educational attainment
Adults 25 and older, Valley, 2017



EMPLOYMENT OPPORTUNITIES AND EDUCATION

Adults with high school diplomas or college degrees have more employment options and higher potential earnings, on average, than those who do not finish high school.²⁰⁸ Within the Valley, median earnings for an adult ages 25 and older with no high school diploma were about \$29,100 in 2017. An associate's degree or some other college experience, even without a four-year degree, puts Valley adults at an advantage: earnings for adults with some college experience or an associate's are \$45,000. Adults with at least a bachelor's degree earn an average of \$69,500.²⁰⁹ In 2017, Valley adults between the ages of 25 and 64 who did not have high school diplomas were over four times more likely to be unemployed (14 percent) than those that had at least a bachelor's degree.²¹⁰ Between 2000 and 2017, the share of Valley residents ages 25 and older with a bachelor's degree or higher increased from 23 to 32 percent, while the share without a high school diploma decreased from 15 to 8 percent.²¹¹

Earnings for Valley adults with some college experience or an associate's are \$45,000, while adults with at least a bachelor's degree earn an average of \$69,500.

Figure Notes

General note on DataHaven Community Wellbeing Survey

One of the major sources used in this report is the DataHaven Community Wellbeing Survey (CWS). This survey was most recently carried out from March to November 2018, during which 16,043 randomly-selected adults were interviewed, including residents from all 169 towns in Connecticut. The 2015 iteration of the DataHaven CWS had a similar sample size and scope. Questions on the CWS are compiled by DataHaven and the Siena College Research Institute from local, national, and international sources and best practices, based on extensive input from an advisory committee of Connecticut agencies and non-profits as well as a research advisory committee of regional and national practitioners, academics, and experts in survey research. All reported CWS estimates are weighted in order to accurately represent the underlying adult population within each region, town, or neighborhood. For more information and crosstabs of data, see <https://ctdatahaven.org/reports/datahaven-community-wellbeing-survey>

INTRODUCTION

Figure i.01 2018 DataHaven Community Wellbeing Survey sample characteristics - Survey sample characteristics and adult population in the Valley

DataHaven analysis (2019). Population by sex and age are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B01001, Sex by Age. Population by age and race are from U.S. Census Bureau 2010 Decennial Census SF1 Table P12; and subtables P12B, Sex by Age (Black or African-American Alone); P12H, Sex by Age (Hispanic or Latino); and P12I, Sex by Age (White Alone, not Hispanic or Latino). Available at <https://factfinder.census.gov>. Weighted survey sample is the share of 2018 DataHaven Community Wellbeing Survey respondents in the Valley Region by gender, age, and race/ethnicity (after being weighted to correct for under- or over-sampling so they accurately represent the adult population). See Community Wellbeing Survey note at the beginning of this section.

Figure i.02 DataHaven Personal Wellbeing Index

DataHaven analysis (2019) of questions from 2018 DataHaven Community Wellbeing Survey. The Personal Wellbeing Index is an aggregate of survey participants' positive ratings on four indicators about their health: (1) current anxiety, (2) current happiness, (3) satisfaction with their life, and (4) overall self-rated health. Likert-style responses (e.g. "excellent," "very good," "good," "fair," "poor") were converted to scaled numeric values, averaged, and used for factor analysis to get a single composite score for each location and demographic group. These scores were then scaled to range from 0 (lower ratings of health) to 1,000 (higher ratings of health).

Figure i.03 DataHaven Personal Wellbeing Index components by demographic group - Share of adults, 2018 DataHaven Community Wellbeing Survey

See Figure i.02. Note that the Personal Wellbeing Index assigns the higher value to larger shares of adults reporting that they did not feel anxious (the

positive or preferred response). However, in this table, we present the share of adults who reported that they did feel anxious.

Figure i.04 Community cohesion, 2018

DataHaven analysis (2019) of questions from the 2018 and 2015 DataHaven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown. Data are disaggregated by geographic area, self-reported age group, and household income. See Community Wellbeing Survey note at the beginning of this section.

Figure i.05 Community assets, 2018

DataHaven analysis (2019) of questions from the 2018 and 2015 DataHaven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown. Data are disaggregated by geographic area, self-reported age group, and household income. See Community Wellbeing Survey note at the beginning of this section.

CHAPTER 1

Chapter 1 Dashboard Indicators

Homeownership rate, 1980–2017

DataHaven analysis (2019). 1980 figures are from GeoLytics and Urban Institute. 2013. CensusCD Neighborhood Change Database (NCDB). And U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B25003, Tenure. Available at <https://factfinder.census.gov>.

Median home values, 2000–2017

DataHaven analysis (2019) of U.S. Census Bureau 1990 Decennial Census Summary File 3, Table H085. See Figure 1.11 for 2017 figures.

Population growth, 1990–2017

See Figure 1.01

Poverty rate, 2000–2017

DataHaven analysis (2019). 2000 figures are from U.S. Census Bureau Decennial Census SF3 Tables P88, Ratio of Income in 1999 to Poverty Level; and PCT50, Age by Ratio of Income in 1999 to Poverty Level. See Figure 1.06 for 2017 figures.

