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

Connecticut, September, 2010

A Report to

Rosa M. Biaggi, MPH, MPA
PI, Maternal, Infant, and Early Childhood Home Visiting Program
Director, Title V MCH Block Grant
Chief, Family Health Section
Connecticut Department of Public Health

By

The Connecticut Home Visiting Needs Assessment Group

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Membership

The Connecticut Home Visiting Needs Assessment Group

Carol L Stone, PhD, MPH, MA, MAS, *Administrator*
Supervising Epidemiologist, State of Connecticut Department of Public Health

Connecticut Commission on Children **(COC)**
Dawn Homer-Buithiette, Parent Engagement and Family Policy Director
Elaine Zimmerman, Executive Director

State of Connecticut Department of Children and Families **(DCF)**
Rudolph Brooks, Bureau Chief for Prevention
DeAnna Lia, Director of Prevention

State of Connecticut Department of Corrections **(DOC)**
Michelle Hayward, Counselor Supervisor

State of Connecticut Department of Developmental Services **(DDS)**
Linda Goodman, Director, Birth To Three System
Lynn Johnson, Assistant Director, Birth To Three System

State of Connecticut Department of Education **(SDE)**
Andrea Brinnel, M Ed, Education Consultant
Louis Tallarita, MSW, Education Consultant

State of Connecticut Department of Mental Health and Addictive Services **(DMHAS)**
Elaine Flynn-York, LCSW, Behavioral Health Clinical Manager
Terry Nowakowski, LCSW, Assistant Director of Statewide Services

State of Connecticut Department of Public Health **(DPH)**
Rosa M. Biaggi, MPH, MPA, Chief, Family Health Section, State Title V Director
Janet Brancifort, MPH, Public Health Services Manager
Lisa Davis, RN, MBA, Chief, Public Health Initiatives Branch
Linda Ferraro, Office of Oral Public Health
Mark Keenan, RN, MBA, Supervising Nurse Consultant, State Title V CYSHCN Director
Donna Maselli, RN, MPH, Nurse Consultant
Kevin Sullivan, Health Program Associate

State of Connecticut Department of Social Services **(DSS)**
Laura Victoria Barrera, State Healthy Start Program
Linda Harris, Program Director
Karen Foley-Schain, Executive Director, Children's Trust Fund
Grace-Ann Whitney, PhD, MPA, Director, Head Start State Collaboration Office

Child FIRST Connecticut
Darcy Lowell, MD, Executive Director
Mary Peniston, MPA, Associate Director

Child Health and Development Institute of Connecticut **(CHDI)**
Judith Meyers, PhD, President and CEO

SERC
Pam Langer, MA, State Leader, ConnPAT

University of Connecticut School of Medicine
Mary Beth Bruder, PhD, Director, Center for Excellence in Developmental Disabilities
Molly Cole, Associate Director, Center for Excellence in Developmental Disabilities

Women's Health Subcommittee, Medicaid Care Management Oversight Council
Amy Gagliardi, MA, IBCLC, RLC, Chair

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I. At Risk Communities[1] in Need for Maternal, Infant, and Early Childhood Visiting Services within Connecticut

Connecticut Demographics

Resident Population

Connecticut, a state of 5,544 square miles in the northeast portion of country, was home to an estimated 3,501,252 people in 2008 (Backus & Mueller, 2009). The State neighbors Rhode Island, Massachusetts, and New York. Twelve percent of its residents in 2008 were under the age of 10 years, and an additional 14% were between the ages of 10 and 19 years. Among all residents of Connecticut, 74% were non-Hispanic White/Caucasian, 10% were non-Hispanic Black/African American, and 12% were Hispanic. Fifty-one percent of the population was female, and among all women in the State, 39% were of childbearing age (15-44 years old). Among all women of childbearing age, 70% were non-Hispanic White/Caucasian, 12% were non-Hispanic Black/African American, and 15% were Hispanic. The distribution of minority race/ethnicities among women of childbearing age was, therefore, elevated relative to the total population.

Connecticut residents are distributed among 169 towns and eight counties. Whereas the majority of towns within Connecticut in 2008 had a population at or below the average town size of 20,717, a number of towns exceeded this average (**Table I and Appendix 1**; DPH, 2009a). Thirty-one towns exceeded this average by one standard deviation, with a population of no more

Table I
Large Towns and High Unemployment in Connecticut, 2008

County	Number of Towns	Number of Large Towns [1]	Number of Towns with High Unemployment [2]	Large Towns with High Unemployment [3]
Fairfield	23	12	2	Bridgeport, Stratford
Hartford	29	16	8	Bloomfield, Bristol, East Hartford, Hartford, New Britain
Litchfield	26	3	5	Torrington, Watertown
Middlesex	15	1	1	
New Haven	27	13	10	East Haven, Meriden, Naugatuck, New Haven, Waterbury, West Haven
New London	21	3	5	New London, Norwich
Tolland	13	2	1	
Windham	15	1	9	Windham
Total	**169**	**51**	**41**	

[1] - number of towns with an estimated population size that exceeds the state's average town size of 20,717.
[2] - number of towns with an unemployment rate that exceeds the statewide average of 5.7%.
[3] - towns with both a population that exceeds 20,717 and an unemployment rate that exceeds 5.7%.

Source: C. Stone (2010) Connecticut Department of Public Health, Hartford, Connecticut.

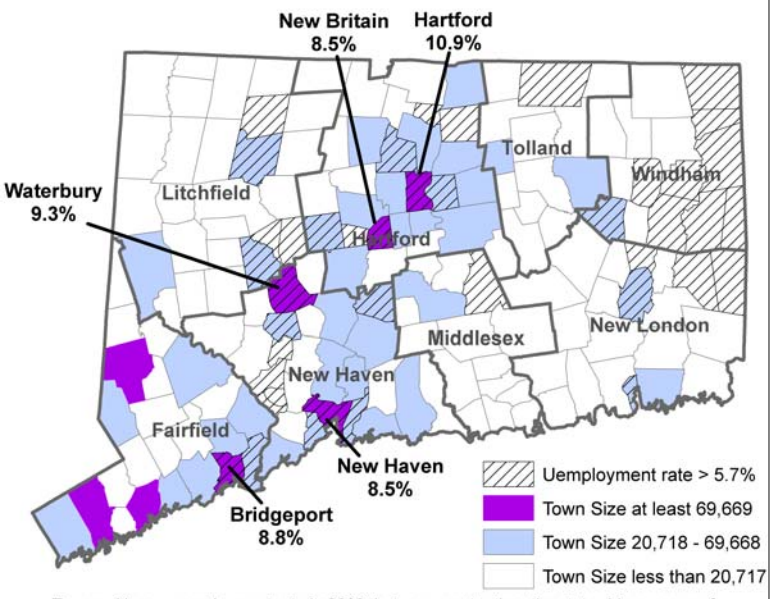
[1] The term "community" for the purposes of determining those at risk for maternal, infant, and early childhood services in Connecticut will be the sub-geographies of towns, or, in the case of rural areas of the state, clusters of towns.

than 45,193, and twelve additional towns exceeded this average by two standard deviations (population up to 69,668). Only eight towns exceeded a population size of 69,668. These towns were Bridgeport (136,405), Hartford (124,062), New Haven (123,669), Stamford (119,303), Waterbury (107,037), Norwalk (83,185), Danbury (79,256), and New Britain (70,486). Among the 29 towns located within Hartford County, over 50% (16) exceeded the State's average town size of 20,717. Fairfield and New Haven Counties also had over 50% large towns. Litchfield, Middlesex, New London, and Tolland Counties, however, had far fewer large towns.

Unemployment

Compared to a statewide unemployment rate in 2008 of 5.7%, and a U.S. unemployment rate of 5.8% (U.S. Department of Labor, 2010a), the unemployment rate within the eight towns in Connecticut with the highest resident population varied from a low of 4.7% to a high of 10.9% (Connecticut Economic Resource Center, 2009; **Map 1 and Appendix 1**). Towns with the highest unemployment rates included Hartford (10.9%), Waterbury (9.3%), Bridgeport (8.8%), and New Britain and New Haven (8.5%). In contrast, the towns of Stamford, Norwalk, and Danbury, also with a high resident population, had unemployment rates below the statewide average. A total of 41 towns in the State had an unemployment rate that was greater than the statewide average (etched areas). Of all the towns in the State with a higher than average unemployment rate, 60% (9 of 15) were located in Windham County, 37% (10 of 27) were in New Haven County, and 27% (8 of 29) were in Hartford County (**Map 1** and **Table I**). Only two towns with high unemployment rates were located in Fairfield County. Of all the 41 towns with high unemployment, only 18 had a population size that exceeded the statewide average size. Some towns with a high level of unemployment are classified by the Connecticut State Office or Rural Health as rural towns (http://ruralhealthct.org/towns.htm), with small resident population size. Eight towns in Windham County, for instance, had a small resident population and a high concentration of unemployment. These data indicate that although large urban areas of the State have the greatest concentration of Connecticut residents at risk for adverse social and medical outcomes, other

Map 1
Estimated Population and Unemployment Rates
Connecticut, 2008



Towns with an unemployment rate in 2008 that was greater than the statewide average of 5.7% are shown. The average town population in 2008 was 20,717, and the town size that was two standard deviations greater than the statewide average was 69,669.

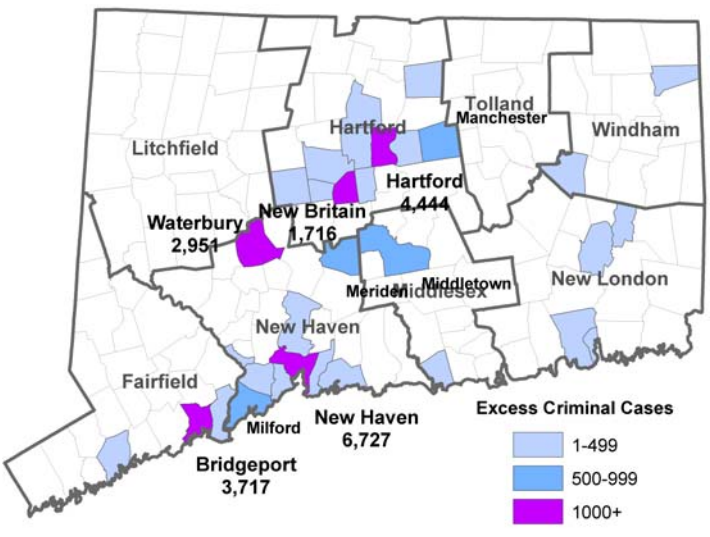
Source: C. Stone (2010) Connecticut Department of Public Health, Hartford, Connecticut
Town population estimates for 2008 were obtained from HISR, DPH
(http://www.ct.gov/dph/lib/dph/hisr/hcqsar/population/excel/pop_towns2008.xls).
Town unemployment rates for 2008 were obtained from town profiles generated by the Connecticut Economic Resource Center (http://www.cerc.com/TownProfiles/default.asp).

areas surrounding these larger cities are also of increased concern, as well as some rural areas of the State. The State's unemployment rate has increased since 2008 to a high of 9.2% in March, 2010 (U.S. Department of Labor, 2010b), indicating that unemployment rates across the State worsened. In June, 2010, the unemployment rate in the State had dropped to 8.8%, but unemployment in selected areas of the State remained quite high (Connecticut Department of Labor, 2010). In the towns of Hartford, Waterbury, Bridgeport, New Britain, and New Haven, for instance, unemployment was at 15.5%, 14.1%, 13.3%, 12.4%, and 12.7%, respectively. These figures are well above the unemployment rates that existed just two years earlier.

Homelessness

An extreme consequence of unemployment is poverty and homelessness. On the evening of January 28 2009, 3,320 households in Connecticut were living in homeless shelters, and 430 of these households were families, with a total of 801 children (Connecticut Coalition to End Homelessness, 2009). From January through March, 2009, 222 young children (up to five years of age) entered shelters for the homeless across the State, representing 48% of all children entering homeless shelters, and 8.3% of the shelter population (G. Whitney, DSS, *personal communication*). Programs funded by DSS through the U.S. American Recovery and Reinvestment Act serves five regions of the State, as well as the towns of Bridgeport, Hartford, New Britain, New Haven, and Waterbury (Connecticut Coalition to End Homelessness, 2010). Children of homeless families are among the most fragile and of the highest need within the State. Services to this sub-population need to be a priority, yet it is unclear what existing home visiting programs in the State serve this very vulnerable population. Community-based needs assessments, such as that prepared by Head Start and Early Head Start programs, are needed in the State and could include a future component to assess home visiting.

Map 2
Uniform Crime in Connecticut, 2008
Exess Criminal Cases



Excess criminal cases in calendar year 2008 wre calculated for all towns in the state based on a statewide crime rate of 2,805 per 100,000 people.

Source: C. Stone, Connecticut Department of Public Health, Hartford, Connecticut. Crime statistics were obtained from the Department of Public Safety (http://www.dir.ct.gov/dps/ucr/ucr.aspx).

Crime

Throughout the state of Connecticut in calendar year 2008, there were a total of 98,210 uniform crime reports (State of Connecticut Department of Public Safety, 2010). There were 128 reported murders, 685 rapes, 4,049 robberies, and 5,906 aggravated assaults. There were 63,497 cases of larceny that included largely items

stolen from motor vehicles or buildings, and shoplifting. The overall crime rate in the State was 2,805 per 100,000 people. Scattered across Connecticut were clusters of towns with excess criminal cases [2] (**Map 2**). Relative to the overall crime rate, towns with a very high number of excess criminal cases included New Haven, with 6,727 excess cases of crime, followed by Hartford (4,444), Bridgeport (3,717), Waterbury (2,951) and New Britain (1,716). Other towns with excess criminal cases of at least 500 included Manchester (697), Milford (616), Middletown (581), and Meriden (579). All towns with an excess number of criminal cases had a population of at least 48,000. Smaller towns, such as East Windsor, Plainville, and Orange, had elevated numbers of excess criminal cases (171, 164, and 109, respectively).

Although higher than expected crime rates were scattered across the State and most counties, large excess criminal cases were concentrated in urban areas of the State and neighboring towns. For instance, although New Haven had a very high excess number of criminal cases, surrounding towns such as East Haven, Branford, Hamden, West Haven, and Orange also had an excess number of criminal cases. Eleven towns in Hartford County had excess cases of crime, comprising 38% of the towns in that county, and nearly 30% of the towns in New Haven County had excess cases of crime.

Domestic Violence

Of the 128 murders that occurred within Connecticut during calendar year 2008, nearly 60% occurred in Hartford (32), New Haven (23), or Bridgeport (20) (State of Connecticut Department of Public Safety, 2010). Most murders within these three cities were to unknown victims, and only three were to current or past family members. Of the remaining 53 murder cases scattered across the State, 21 were domestic, suggesting that murders outside large urban areas tend to involve current or past family members. Many more cases of domestic abuse of all ages were reported by emergency rooms across Connecticut in calendar year 2006 (E. Boulay, DPH; *personal communication*). A total of 246 cases were reported by emergency rooms in the State during that year, and 83% (205) were to females. Among male cases of reported abuse, 50% occurred to boys between the ages of 5 and 14 years. Among female cases, all age groups between 5-44 years were uniformly affected, with about 20-22% of the cases each reported among 5-14, 15-24, 25-34, and 35-44 age categories. Among non-Hispanic White/Caucasians, 5% of all emergency room visits in calendar year 2006 was attributed to domestic violence. In sharp contrast, 17% of all emergency room visits among non-Hispanic Black/African Americans was attributed to domestic violence, and 13% of all visits among Hispanics was attributed to domestic violence (M. Mukhtar, DPH, *personal communication*).