Low-income rate, 2000–2017

See note on "Poverty rate, 2000–2017" above. As described in the report text, "low-income" is defined here as individuals living in households where the household income is less than twice (200 percent of) the federal poverty level.

Median household income, 1990–2017

DataHaven analysis (2019). 1990 figures come from U.S. Census Bureau Decennial Census SF3 Table P80A, accessible via Census Data API. See Figure 1.06 for 2017 values. Inflation adjustment for 1990 incomes was done using the Bureau of Labor Statistics' Consumer Price Index, Urban Consumers, Research Series (CPI-U-RS), available at <https://www.bls.gov/cpi/research-series/home.htm>.

Figure 1.01 Population and growth, 1990 and 2017

DataHaven analysis (2019). 1990 population figures are from the U.S. Census Bureau Decennial Census, SF1 Table P11, accessible via Census Data API. 2017 population figures are from U.S. Census Bureau American Community Survey 2017 5-year estimate, Table B01001. 2000 median age is from U.S. Census Bureau Decennial Census, SF1 Table P13, Median

Age by Sex. 2017 median age is from U.S. Census Bureau American Community Survey 2017 5-year estimate, Table B01002, Median Age by Sex. Unless otherwise noted, all above tables available at <https://factfinder.census.gov>. Population density is based on 2017 population (above) and land area calculated as the population per square mile from U.S. Census Bureau TIGER/Line shapefiles, available at <https://www.census.gov/programs-surveys/geography/geographies/mapping-files.html>.

Figure 1.02 Population and change by age group, 1990–2035

DataHaven analysis (2019). 1990 and 2000 figures are from the U.S. Census Bureau Decennial Census; for 1990, SF1 Table P11; and for 2000, SF1 Table P12, Sex by Age. 2015 figures are from U.S. Census Bureau American Community Survey 2015 5-year estimates Table B01001. 1990 figures accessible via Census Data API; all other above tables available at <https://factfinder.census.gov>. 2035 projected figures are from the Connecticut State Data Center (2017) 2015–2040 Population Projections—Town Level. Available at <https://data.ct.gov/resource/hxnh-2e3k>.

Figure 1.03 Population by age and race, 2010

DataHaven analysis (2019) of U.S. Census Bureau Decennial Census SF1 Table P12; and subtables P12B, Sex by Age (Black or African-American Alone); P12H, Sex by Age (Hispanic or Latino); and P12I, Sex by Age (White Alone, not Hispanic or Latino). Available at <https://factfinder.census.gov>.

Figure 1.04 Non-White share of population, 1990–2017

DataHaven analysis (2019). 1990 figures are from U.S. Census Bureau Decennial Census SF1 Tables P1 and P8, accessible via Census Data API. 2017 figures are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B03002, Hispanic or Latino Origin by Race. Available at <https://factfinder.census.gov>.

Figure 1.05 Population share by race/ethnicity, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B03002, Hispanic or Latino by Origin. Available at <https://factfinder.census.gov>.

Figure 1.06 Key income indicators, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B19013, Median Household Income in the Past 12 Months; C17002, Ratio of Income to Poverty Level in the Past 12 Months; and B17024, Age by Ratio of Income to Poverty Level in the Past 12 Months. Available at <https://factfinder.census.gov>. As described in the report text, "low-income" is defined here as individuals living in households where the household income is less than twice (200 percent of) the federal poverty level.

Figure 1.07 Share of house holds under ALICE threshold, 2016

DataHaven analysis (2019) of 2018 Connecticut United Way's ALICE Report data for United Way of Beacon Falls and Naugatuck and Valley United Way. Available at <https://alice.ctunitedway.org/aliceupdate/>. Data were aggregated for these two catchment areas, and include all households below the ALICE threshold (including those below the poverty line). ALICE (Asset Limited Income Constrained) households are considered those earning more than the Federal Poverty Level, but less than the

basic cost of living for a given geographic area. For more information about how the ALICE threshold is calculated, see United Way of Connecticut. (2018). ALICE: A study of financial hardship in Connecticut. Available at http://alice.ctunitedway.org/wp-content/uploads/2018/08/CT-United-Ways-2018-ALICE-Report-8.13.18_Hires-1.pdf.

Figure 1.08 Financial hardship, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. For share “just getting by,” survey participants, when asked how well they were managing financially, responded that they were just getting by, finding it difficult, or finding it very difficult. Less than two months savings is based on participants’ estimate. Negative net worth is based on participants’ estimates of whether they would have money left over were their household to liquidate its assets and major possessions and pay off all debts. Transportation insecurity (hardship) is defined as the share of participants reporting that at some point in the past 12 months, they could not go somewhere due to lack of reliable transportation. Likewise, food insecurity (hardship) is defined as the share of participants reporting that at some point in the past 12 months, they were unable to afford to buy food they needed. Values are disaggregated by location and self-reported demographic groups. See Community Wellbeing Survey note at the beginning of this section.

Figure 1.09 Homeownership rate by race/ethnicity, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B25003, Tenure; B25003B, Tenure (Black or African American Alone Householder); B25003H, Tenure (White Alone, Not Hispanic or Latino Householder); and B25003I, Tenure (Hispanic or Latino Householder). Tables available at <https://factfinder.census.gov>.

Figure 1.10 Median renter household income and minimum household income to afford 2br housing, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B25031, Median Gross Rent by Bedrooms; B25042, Tenure by Bedrooms; and B25119, Median Household Income the Past 12 Months (in 2017 Inflation-Adjusted Dollars) by Tenure. Available at <https://factfinder.census.gov>. For comparison, we only studied two-bedroom apartments, both for median rent and median household income. Because some towns have few renters, leading to larger margins of error, values were filtered to only include towns with relatively small margins of error compared to median rent and where at least 20 percent of households were renter-occupied. Rent is considered affordable based on Federal Department of Housing and Urban Development (HUD) guidelines that housing costs total no more than 30 percent of a household’s total income. We calculated the minimum household income needed for the median rent of a two-bedroom apartment to be affordable under this guideline, and consider the shortfall to be the difference between this minimum household income and the median income of a renter household in a two-bedroom apartment.

See also HUD, “Defining Housing Affordability,” <https://www.huduser.gov/portal/pdredge/pdr-edge-featd-article-081417.html>.

Figure 1.11 Measures of municipal fiscal health and housing

DataHaven analysis (2019). Equalized net grand list (ENGL) is from the fiscal years 2013–2017 municipal fiscal indicators database from the Connecticut Office of Policy and Management (OPM), available at <https://portal.ct.gov/OPM/IGP-MUNFINSR/Municipal-Financial-Services/Municipal-Fiscal-Indicators>. Values included are for fiscal year 2017. ENGL is divided by 2017 town populations to get per-capita values. Municipal gap/surplus comes from the New England Public Policy Center. Municipal surplus per capita (2012) is the difference between a town’s municipal capacity per resident, or the amount of money from tax revenue available to that municipality, and municipal cost per resident, or the amount of money needed to cover the town’s estimated public expenses. Negative values signify a gap in funding available to cover those costs. See Zhao, B., & Weiner, J. (2015). Measuring municipal fiscal disparities in Connecticut. Federal Reserve Bank of Boston, New England Public Policy Center Research Report, 15-1. Median housing value comes from the U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B25077, Median Value (Dollars). Available at <https://factfinder.census.gov>. Data on housing permits from Connecticut Department of Economic and Community Development Export, Housing, and Income Data, available at https://portal.ct.gov/DECD/Content/About_DECD/Research-and-Publications/O1_Access-Research/Exports-and-Housing-and-Income-Data.

CHAPTER 2

Chapter 2 Dashboard Indicators

Premature death rate (YPLL-75) per 100,000 residents per year, 2008–2012 and 2010–2014: breast cancer; drug overdoses; fetal/infant death; heart disease; and suicide

See Figure 2.03.

Rate of non-adequate prenatal care, 2006–2010 and 2011–2015

See Figure 2.05.

Figure 2.01 Share of adults reporting self-rated health as excellent or very good, 2018

DataHaven analysis (2019) of question from the 2018 DataHaven Community Wellbeing Survey. The indicator shown here indicates the percentage of adults who answered affirmatively to the questions shown. Data are disaggregated by household income. See Community Wellbeing Survey note at the beginning of this section.

Figure 2.02 Estimated life expectancy in years, 2010–2015

DataHaven analysis (2019) of National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015. National Center for Health Statistics. 2018. Available from <https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html>. Town and regional averages were calculated as population-weighted means of available Census tract values. See also Arias, E., Escobedo, L. A., Kennedy, J., Fu, C., & Cisewski, J. (2018). U.S. Small-area Life Expectancy Estimates Project: Methodology and Results Summary. Vital and Health Statistics. Series 2, Data Evaluation and Methods Research, (181), 1–40.

Figure 2.03 Years of potential life lost before age 75 per 100,000 residents by leading causes of premature death, 2008–2012 and 2010–2014

DataHaven analysis (2019) of data from the Connecticut Department of Public Health. For Years of Potential Life Lost (YPLL), we created annualized YPLL rates (or “Premature Death Rates”) by cause using the 2008–2012 and 2010–2014 datasets at the town level; geographies presented here include the state and the Valley Region. Data represent annualized averages over these five year period of time. We calculated the YPLL rate as the sum of the YPLL divided by (the total population under 75 years old*5)*100,000. The average YPLL under 75 years of age, or “Years Lost Per Death,” was calculated by taking the sum of the YPLL divided by the number of deaths under 75 years of age. For YPLL due to fetal/infant deaths (summed fetal deaths plus infant deaths), we used annualized CTDPH data and used an average age at death of 0.5 years, hence the average YPLL of 74.5 years per death computed for these deaths as the basis of the comparison to standard causes of death.

Figure 2.04 Years of potential life lost before age 75 per 100,000 residents by selected causes of death, 2010–2014

See note for Figure 2.03. Geographies presented here include the Valley Region and its individual towns.