A total of 19 abuse shelters exist in Connecticut and are managed by the State (http://www.sboard.org/shelters/ct.htm). In 2004, 652 children aged five years and younger

[2] Excess statistics are used throughout this report and refer to the number of excess events that occur beyond the number expected for each town in Connecticut. The excess value is calculated from the difference between the actual and expected number of events. The expected number of events for each town is calculated by multiplying the statewide percent or rate and the population at risk in each town. Excess statistics provide a balance between the number of events, which is completely dependent on town size, and town rate or percent, which is completely independent of town size.

entered shelters for domestic violence in the State (G. Whitney, DSS, *personal communication*). This represented 54% of all children entering domestic violence shelters and 28% of the total domestic violence shelter population. Similar to young children living in homeless shelters, this is a very fragile population, and home visiting services to this group need to be a priority in the State.

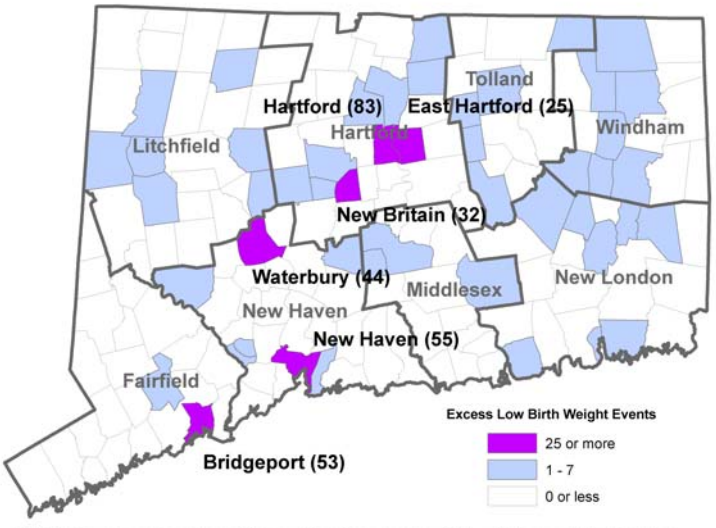
Maternal, Birth, and Infant Outcomes

During calendar year 2008, there were a total of 40,388 births to Connecticut residents (DPH, 2010). Of these, 58% were to non-Hispanic White/Caucasian women, 12% were to non-Hispanic Black/African American women, and 21% were to Hispanic women. Compared to the racial/ethnic distribution of women in Connecticut and the distribution of women of childbearing years noted above, the racial/ethnic distribution of births is weighted more heavily toward mothers of minority race/ethnicity, with a smaller percentage of births to non-Hispanic White/Caucasian mothers.

Among all births to non-Hispanic Black/African American women in Connecticut during 2008, 54% were to residents of one of the five towns described above with high unemployment rates (Bridgeport, Hartford, New Britain, New Haven, and Waterbury). Among births to Hispanic women, 48% were to residents of these towns. Only 9% of all births to non-Hispanic White/Caucasian women were residents of these towns. These data indicate that births to women of minority race/ethnicity are more likely in large towns of Connecticut with the highest unemployment rates.

Over one-fourth of all births to Connecticut residents in calendar year 2008 occurred to mothers who were born in countries other than the United States (11,417; 28%). The State ranked eighth among all states across the country for births to foreign-born mothers in 2006, with a U.S. average of 25% (Kids Count, 2010). Of births to foreign-born mothers, the largest percentage was to women born in Puerto Rico (14%; 1,601). Other countries frequently reported as the mother's country of birth including Mexico, India, Jamaica, Brazil, Ecuador, and Poland. These data indicate that Connecticut babies are born into a wide range of cultures and mores, and that perinatal interventions in the State must be sensitive to these various and diverse backgrounds.

Map 3
Excess Singleton Low Birth Weight
Connecticut, 2008



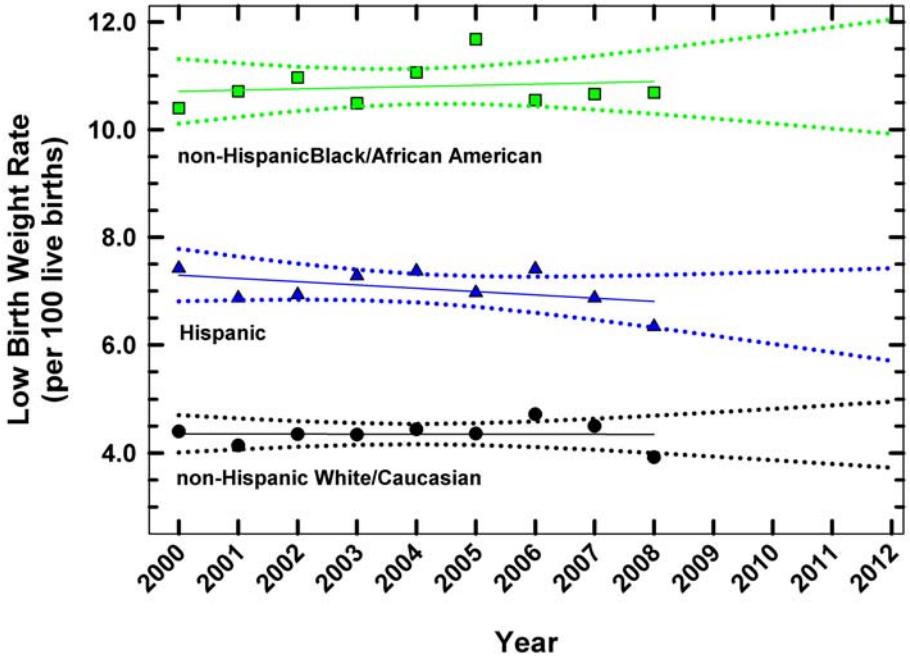
Shaded towns represent a positive number of excess low birth weight events for calendar year 2008. The town of residence at birth is shown. Excess low birth weight events were calculated by comparing actual events with expected events, assuming a statewide rate of 5.8 per 100 live births. The number of excess events are shown in parentheses.

Source: C. Stone (2010) Connecticut Department of Public Health, Hartford, Connecticut. Low birth weight was obtained from birth records for calendar year 2008, courtesy of HISR, DPH.

Low Birth Weight and Preterm Birth [3]

The overall low birth weight rate among singleton [4] births in the State during 2008 was 5.8 per 100 live births. Based on this overall rate, the expected number of low birth weight events was calculated for each town in the State and compared to the actual number of low birth weight events experienced in the town (**Map 3 and Appendix 1**). The largest number of excess low birth weight events in the State during 2008 occurred in the town of Hartford, with 83 excess births. Other towns with a high level of excess births included New Haven (55), Bridgeport (53), Waterbury (44), New Britain (32), and East Hartford (25). Forty-three other towns in Connecticut had a positive number of excess low birth weight events, but the number of excess

Figure 1
Trends in Singleton Low Birth Weight Rates
Connecticut, 2000-2008, by Race/Ethnicity



Actual low birth weight rates for years 2000-2008 (symbols) were evaluated for singleton births across the state. Trends in Low birth weight rates (solid lines) were determined by linear regression for years 2000-2008. Projected 95% confidence ranges of low birth weight rates, in the absence of additional public health interventions, were evaluated for years 2009-2012 (dotted lines).

Source: C. Stone (2010), Connecticut Department of Public Health, Hartford, Connecticut.
Low birth weights were obtained from birth records for calendar years 2000-2008, provided courtesy of HISR, DPH.

[3] A low birth weight is defined as a birth weight less than 2,500 grams, or about 5.5 pounds. A preterm birth is a birth at less than 37 weeks gestation. Preterm birth is calculated from multiple data fields of inconsistent quality and is not precise. For this reason, only low birth weight is used in this report to identify communities in need for maternal, infant, and early childhood home visiting services.

[4] A pregnancy can be singleton, with a single developing fetus, or multi-fetal, with multiple developing fetuses.

births was no more than seven, and these towns were scattered among urban and rural areas of the State.