Figure 2.05 Birth outcomes, 2006–2010 and 2011–2015

DataHaven analysis (2019) of data from the Connecticut Department of Public Health Vital Statistics for the 2006–2010 and 2011–2015 periods, available at <https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports>. Low birthweight is defined as 2,500 grams (roughly 5.5 pounds). Non-adequate prenatal care indicate that the mother attended fewer than 80 percent of expected prenatal care visits, or did not start attended visits until the second trimester. Both the low birthweight rate and non-adequate prenatal care rates are given as a percent of total births for each of the 5-year periods. Percent change in both indicators are given as a percent change in the rate of each.

Figure 2.06 Lead Poisonings and Screenings, 2013–2016

DataHaven analysis (2019) of data from the Connecticut Department of Public Health, Lead and Healthy Homes Program - Annual Disease Surveillance Reports for 2013 and 2016, available at <https://portal.ct.gov/DPH/Environmental-Health/Lead-Poisoning-Prevention-and-Control/Surveillance-and-Screening>. Note that the Centers for Disease Control and Prevention (CDC) changed its guidelines in 2012: elevated blood lead levels, previously defined as 10 ug/dL, are now defined as 5 ug/dL.

Figure 2.07 Asthma prevalence by public school district, 2009–2011 and 2012–2014

DataHaven analysis (2019) of data from the Connecticut Department of Public Health School-Based Asthma Surveillance Reports of 2014 and 2019, available at <https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/Asthma/Asthma-Burden-Report>.

Figure 2.08 Annual absolute and relative age-adjusted encounter rates per 10,000 residents, 2012–2014 and 2015–2017

DataHaven analysis (2019) of CHIME data. 2018. Data about residents’ visits to hospitals and emergency rooms may be used as a tool to examine

variations in health and quality of life by geography and within specific populations. Unless otherwise noted, all information from this source is based on a DataHaven analysis of 2012–2014 and 2015–2017 CHIME data provided by the Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven.

The CHIME hospital encounter data extraction included de-identified information for each of over 10,000,000 Connecticut hospital and emergency department encounters incurred by any residents of any town in Connecticut during the six year period studied. Any encounter incurred by any resident of these towns at any Connecticut hospital would be included in this dataset, regardless of where they received treatment. Each encounter observation had a unique encounter ID and was populated with one or more “indicator flags” representing a variety of conditions. Each encounter could include multiple indicator flags. Because CHIME is Connecticut-based, only hospital encounters occurring in CT were captured; therefore, encounters for individuals residing in CT towns bordering other states are more likely under-reported in some cases.

Annualized encounter rates were calculated for the indicator flags assigned within the dataset including Asthma, COPD, Substance Abuse, and many other conditions. Analyses in this document describe data on “all hospital encounters” including inpatient, emergency department (ED), and observation encounters. Annualized encounter rates per 10,000 persons were calculated for the three-year period 2012–2014 and the three-year period 2015–2017 by merging CHIME data with population data. For each geographic area and indicator, our analysis generally included an annualized encounter rate for populations in each of six age strata (0–19, 20–44, 45–64, 65–74, 75–84, and 85+ years), and by gender, as well as a single age-adjusted annualized encounter rate. It is important to note that there is no way to discern the unique number of individuals in any zip code, town, area or region who experienced hospital encounters during the period under examination or the number of encounters that represented repeat encounters by the same individual for the same or different conditions. To better examine encounter rates for asthma, a more appropriate set of age groupings was used (0–4, 5–19, 20–44, 45–64, 65–74, and 75+ years), so age-adjusted rates were not calculated for asthma. Please contact DataHaven for further information.

Figure 2.09 Chronic disease, encounter rates per 10,000 residents 2015–2017
See Figure 2.08.

Figure 2.10 Access to healthcare, 2018
DataHaven analysis (2019) of questions from the 2018 and 2015 DataHaven Community Wellbeing Survey. Survey participants were asked several questions about their access to and use of medical care, including whether at any point in the previous 12 months they postponed or did not receive medical care they needed. See Community Wellbeing Survey note at the beginning of this section.

Figure 2.11 Health risk factors, 2018
DataHaven analysis (2019) of questions from 2018 and 2015 DataHaven Community Wellbeing Survey. Adult respondents were asked to rate their overall health; report recent levels of depression and anxiety; and report whether they had even been told by a doctor or medical professional that they had diabetes or asthma. Participants reported their height and weight, from which their body mass index (BMI) was

calculated; obesity in adults is defined as a BMI of 30 or higher. For food insecurity—referred to as “food hardship” in this report—participants were asked whether there had been times in the past 12 months that they did not have enough money to provide food for their families. Smoking rates were calculated based on the number of participants who estimated having smoked at least 100 cigarettes in their entire lives; those who said they had were then asked whether they smoked every day, some days, or not at all. Smoking prevalence for the entire population was then extrapolated from these two figures. Participants were asked to self-report whether they currently have health insurance, and whether they had seen a dentist in the past 12 months. See Community Wellbeing Survey note at the beginning of this section.

Figure 2.12 Recent feelings of anxiousness or depression, 2018
DataHaven analysis (2019) of questions from 2018 and 2015 DataHaven Community Wellbeing Survey. Adult respondents were asked how frequently they felt depressed or anxious in the past 30 days. These numbers reflect the share of respondents who felt mostly or completely anxious, or reported that they were depressed more than half the days. Values are disaggregated by location and self-reported demographic groups. See Community Wellbeing Survey note at the beginning of this section.

Figure 2.13 Age-adjusted monthly rate of drug overdose deaths per 1 million residents, 2012–2018
DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at <https://data.ct.gov/resource/rybz-nyjw>. Data is given for each individual to have died in Connecticut of a drug overdose from 2012 to 2018. For this analysis, data was filtered to only include people with a Connecticut town listed as their place of residence at the time of death and with their age on record. Monthly counts by age were used to calculate crude rates of overdose deaths per 1 million residents of each age group. To get age-adjusted rates, crude rates by age group were then weighted with the U.S. Centers for Disease Control and Prevention (CDC) 2000 U.S. Standard Population 18 age group weights available at <https://seer.cancer.gov/stdpopulations>. The rates shown here are 6-month rolling averages; that is, the rate for any given point shown in the chart represents the age-adjusted overdose death rate for that month averaged with the rates of the five months preceding it.

Figure 2.14 Overdose deaths by substance, 2015–2018
DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at <https://data.ct.gov/resource/rybz-nyjw>. Shown here are aggregated counts of accidental overdose deaths between 2015 and 2018, with annualized age-adjusted rates over that period. In data on drug overdose deaths, individuals are marked for several common substances that may be found by the medical examiner, and may also have a more detailed cause of death written out. The categories in the data include heroin, fentanyl, and generic names of several opioids, such as oxycodone and hydromorphone. We used text mining techniques to find additional names of opiates and opioids from the cause of death text in order to fill in cases where those substances were not checked off otherwise, relevant substances didn't fit into a given category, or where substances were misspelled or abbreviated. In total, more than a dozen substances were included as search terms to mark a death as opiate- or opioid-related; these deaths may have involved non-opiates as well. Similarly, cases

were marked as fentanyl-related if either checked categories or text fields reported fentanyl or any fentanyl-analogues being found. See Figure 2.13 for details on age-adjustment.

Figure 2.15 Substance abuse, encounter rates per 10,000 residents 2015–2017
See Figure 2.08.

Figure 2.16 Infectious diseases, 2014–2018
Data on select communicable disease cases reported to the Naugatuck Valley Health District (NVHD) from 2014–2018. See NVHD Annual Report, 2017–2018.

CHAPTER 3

Chapter 3 Dashboard Indicators
SBAC pass rates for English/language arts and math, 2014–2015 and 2017–2018
See Figure 3.05. Figures for 2014–2015 school year also come from CTSDE via EdSight.

Four-year high school graduation rate, class of 2011 and class of 2017
See Figure 3.05. Figures for class of 2011 also come from CTSDE via EdSight.

Chronic absenteeism rate, 2013–2014 and 2017–2018
See Figure 3.05. Figures for 2013–2014 school year also come from CTSDE via EdSight.

Students eligible for free or reduced-price meals, 2014–2015 and 2018–2019
See Figure 3.05. Figures for 2014–2015 school year also come from CTSDE via EdSight.

Share of three- and four-year-olds enrolled in preschool, 2000–2017
See Figure 3.01.

Figure 3.01 Share of three- and four-year-olds enrolled in preschool, 2000–2017
DataHaven analysis (2019). 2000 preschool enrollment figures are from the U.S. Census Bureau Decennial Census, Summary File 3 Table PCT23, Sex by School Enrollment by Age for the Population 3 Years and Over. 2017 preschool enrollment figures are from U.S. Census Bureau American Community Survey 2017 5-year estimate, Table B14003, Sex by School Enrollment by Age for the Population 3 Years and Over, available at <https://factfinder.census.gov>.

Figure 3.02 Childcare capacity for infants and toddlers under age three, 2018
DataHaven analysis (2019) of data from the 2-1-1 Child Care Annual Capacity, Availability and Enrollment Survey, available at <https://www.211childcare.org/reports/annual-survey-2018>. Note that childcare provider slot capacity is calculated as enrolled slots plus vacant slots.

Figure 3.03 Share of K–12 students by race/ethnicity, 2018–2019
DataHaven analysis (2019) of 2018–2019 school year enrollment data from the Connecticut State Department of Education, accessed via EdSight at <http://edsight.ct.gov>. For this and other indicators based on public school districts, regional districts were included as parts of regions to which their sending towns belong; in some cases, these towns also run their own districts for elementary school, but send middle and/or high school students to the regional district.

Figure 3.04 High-needs students, 2018–2019

See Figure 3.03.