The average newborn hospitalization charge for a low birth weight baby in Connecticut during 2006 was $54,840, a figure 15-times higher than the charge for a baby born with a higher birth weight (DPH, 2009b). Newborn hospitalization charges associated with low birth weight increased 10% in 2007 to $60,574 (J. Olson, DPH, *personal communication*). The high cost of low birth weight is a burden to the State, and programs addressing the health of women during, and even before, pregnancy are needed that address the risk factors associated with this adverse birth outcome.

Significant racial/ethnic disparities in singleton low birth weight rates have persisted within Connecticut throughout the decade ($p < 0.05$; **Figure 1**). Among non-Hispanic White/Caucasian women, the singleton low birth weight rate has remained constant at about 4.3 per 100 live births, and, in the absence of additional interventions, the rate is not expected to change significantly in the near future. Among singleton births to Hispanic women, the rate of low birth weight has decreased slightly since 2000, and in calendar year 2008, the low birth weight rate was 6.3 per 100 live births. Despite the expected decrease, the rate of low birth weight among Hispanic women is expected to remain significantly greater than that among non-Hispanic White/Caucasian women ($p < 0.05$). The singleton low birth weight rates among non-Hispanic Black/African American women has exhibited a slight increasing trend since calendar year 2000, with a 2008 rate of 10.7 per 100 live births. This rate is 2.5 times higher than that among non-Hispanic White/Caucasian women, and this increasing trend is expected to continue in the near future, resulting in greater disparities.

These data indicate that culturally-sensitive interventions are needed to address low birth weight rates in the State, and that in the absence of a concerted and coordinated response, low birth weight rates are not likely to be effectively reduced. Recent efforts to address low birth weight in the State include: 1) a strategic plan within the Family Health Section of DPH (Davis et al, 2009); 2) A report on all activities within DPH that address low birth weight (DPH, *pending*); 3) A report recommending strategies to address racial/ethnic disparities in low birth weight (Morin, 2008); 4) New State legislation to monitor low birth weight as a consequence of the recession (Connecticut Public Act 10-133); and 5) A recent publication about Women's Health in the State by the Women's Health Subcommittee of the Connecticut Medicaid Care Management Oversight Council (Gagliardi, 2008). Future efforts to address low birth weight are expected to continue in the future.

Fetal and Infant Mortality

Within Connecticut, the overall feto-infant[5] mortality rate among babies born during the calendar years 2005 through 2007 with a weight of at least 500 grams and a gestational age of at least 24 weeks was 6.9 per 1,000 live births and fetal deaths (**Table II**). Whereas the feto-infant mortality rate for babies born to non-Hispanic White/Caucasian women was 5.2 per 1,000, the rate for babies born to non-Hispanic Black/African American women was 2.5-fold higher (13.1

[5] Feto-infant mortality rates are calculated using fetal deaths, as well as deaths to infants before one year of age.

per 1,000 live births and fetal deaths), and the rate to Hispanic women was also elevated (8.1 per 1,000 live births and fetal deaths).

Table II
Fetal and Infant Death Rates, by Race/Ethnicity and Perinatal Period
per 1,000 live births and fetal deaths

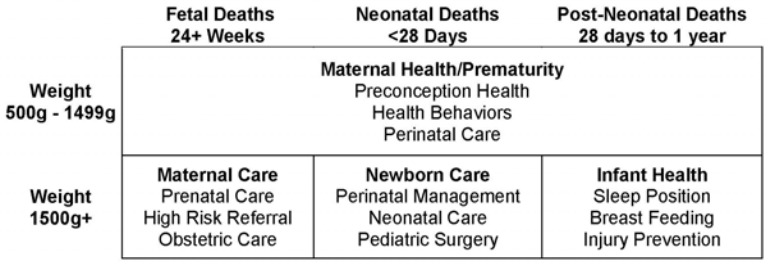
Connecticut Birth Cohort 2005-2007

Maternal Race/Ethnicity	Very Low Weight (500-1499 grams)	Fetal Deaths (24+ weeks)	Neonatal (< 28 days)	Post-Neonatal (28+ days)	Feto-Infant
Non-Hispanic White/Caucasian	2.26	1.40	0.79	0.70	5.16
Non-Hispanic Black/African American	7.35	2.90	1.01	1.82	13.08
Hispanic	4.04	1.82	0.99	1.23	8.07
All Race/Ethnicities	**3.33**	**1.69**	**0.88**	**0.98**	**6.88**

Source: C. Stone (2010) Connecticut Department of Public Health, Hartford, Connecticut.
Fetal death files and live birth records linked to death records were provided courtesy of HISR, DPH.

For over a decade, the Perinatal Periods of Risk (PPOR) approach has been used in developing and developed countries to monitor and investigate fetal and infant mortality (CityMatch, 2010). The technique organizes deaths into distinct categories that help communities identify intervention strategies. Within Connecticut among the 2005 through 2007 birth cohort combined, the approach revealed disparities in mortality rates to very low birth weight births, fetal deaths, neonatal deaths, and post-neonatal deaths (**Table II**). The greatest disparity was observed among deaths to very low birth weight babies, in which the mortality rate among babies born to non-Hispanic Black/African American women was 3.2 times higher than that among babies born to non-Hispanic White/Caucasian women (7.4 per 1,000, and 2.3 per 1,000, respectively). High mortality rates in this category indicate that preventive public health interventions are needed within Connecticut in the areas of preconception health, healthy behaviors, and early and adequate prenatal care, and these strategies are in particular need among women of minority race/ethnicity.

Perinatal Periods of Risk Conceptual Framework



Some areas of the State in fiscal year 2008 had established local Fetal and Infant Mortality Review (FIMR) programs. These geographic areas in the past have included the greater New Haven area, the areas of Hartford and East Hartford, Windham, New Britain, and Manchester/Vernon. Other geographic areas of high need for preventive interventions, however, did not have FIMR groups, and included Bridgeport and Waterbury. Of the roughly 260 annual infant deaths that occur in the State, about 200 occur within the first month of life, and 50% of these neonatal deaths are associated with a low birth weight. Low birth weight and infant

mortality are closely associated adverse events (C. Stone, *personal communication*). Statewide public health interventions to address infant mortality, therefore, must also include efforts to prevent low birth weight, and must include a broader range of geographies.

Infant Deaths Due to Neglect or Abuse

In a recent document by the national group Fight Crime: Invest in Kids (Christeson et al, 2008), it was reported that in 2006, there were 20,174 cases of childhood abuse or neglect, and from 2000 through 2006, there were a total of 54 children who were killed by abuse or neglect. Vital records data indicate that during this time period, there were 16 deaths to infants as a result of homicide (DPH, 2010). It has been estimated that the number of murder cases reported formally is underestimated by three fold (Christeson et al, 2008). This suggests that the actual number of homicides to infants may be as high as 48. Connecticut has an established Child Fatality Review Board that reviews unexplained and unexpected deaths to children who have been under the care of the State (State of Connecticut Office of the Child Advocate; http://www.ct.gov/oca/cwp/view.asp?a=1303&Q=254872&ocaNav=|). This review process may help, in part, address the extensive degree of underreporting that occurs with infant homicide. In addition, intensive home visiting programs managed by DCF may help reduce deaths to infants that result from abuse and neglect (Christeson et al, 2008).

Maternal, Birth, and Infant Risk Factors

A variety of risk factors contribute to low birth weight nationally, and can be categorized into medical health issues, lifestyle choices, social and mental health issues, home and work environmental issues, and family history (Davis, et al, 2009). Some of these risk factors have been substantiated in Connecticut, and include the following: low weight gain during pregnancy,

Table III
Births to Connecticut Residents
Method of Delivery, 2008 *

Maternal Race/Ethnicity	Method of Delivery Payment			
	Private Insurance	Public Insurance	None/ Self Pay	Total
non-HispanicWhite/Caucasian	18,286	4,025	465	22,776
non-Hispanic Black/African American	1,954	2,839	166	4,959
non-Hispanic Other Race	2,189	506	56	2,751
Hispanic	2,631	4,638	1,091	8,360
Total	25,060	12,008	1,778	38,846

*Data calculated from births to Connecticut residents in calendar year 2008, using final birth records provided courtesy of HISR, DPH. Values exclude unknown method of delivery payment and unknown race/ethnicity.

Source: C. Stone & J. Morin (2010) Connecticut Department of Public Health, Hartford, Connecticut.

and chronic or pregnancy-induced hypertension (medical health); minority race and ethnicity, as well as lower educational status, Medicaid status, unmarried status, first time pregnancy, and advanced maternal age (social and mental health); tobacco use during pregnancy (lifestyle); and some birth defects (environment and family history) (Stone and Mueller, 2009). Underlying many of these risk factors are infants born into poverty, inadequate or late prenatal care, tobacco use during pregnancy, and perinatal depression. These risk factors, and their geographic distributions, are described below.

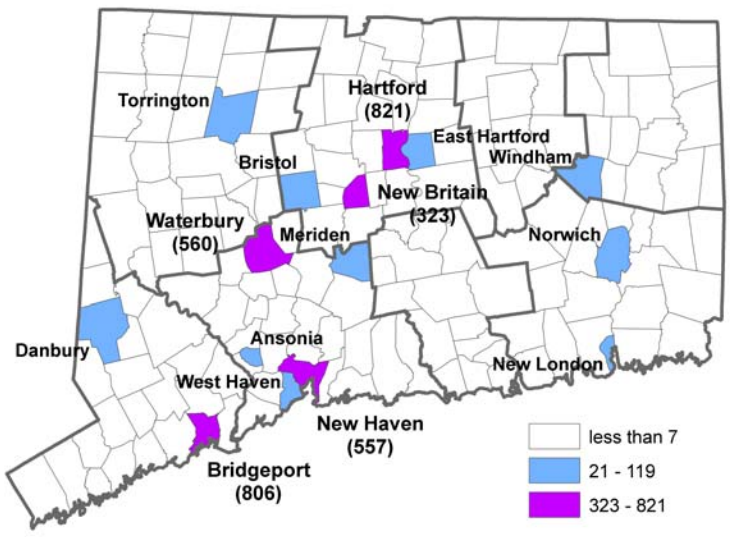
Infants Born into Poverty

Birth records do not contain specific economic indicators, however they do record the method of payment for delivery of every birth in the State, including methods of public insurance. This information can be used as a proxy for economic status.

During calendar year 2008, of the 38,846 births to Connecticut residents *for which there was complete information*, 25,060 (64%) were paid by private insurance, and 12,008 (31%) were paid by public insurance (**Table III**). An additional 1,778 (4 %) were either paid by the patient or were not paid and were absorbed by the State's medical system. Among deliveries in the State during calendar year 2008 to non-Hispanic White/Caucasian women, 18% were paid by public insurance, and 2% were either self-paid or absorbed by the medical system. In sharp contrast, 57% of deliveries to non-Hispanic Black/African American women were paid by public insurance. Among deliveries to Hispanic/Latino women, 55% were paid by public insurance, and another 13% were either self-paid or were absorbed by the medical system

Overall, 35% of all deliveries in Connecticut for which there was complete information were paid by either public insurance or the individual (self-paid), or were absorbed by the medical system. Compared to this overall percent, five towns had a high excess of deliveries paid by non-private sources (**Map 4 and Appendix 1**). These towns were the larger urban towns Hartford (821 excess deliveries; 74% of all deliveries), Bridgeport (806; 70%), Waterbury (560; 69%), New Haven (557; 64%), and New Britain (323; 67%). Other towns with an excess of at least 21 deliveries paid by non-private

Map 4
Births to Connecticut Residents in 2008
Excess Deliveries Paid by Non-Private Sources



Excess births to Connecticut residents in calendar year 2008 that were paid by non-private sources were calculated for all towns in the state based on a statewide percent of 35%. Non-private payment sources included all public insurance sources, as well as self-pay and no insurance.

Source: C. Stone & J. Morin (2010) Connecticut Department of Public Health, Hartford, Connecticut. Birth records were provided courtesy of HISR, DPH.

sources included: New London (119; 67%), East Hartford (110; 50%), Norwich (93, 53%), Windham (87, 64%), West Haven (81, 48%), Danbury (75, 42%), Torrington (58, 50%), Meriden (36, 39%), Bristol (26, 39%), and Ansonia (21, 45%).

A number of public insurance programs exist in the State, including HUSKY A, HUSKY B, Fee-For-Service, and State Administered General Assistance. The statewide average of deliveries in calendar year 2000 to women enrolled specifically in HUSKY A was 22.4%. Thirty-three towns in that year had a percent HUSKY A enrollment at delivery that exceeded this percentage (**Table IV**). Seven (47%) of these towns were located in Windham County, an area of the State with only one large town (**Table I**). Deliveries to women enrolled in HUSKY A who lived in Hartford, Litchfield, New London, and New Haven Counties each accounted for 21-23% of the towns in those counties. A smaller percentage of HUSKY A births occurred in Fairfield and Middlesex Counties.

The distribution of towns with a high percentage of HUSKY A births changed considerably from calendar year 2000 to calendar year 2007 (**Table IV**). Whereas 47% of the towns in Windham County in calendar year 2000 had a high percentage of HUSKY A births, that percentage nearly doubled to 73% of the towns in that county during calendar year 2007. Only four of the County's 15 towns did not have a high percent of HUSKY A enrollment at delivery. Litchfield County, with only three large towns (**Table I**), also increased from 23% to 35% of its towns with a high percentage of HUSKY A births. An increase in HUSKY A enrollment at delivery from calendar years 2000 to 2007 occurred within all counties of the State to a lesser degree. Only Tolland County did not change in the percent of towns with high HUSKY A enrollment; Coventry replaced Union as a town with a high percentage in 2007. These data

Table IV
Births To Connecticut Residents
Distibution of HUSKY A Enrollees, 2000 & 2007

	Number of Towns with High % HUSKY A Enrollment [1]		
County	**2000**	**2007**	**Towns with High Percent HUSKY A Enrollment (2007) [2]**
Fairfield	1 (4%)	2 (9%)	Stratford
Hartford	6 (21%)	10 (34%)	East Windsor, Enfield, Windsor, Windsor Locks
Litchfield	6 (23%)	9 (35%)	Cornwall, Norfolk, Thomaston, Washington
Middlesex	1 (7%)	4 (27%)	Middletown, Old Saybrook, Westbrook
New Haven	6 (22%)	7 (26%)	East Haven
New London	3 (23%)	6 (28%)	Griswold, Montville, Waterford
Tolland	3 (23%)	3 (23%)	Coventry
Windham	7 (47%)	11 (73%)	Brooklyn, Hampton, Pomfret, Scotland, Thompson
Total	**33 (19%)**	**52 (31%)**	

[1] - Towns with a percent HUSKY A enrollment at delivery that exceeded the statewide average of 22.4% in calendar year 2000. Percent of towns within each county with a high percent of HUSKY A enrollment at delivery are shown in parentheses.

[2] - Towns within each county that had a high percent of HUSKY A enrollment at delivery in calendar year 2007, but did not have a high percent in calendar year 2000.

Data were obtained for calenar years 2000 and 2007, using birth records provided courtesy of HISR, DPH. Birth records were linked to HUSKY A enrollment data by Connectitcut Voices for Children, with funding by the Connecticut Department of Social Services.

Source: C. Stone (2010) Connecticut Department of Public Health, Hartford, Connecticut.

indicate that whereas areas of high need in earlier years were largely focused in large urban areas, that need has spread in the State and now includes a larger portion of the State, including small rural towns. This suggests that a multi-tiered strategy of intervention may be needed to address perinatal health in the State; one tier focused on large urban areas, and a second tier focused on groups of towns in more rural areas.