Figure 3.05 Share of public K–12 students meeting achievement measures, 2017–2018

DataHaven analysis (2019) of data from the Connecticut State Department of Education, accessed via EdSight at <http://edsight.ct.gov>. Graduation rates presented are four-year cohort graduation rates, giving the percentage of students in the graduating class of 2017 who earned a high school diploma alongside the cohort with which they started 9th grade. A student is considered chronically absent if they miss at least 10 percent of the school days for which they were enrolled in a year for any reason; the chronic absenteeism rate is then the percentage of enrolled students who are chronically absent in a year. The Smarter Balanced Assessment Consortium (SBAC) standardized test is the Common Core-aligned test used in Connecticut since 2015 for both English/language arts (ELA) and math. Students are considered to pass a test if they score as meeting or exceeding grade-level goals; proficiency rates here are the share of students taking each test who passed. Chronic absenteeism and SBAC proficiency rates are from the 2017–2018 school year.

Figure 3.06 Chronic absenteeism, 2013–2014 and 2017–2018

See Figure 3.05. Figures for 2013–2014 school year also come from CTSDE via EdSight.

Figure 3.07 Four-year high school graduation rate, class of 2011 and class of 2017

See Figure 3.05. Figures for class of 2011 also come from CTSDE via EdSight.

Figure 3.08 Number and percentage of students enrolling in, persisting in, and graduating from college

DataHaven analysis (2019) of data from the Connecticut State Department of Education, accessed via EdSight at <http://edsight.ct.gov>. Enrollment rates are defined as the percentage of students from a given graduating class who enroll in college within one year of graduation. Persistence rates are defined as the percentage of students who, after enrolling in college within one year of high school, continue into a second, consecutive year of college. Attainment rates are the percentage of students who earn a two- or four-year degree within six years of graduating high school, out of the entire high school graduating class. The most recent available data is shown here, which is the high school graduating class of 2014 for graduation, enrollment, and persistence rates, and the class of 2010 for degree attainment rates.

CHAPTER 4

Chapter 4 Dashboard Indicators

Population growth for seniors (ages 65+), younger seniors (ages 65–79), and older seniors (ages 80+), 1990–2017

See Figure 1.01

Population projection for seniors (ages 65+), younger seniors (ages 65–79), and older seniors (ages 80+), 2017–2035

See Figure 4.01.

Figure 4.01 Share of senior population ages 65+, 2017–2035

DataHaven analysis (2019). Population by age are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B01001.

2035 projected figures are from the Connecticut State Data Center (2017) 2015–2040 Population Projections—Town Level. Available at <https://data.ct.gov/resource/hxnh-2e3k>.

CHAPTER 5

Chapter 5 Dashboard Indicators

Job count, 2000–2017

See Figure 5.02.

Share of residents with at least a bachelor's degree, 2000–2017

See Figure 5.08. 2000 figures are from the U.S. Census Bureau Decennial Census, Table P037, Sex by Educational Attainment for the Population 25 Years and Over.

Annual average wage, 2000–2017

See Figure 5.02.

Figure 5.01 Number of jobs by sector, 2000–2017

DataHaven analysis (2019) of U.S. Census Bureau Quarterly Workforce Indicators, available at <http://qwexplorer.ces.census.gov/> at the county level, for Fairfield and New Haven Counties. Industries are categorized based on the North American Industry Classification System (NAICS); those shown are the top 8 sectors by number of jobs in 2017. Numbers shown for 2000 and 2017 are their respective years' annual averages, not quarterly counts.

Figure 5.02 Job and wage growth by town, 2000–2017

DataHaven analysis (2019) of Connecticut Department of Labor Quarterly Census of Employment and Wages (QCEW) by town, available at https://www1.ctdol.state.ct.us/lmi/202/202_annualaverage.asp. Values included are annual averages. Annual average wages are inflation-adjusted to 2017 dollars. Note, town-level QCEW data should be treated as estimates and may differ slightly from data available elsewhere.

Figure 5.03 Net job growth, 2000–2017

See Figure 5.02.

Figure 5.04 Job count by town, 2017

See Figure 5.02.

Figure 5.05 Where Valley residents work, 2015

DataHaven analysis (2019) of U.S. Census Bureau Longitudinal Employer-Household Dynamics Origin-Destination Employment Statistics, available at <http://lehd.ces.census.gov/data/>. For the purposes of this figure, Eastern Connecticut is defined as Middlesex, New London, Tolland, and Windham Counties; Greater Bridgeport is defined as the towns of Bridgeport, Easton, Fairfield, Monroe, Stratford, and Trumbull; Greater Hartford includes all of Hartford County; Greater New Haven includes the towns of Bethany, Branford, East Haven, Guilford, Hamden, Madison, Meriden, Milford, New Haven, North Branford, North Haven, Orange, Prospect, Wallingford, West Haven, and Woodbridge; Greater Waterbury includes the towns of Cheshire, Middlebury, Plymouth, Southbury, Thomaston, Waterbury, Watertown, Wolcott, and Woodbury; Lower Fairfield County includes the towns of Darien, Greenwich, New Canaan, Norwalk, Stamford, Weston, Westport, and Wilton; Western Connecticut includes the towns of Barkhamsted, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Colebrook, Cornwall, Danbury, Goshen, Harwinton, Kent, Litchfield, Morris, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, North Canaan, Redding, Ridgefield, Roxbury, Salisbury, Sharon,

Sherman, Torrington, Warren, Washington, and Winchester. The Valley is the region as defined in this report. Valley workers working outside of Connecticut hold jobs in Massachusetts, New Jersey, New York, Pennsylvania, or Rhode Island.