Starting October of 2005, DSS implemented expedited eligibility for pregnant women via the network of state Healthy Start program offices (LV. Barrera, DSS, *personal communication*). In addition, the Agency initiated presumptive eligibility for children using additional community health centers, outpatient departments and community-based organizations. In January, 2008, the Agency increased HUSKY eligibility for pregnant women from under 185% of the federal poverty level to under 250% of the federally poverty level. More recently, starting in March 2010, DSS extended presumptive eligibility to both pregnant women and children. These enhancements in Medicaid eligibility for low-income families has resulted in record numbers of families covered by public insurance. These changes may, in part, explain the increased use of HUSKY among pregnant women.

Table V
Prenatal Care Initiation in Connecticut
by Race/Ethnicity, Connecticut, 2008

	Mother's Race and Ethnicity			
Timing of Prenatal Care Initiation	non-Hispanic White/Cauc	non-Hispanic Black/Af. Am.	Hispanic	All Races
Early Care	21,397 (92.0%)	3,967 (80.2%)	6,908 (80.1%)	34,714 (87.9%)
Late or No Care	1,874 (8.0%)	981 (19.8%)	1,712 (19.9%)	4,923 (12.4%)

Data were obtained from birth records for calendar year 2008, provided courtesy of HISR, DPH.

Source: K. Richardson, Connecticut Department of Public Health, Hartford, Connecticut.

Late Prenatal Care [6]

Of all births to Connecticut residents in 2008, 88% received early prenatal care (**Table V**), a value that compares well with the U.S. overall percent of 84%, and that is close to the Healthy People 2010 goal of 90% (CDC Wonder, 2010). When broken down by race/ethnicity, however, disparities in the State become apparent. Whereas 92% of non-Hispanic White/Caucasian women received early prenatal care in 2008, only 80% of non-Hispanic Black/African American women and 80% of Hispanic/Latino women received early care. Further, Connecticut women who lived in primary care Health Professional Shortage Areas (HPSA) as designated by the U.S. Health Resources and Services Administration (*http://hpsafind.hrsa.gov/HPSASearch.aspx*),

[6] Late prenatal care is care initiated beyond the first trimester of pregnancy. Early prenatal care is care initiated during the first trimester, or first three months of pregnancy.

were two times more likely to receive late or no prenatal care, compared to women who did not live in a HPSA ($p<0.0001$; K. Richardson, DPH, *personal communication*). Only 81% of women who lived in HPSA-designated areas received early prenatal care, compared to 90% of women who did *not* reside in HPSA-designated areas. These data suggest that early prenatal care may, in part, be the result of limited access to prenatal care services, and this possibility needs to be explored more fully.

Tobacco Use During Pregnancy

The use of tobacco during pregnancy has been demonstrated to increase the risk of a low birth baby, both nationally (Surgeon General, 1983), and within the State of Connecticut (Stone and Mueller, 2009). Based on information contained in births records, only 0.8% of Connecticut mothers who gave birth in 2008 reported smoking during pregnancy (C. Stone, DPH, personal communication). There was a wide variation in tobacco use during pregnancy, however, when examined by town. In the town of Putnam, a rural area of Windham County, 18% of the mothers who gave birth in 2008 reported smoking during pregnancy. Four additional towns in Windham County also had a very high percent of mothers who smoked during pregnancy, and included Thompson and Plainfield (16%), Brooklyn (15%) and Killingly (14%). Two towns in another largely rural county in Connecticut, Litchfield County, also had high percentages of mothers who smoked during pregnancy (Winchester, 17%; Torrington, 15%). These data indicate that rural counties of the State are in high need of services that both increase awareness of tobacco use during pregnancy, as well as smoking cessation programs for pregnant women.

Perinatal Depression

Information about maternal depression prevalence in Connecticut is not readily available. Results of a point-in-time survey conducted in 2003, however, probed a variety of social risk factors for adverse births. The survey was conducted of women two to four months postpartum. Results of the survey, reported by J. Morin (2006), revealed that a majority of respondents reported happy times with few or no problems. Among non-Hispanic Black/African American women, 8.1% (95% CI: 2.4%, 13.7%) indicated that their pregnancy was one of the worst times in their life. This percent was nearly 3-times times higher than that reported by non-Hispanic White/Caucasian women (2.8%). Relative to non-Hispanic White/Caucasian women, a greater percentage of women of minority race and ethnicity reported that their pregnancy was a hard time in their life. These results do not explore the reasons why women of minority race and ethnicity experience more difficulty, but growing evidence indicates that emotional support is an important component to healthy maternal and birth outcomes (Hodnett et al, 2010).

Childhood Development Outcomes

Early Language Development

Good early childhood development requires good health and well-being. Language acquisition begins long before the first babbles or the first words (COC, 2002). A baby's brain is preparing to speak before any speech sounds are uttered. As human beings, we communicate

with all of our senses. We can begin a dialogue with a touch, a special look, a silly sound, or a sentence. A newborn's brain is pre-wired to pay attention to all language sounds. Over the first few months of life, an infant learns to pay particular attention to the special sounds of the family culture and language. Early pleasurable experiences, such as hearing the sounds of language, looking at a parent's smile, and playing "peek-a-boo" lay pathways in the brain that facilitate later learning. Children in their first 24 months of life need exposure to words and books (COC, 2006). In the first three years of life, when a child makes the most dramatic gains in language development, the child's brain is producing most of the synapses, or pathways, between brain cells that remain through life. Those that are not activated tend to disappear.

Little statewide and town-level data are available to monitor the health and development of young children in Connecticut, yet this time period is critical to childhood development, and the earlier years of childhood development are strong indicators of school readiness and academic achievement later in life. Data systems that track this early time period in childhood development are needed, especially within families at high risk for poor childhood development outcomes. Existing record-level databases, such as the State's Immunization Registry, may be one source of information about young children that could be built upon to monitor this developmental stage.

Early Scholastic Achievement

Unlike measures used with children in later years, data for children at early ages of development can be unreliable due to the variability of young children's development. From

Table VI
Connecticut Mastery Test (CMT) Performance
Third Grade, By Subgroup, 2008

Subgroup	Percent At or Above Goal (%)		
	Reading	Writing	Mathematics
Race/Ethnicity			
White/Caucasian	79.3	72.7	71.4
Black/African American	26.6	42.7	32.7
Hispanic	24.0	41.1	36.3
Asian American	82.4	79.8	77.7
American Indian	62.7	61.2	53.9
Sex			
Male	48.8	55.2	60.6
Female	56.3	72.1	59.9
Eligibility for Free/Reduced Meals			
Not Eligible	65.2	74.4	72.5
Eligible	43.3	40.4	34.6

Source: State Department of Education: Data Interaction for Connecticut Mastery Test, 4th Generation, Subgroup Selections, 2008, Grade 3 (http://solutions1.emetric.net/cmtpublic/Default.aspx), accessed August 6, 2010.

infancy to age five, young children grow physically, emotionally, and socially at a pace more rapid that at any other time in life. Children develop skills and knowledge in an episodic, uneven fashion, and an assessment at any single point in time may over overestimate or underestimate their true level of development and learning. (Wagner, 2003).

Among third grade students in elementary schools across the State in 2008, 68%, 83%, and 81% met the State's goal in writing, reading and mathematics components, respectively, of the Connecticut Mastery Test (CMT; **Table VI**). More than one in three of all towns in Connecticut met or exceeded these percentages for all three components. Twenty-seven towns, however, did not meet these percentages for any of the components (**Appendix 2**). An additional 12 towns did not achieve these percentages in two components of the CMT.

Connecticut has one of the worst achievement gaps on the United States. While 71% of White/Caucasian students in grade 3 met the reading goal on the 2007 CMT, only 24% of black students and 23% of Hispanics did so. (**Table VI**) Statewide, only 52% of Grade 3 students reached the reading goal. Further, the 2009 National Assessment of Educational Progress (NAEP) results in reading and mathematics show that, although Connecticut's students are some of the highest performing in the country (NAEP; http://nces.ed.gov/nationsreportcard/naepdata/dataset.aspx), achievement gaps are among the largest in the nation. According to 2009 NAEP results, 57% of Connecticut's Grade 4 students overall were not proficient in reading. Among White/Caucasian students, 48% were not proficient in reading. In sharp contrast, 78% of Black/African American students were not proficient in reading, and 85% of Hispanic students were not proficient.

In a competitive global economy, the gaps measured by NAEP, Connecticut Mastery Tests, and other standardized tests translate into an unaffordable loss for the students involved and for their communities (A. Brinnell, SDE, *personal communication*). The causes of poor school performance are complex. We know that early childhood care and education, including access to high quality early learning opportunities and home visiting services, can have a positive impact on children's learning outcomes. Building a comprehensive, integrated early care and education system in Connecticut will give vulnerable populations the opportunity to build a strong foundation for future success.

These data indicate that many children in the State are not entering school adequately prepared for critical reading, writing, and mathematics skills. Early childhood institutions, such as daycare centers and elementary schools, must be included in community-based strategies that help prepare young children for school readiness. These community-based organizations must also coordinate closely with state agencies such as the SDE, Department of Higher Education, Haskins Lab, Family Resource Centers, Literacy Councils, and DCF.

High School Dropout Rates

During the five academic years ending in 2004-2008 combined, the statewide high school dropout rate was 1.9 per 100 students (**Table VII**; SDE, 2009a). Within the State, 34 towns had high school dropout rates that exceeded this overall rate. Among these towns, Norwich had the highest dropout rate of 16.0 per 100 students during this time period. This value was nearly 10 times higher than the statewide rate. Other towns with a very high dropout rate included

Winchester (11 per 100), Bridgeport (6.8 per 100), New Haven and New Britain (5.4 per 100), and Killingly (5.3 per 100).

A Priority School District program exists in the State to provide grants to communities in need of enhanced educational services (SDE, 2010a). These grants are provided particularly to address high school dropout rates. The funds are used to create or expand innovative programs, support early reading programs, increase technology, strengthen parent involvement, and fund accreditation activities. School districts funded by the program for the academic year 2010-2011 included: Ansonia, Bridgeport, Bristol, Danbury, East Hartford, Hartford, Meriden, New Britain, New Haven, New London, Norwalk, Norwich, Stamford, Waterbury, and Windham.

Table VII
Towns with Elevated High School Dropout Rates *
Connecticut, Academic Years Ending 2004-2008

Town	Ave Dropout Rate	Priority District	Town	Ave Dropout Rate	Priority District
Fairfield County			**Hartford County**		
Bridgeport	6.8	Yes	New Britain	5.4	Yes
Danbury	2.3	Yes	Hartford	4.6	Yes
Stamford	2.2	Yes	East Hartford	2.6	Yes
Shelton	2.1		Enfield	2.4	
			Windsor Locks	2.3	
Litchfield County			**Middlesex County**		
Winchester/Winsted	10.9		none		
Torrington	4.8		**New Haven County**		
Plymouth	3.0		New Haven	5.4	Yes
Windsted	2.2		Seymour	2.5	
Canaan, Cornwall, Kent, North Canaan, Salisbury, Sharon	2.2		Ansonia	2.2	Yes
New London County			**Windham County**		
Norwich	16.0	Yes	Killingly	5.3	
New London	4.0	Yes	Plainfield	4.3	
Griswold	3.3		Putnam	3.8	
Tolland County			Windham	3.7	Yes
Stafford	2.4		Thompson	2.5	
Vernon	2.7				
Statewide	**1.9**				

* - The average high school dropout rate for academic years ending in 2004-2008 were calculated for all towns in Connecticut, per 100 students. Towns with dropout rates above the statewide average of 1.9 per 100 are shown in the table. Towns with Priority School District funding in the academic year ending 2011 are also shown. All data obtained from the Connecticut Department of Education.

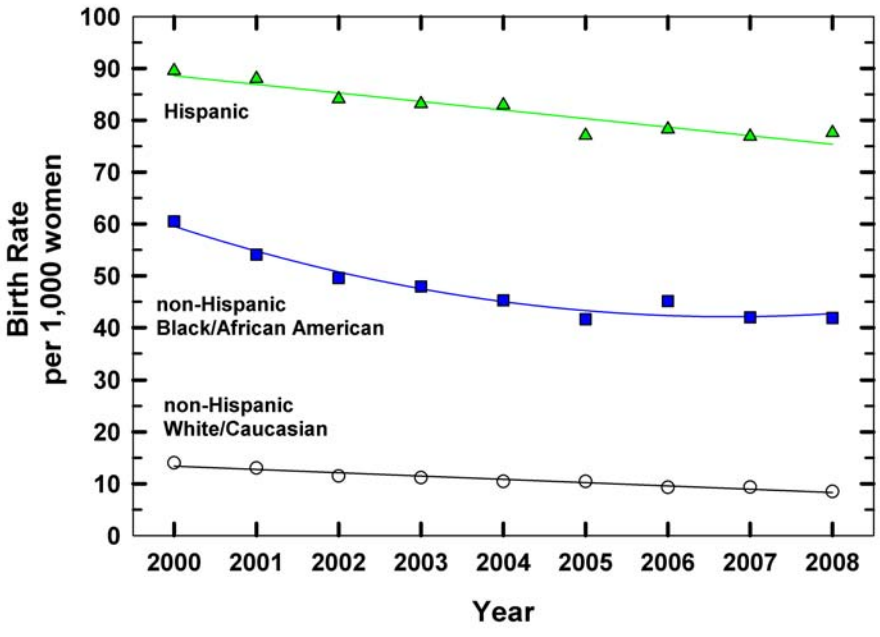
Teen Parenthood and Low Educational Attainment

Statistically significant disparities in teen birth rates have persisted in Connecticut throughout the decade, particularly among non-Hispanic Black/African American and Hispanic teens between 15-19 years old, compared to non-Hispanic White/Caucasian teens (**Figure 2**; $p <$

0.001). In 2008, one in every 13 Hispanic women between 15 and 19 years of age gave birth to a baby (78 per 1,000), a figure over nine times higher than that among non-Hispanic White/Caucasian women (8.5 per 1,000). The teen birth rate among non-Hispanic Black/African American women was over four times higher (41.8 per 1,000). Teen birth rates among all three race groups have decreased since calendar year 2000, however the decrease has become attenuated since 2005, particularly among non-Hispanic Black/African American women.

Within Connecticut, the town with the highest teen birth rate (ages 15-19 years old) for calendar years 2006-2008 combined was New Britain (75.6 per 1,000), three times higher than the statewide rate of 25.0 per 1,000, and nearly two times higher than the 2007 U.S. rate of 42.5 per 1,000 (Hamilton, et al, 2009; J. Morin & C. Stone, DPH, *personal communication*). Hartford (64.3 per 1,000), Bridgeport (63.7 per 1,000), Waterbury (58.3 per 1,000), New Haven (50.6 per 1,000), Groton (45.5 per 1,000) and Meriden (43.1 per 1,000) had teen birth rates that were at least 1.7-fold higher than the overall statewide rate, and these towns were elevated significantly compared to U.S. rate. Other towns with teen birth rates greater than the statewide average included East Hartford (37.5 per 1,000), Torrington (33.6 per 1,000), Norwich (30.1 per 1,000), New London (29.5 per 1,000), Windham (28.6 per 1,000), West Haven (27.7 per 1,000), Manchester (27.0 per 1,000), and Danbury (26.3 per 1,000).

Figure 2
Teen Birth Rate, Connecticut, 2000-2008
15-19 years old



Source: C. Stone & J. Morin (2010) Connecticut Department of Public Health, Hartford, Connecticut.

Annual birth rates in Connecticut, per 1,000 women 15-19 years old, by maternal race/ethnicity, were generated for calendar years 2000 through 2008. Rates were generated from population estimates and final birth records for 2000-2008. All datafiles were obtained courtesy of HISR, DPH.