Figure 5.06 Commuter import/export 2017, jobs and employment

See Figure 5.02. Employment figures for 2017 are DataHaven analysis (2019) of town-level annual averages from Local Area Unemployment Statistics (LAUS), available at <https://www1.ctdol.state.ct.us/lmi/laus/default.asp>. Commuter import/export is the total number of employed residents in a town subtracted from the total number of jobs available in that town. While not all jobs in any given town are held by workers residing in that town, commuter import/export highlights the mismatch between the number of employed residents living in the Valley and the number of jobs in the region.

Figure 5.07 Transportation in the Valley, 2018

DataHaven analysis (2019) of questions from the 2018 and 2015 DataHaven Community Wellbeing Survey. The share of adults with access to a car often is the share of respondents reporting they had that access “very often” or “fairly often.” Data are disaggregated by geographic area, self-reported age group, and household income. See Community Wellbeing Survey note at the beginning of this section.

Figure 5.08 Educational attainment, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B15003, Educational Attainment for the Population 25 Years and Over. Available at <https://factfinder.census.gov>.

Endnotes

- 1 Organisation for Economic Co-operation and Development (OECD). (2014). Report on the OECD framework for inclusive growth. Meeting of the OECD Council at Ministerial Level, Paris, 6–7 May 2014. Available at http://www.oecd.org/mcm/IG_MCM_ENG.pdf.
- 2 Levy, D., Rodriguez, O., & Villemez, W. (2004). The Changing Demographics of Connecticut—1990 to 2000. Part 2: The Five Connecticut. Storrs, Connecticut: University of Connecticut, Center for Population Research, Series, no. OP 2004-01. Available at <https://www.ctdatahaven.org/data-resources/changing-demographics-connecticut-%E2%80%9494%C2%A01900-2000-part-2-five-connecticuts>.
- 3 DataHaven analysis (2019) of Connecticut State Library. Statistics for Connecticut Public Libraries. Available at <http://libguides.ctstatelibrary.org/dld/stats>.
- 4 DataHaven analysis (2019) of Connecticut Secretary of State. Election Information and Statistics. Available at <https://portal.ct.gov/SOTS/Election-Services/V5-Side-Navigation/ELE---Election-Information>. Voter turnout is defined as the percentage of officially registered voters who are checked as having voted. This includes overseas ballots but does not include absentee voters.
- 5 DataHaven analysis (2019) of crime rates from the Connecticut Department of Emergency Services and Public Protection. Uniform Crime Reporting Program. Available at <https://www.dpsdata.ct.gov/dps/ucr/ucr.aspx>. Violent crime is defined by the FBI as aggravated assault, rape, robbery, and murder. Crime rates referenced are averages of 2013–2014 and 2016–2017 rates.
- 6 See notes for Figure i.04.
- 7 Ibid.
- 8 See notes for Figure i.05.
- 9 Ibid.
- 10 See notes for Figure 1.02.
- 11 Ibid.
- 12 Ibid.
- 13 Ibid.
- 14 See notes for Figure 1.04.
- 15 DataHaven analysis (2019). 1990 figures are from U.S. Census Bureau Decennial Census SF3 Table P42, accessible via Census Data API. 2017 figures are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B05001, Nativity and Citizenship Status in the United States. Available at <https://factfinder.census.gov>.
- 16 See notes for Figure 1.06.
- 17 Ibid.
- 18 See notes for Ch. 1 Dashboard Indicator: Median household income, 1990–2017.
- 19 See notes for Ch. 1 Dashboard Indicator: Poverty rate, 2000–2017.
- 20 U.S. Department of Health & Human Services. 2017 Poverty Guidelines. Available at <https://aspe.hhs.gov/2017-poverty-guidelines>.
- 21 See notes for Ch. 1 Dashboard Indicator: Low-income rate, 2000–2017.
- 22 United Way of Connecticut. (2018). ALICE: A study of financial hardship in Connecticut. Retrieved from http://alice.ctunitedway.org/wp-content/uploads/2018/08/CT-United-Ways-2018-ALICE-Report-8.13.18_Hires-1.pdf
- 23 See notes for Figure 1.07.
- 24 Ibid.
- 25 See notes for Figure 1.08.
- 26 Ibid.
- 27 See notes for Ch. 1 Dashboard Indicator: Homeownership rate, 1980–2017.
- 28 See notes for Figure 1.09.
- 29 DataHaven. (2018). Connecticut Community Well-being Survey. Available at <http://ctdatahaven.org/reports/datahaven-communitywellbeing-survey>.
- 30 U.S. Census Bureau. (2017). American Community Survey 5-year estimates. Tables B25074, Household Income by Gross Rent as a Percentage of Household Income in the Past 12 Months; and B25091. Available at <https://factfinder.census.gov>. See also https://www.hud.gov/program_offices/comm_planning/affordablehousing/.
- 31 See notes for Figure 1.10.
- 32 See notes for Ch. 1 Dashboard Indicator: Median housing values, 2000–2017.
- 33 See notes for Figure 1.10.
- 34 Ibid.
- 35 See <https://ct.211counts.org/>.
- 36 Ibid.
- 37 DataHaven analysis (2019). 2-1-1 Connecticut. Housing & shelter requests, 2014–2018. Provided for the purposes of this report. Counts used to calculate rates include both met and unmet requests.
- 38 Ibid.
- 39 Zhao, B., & Weiner, J. (2015). Measuring municipal fiscal disparities in Connecticut. *Federal Reserve Bank of Boston, New England Public Policy Center Research Report*, 15-1. Retrieved from <https://www.bostonfed.org/publications/new-england-public-policy-center-research-report/2015/measuring-municipal-fiscal-disparities-in-connecticut.aspx>. Note that this analysis only takes into account “nonschool” public services.
- 40 See notes for Figure 1.11.
- 41 Ibid.
- 42 Ibid.
- 43 U.S. Census Bureau. (2017). American Community Survey 5-year estimates. Table B25024, Units in Structure. Available at <https://factfinder.census.gov>.
- 44 See notes for Figure 1.11.
- 45 DataHaven analysis (2019) of 2018 data from Naugatuck Valley Council of Governments. Brownfields are defined by state law as “any abandoned or underutilized site where redevelopment, reuse or expansion has not occurred due to the presence or potential presence of pollution in the buildings, soil or groundwater that requires investigation or remediation before or in conjunction with the redevelopment, reuse or expansion of the property.” More information available from the Connecticut Office of Brownfield Remediation and Development at <http://www.ct.gov/ctbrownfields>.
- 46 See notes for Figure 2.01.
- 47 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. (2017). BRFSS Prevalence & Trends Data. 2017 data. Available at <https://www.cdc.gov/brfss/brfssprevalence>
- 48 DeSalvo, K.B., Bloser, N., Reynolds, K., He, J., & Muntner, P. (2006). Mortality prediction with a single general self-rated health question: A meta-analysis. *Journal of General Internal Medicine*, 21(3), 267–275. <https://doi.org/10.1111/j.1525-1497.2005.00291.x>
- 49 Hero, J., Zaslavsky, A. M., & Blendon, R. J. (2017). The United States leads other nations in differences by income in perceptions of health and health care. *Health Affairs*, 36(6), 1032–40. <https://doi.org/10.1377/hlthaff.2017.0006>
- 50 See notes for Figure 2.02.
- 51 Statement is in reference to tract 09009125200 in Ansonia and tract 09001110600 in Shelton.
- 52 See notes for Figures 2.13 and 2.03.
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Conclusion

By evaluating the trends included in this report, we can better understand where the Valley Region is making progress and where there are opportunities for improvement. Just as an individual's health and well-being are impacted by many interrelated factors, so too is that of the overall community. By using data to identify disparities and inform the actions we take to strengthen the vibrancy, connectedness, and well-being of our region, we can build upon the Valley's high quality of life for years to come, and ensure that all of our residents are thriving. What affects each of us, affects us all.

In the Valley, disparities exist both geographically and demographically. The town or even street where Valley residents live has an impact on their opportunities for success and overall well-being. Furthermore, disparities between racial and ethnic groups, high- and low-income residents, and various age groups have implications for the region as a whole, particularly in light of the increasing diversity among younger residents and the increasing size of the senior population.

It will require the collective efforts of residents, community leaders, and many other stakeholders throughout the Valley to create informed strategies to achieve both short- and long-term impact. The more that we know about ourselves and each other, the better we are able to engage in meaningful dialogues that will foster a more equitable and inclusive Valley for all.

VALLEY COMMUNITY FOUNDATION

253-A Elizabeth Street
Derby, CT 06418
203.751.9162
contactus@valleyfoundation.org
www.valleyfoundation.org

Established in 2004, supported by local donors and governed by civic-minded individuals, the Valley Community Foundation (VCF) serves as the Lower Naugatuck Valley's permanent philanthropic vehicle investing more than a million dollars annually to support the local nonprofit sector. With more than \$26 million in assets, VCF's mission is to make the Valley a better place to live and work, both now and in the future, by connecting private philanthropy to the long-term public good of the Valley.

DATAHAVEN

129 Church Street, Suite 605
New Haven, CT 06510
203.500.7059
info@ctdatahaven.org
www.ctdatahaven.org

DataHaven is a non-profit organization with a 25-year history of public service to Greater New Haven and Connecticut. Its mission is to improve quality of life by collecting, sharing, and interpreting public data for effective decision making. DataHaven is a formal partner of the National Neighborhood Indicators Partnership of the Urban Institute in Washington, DC.