Towns with high teen birth rates in 2008 were correlated with children living in poverty (r = 0.79), and were marginally correlated with high rates of high school dropout (r = 0.55) and high rates of childhood abuse and neglect (r=0.53). These data indicate that strategies to prevent teen pregnancy need to be coordinated with neighboring high schools, and need to include family-centered strategies to prevent multigenerational abuse and neglect. These data also suggest that teen pregnancy prevention strategies should include culturally-sensitive messages of appropriate literacy that reach Hispanic and non-Hispanic Black/African American teens. Home visiting programs for mothers may need to be coordinated within the school setting. High teen birth rates are located predominantly in towns of high and moderate population, but elevated teen birth rates are also located in surrounding areas with less population density.

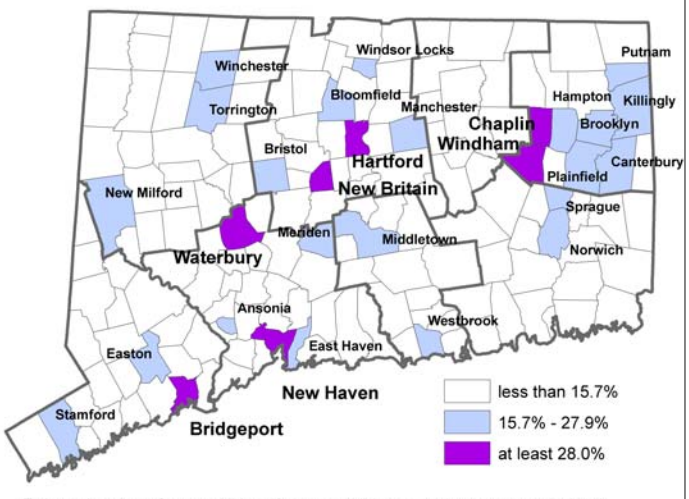
Child Health and Development Risk Factors

Early Childhood Poverty

Estimates of children living in poverty are difficult to measure at sub-geographies within the State of Connecticut. Using U.S. Census Bureau estimates at the county level (U.S. Census Bureau, 2010), and birth records, town level estimates of poverty were developed for three age groups of children: less than five years of age, 5-17 years of age, and 0-17 years of age (C. Stone, DPH, *personal communication*).

Statewide, the estimated number of children aged 0-17 years, inclusive, in Connecticut was 94,235. Of this amount, 32,937 were aged 0-4, inclusive, and 13,786 were less than one year of age (**Table III**). The overall percent of young children aged 0-4, inclusive, in poverty in 2008 was 15.6%. A total of 29 towns in the State exceeded this percent (**Map 5**). Two towns with the highest percent of young children living in poverty were Chaplin and Windham, with 44.9% and 38.6%, respectively, of its young children living in poverty. Both towns are located in Windham County, and Chaplin is considered a small rural town. Other towns with a high percent of early childhood poverty included Hartford (36.9%), Waterbury (34.5%), New Britain (31.6%), Bridgeport (29.8%), New Haven (28.9%), New Milford (26.7%), Putnam (26.6%), and East Haven (25.9%).

Map 5
Early Childhood Poverty in Connecticut
Percent of Children 0-4 years old, 2008



Estimated percent of young children (0-4 years old) in poverty, by town was calculated from county-level estimates produced by the U.S. Census Bureau (Estimates for Connecticut School Districts, 2008 (http://www.census.gov/cgi-bin/saipe/saipe.cgi), and the proportion of births, by town, for calendar years 2004-2008. The overall percent of young chidren in poverty was 15.6%.

Source: C. Stone, Connecticut Department of Public Health, Hartford, Connecticut.

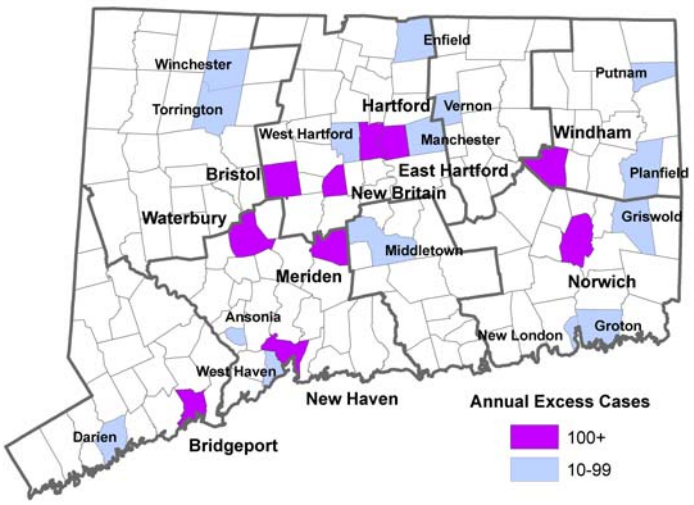
Another proxy for household poverty is the degree to which students are enrolled in the national free/reduced lunch program. In 2008, 29 percent of all schools in the State had at least half of the student body

enrolled in the school lunch program. All schools (100%) in the town of Windham had at least half of the student body enrolled in the program. Other towns with large percentages of program enrollment included: Bridgeport (97% of schools with at least half enrolled), New Britain (93%), Waterbury (90%), Hartford (89%), Norwich (86%), and New Haven (83%).

Childhood Maltreatment

The annual incidence rate of substantiated neglect and abuse among children aged 0-17 years in Connecticut was 1.30 per 1,000 children. Relative to this statewide rate, and compared to the expected number of cases in each of Connecticut's towns, some towns exhibited a large excess of maltreatment cases (**Map 6**). Highest in the State was New Haven, with 544 excess cases of abuse or neglect. Hartford had 434 excess cases, followed by Meriden (270), Bridgeport (260), and New Britain (259). Other towns with a high excess of childhood abuse or neglect were East Hartford (196), Waterbury (153), Windham (150), Bristol (129), and Norwich (129). These towns correlated with domestic abuse cases reported from hospitalizations for all ages, suggesting that life in a violent home affects both adults and children. Family-centered strategies are needed to address families living in violent situations. Towns with high abuse or neglect rates in 2008 also correlated strongly with high crime areas, suggesting that a community approach is needed to effectively address childhood maltreatment in the State overall and within Connecticut's towns. Strategies directed toward individuals must be coupled with community-based strategies.

Map 6
Child Abuse & Neglect
Annual Excess Cases, Connecticut 2008-2010



Annual excess cases of substantiated abuse or neglect (educational, medical, physical, sexual, or educational) were calculated, by town, from a statewide incidence rate of 1.3 per 1,000 children, using data provided courtesy of the State Department of Children and Families.

Source: C. Stone, Connecticut Department of Pubilc Health, Hartford, Connecticut.

Children Affected by Crime

Children of incarcerated parent(s) undergo extreme grief at their loss and instead of support receive humiliation, condemnation, ridicule, and isolation (M. Hayward, DOC, *personal communication*). Most of the children with an incarcerated parent are already in a low-income category. With the loss of financial support due to incarceration, children quickly move into poverty. With the support of a home visiting program, intergenerational incarceration may be prevented. These individuals need guidance about finances, education, and resources when they lose a caregiver. If these children aren't checked on, they may be left with family members who

are inadequately prepared to care for them, resulting in neglect, and by the time a state agency recognizes this, it is too late.

The DOC has programs in place that: 1) assist with family reunification; 2) strengthen family bonds; 3) provide a variety of educational topics that include the dangers of shaking a baby, the importance of parenting and fatherhood, the necessity of prenatal care, and the importance of education for their children and themselves; 4) assistance with child support and applications for modification; 5) job and skills training; and 6) social reunification. These programs are carried over into parole programs for those who discharge with supervision, because the community is where they need the most support and the continuation of services.

Currently, the DOC does not have a home visiting program in place to assist children when their parent(s) become(s) incarcerated. Such a program, however, is greatly needed.

Asthma and High Blood Lead Levels

A variety of unhealthy behaviors and environments are associated with poverty and urban living. These public health problems include asthma, lead poisoning, and poor oral health. Asthma is most prevalent in large urban areas, and within Connecticut, is most prevalent in the towns of Hartford, Bridgeport, New Haven, Stamford, and Waterbury (DPH, 2009c). Although a public health problem for all ages, asthma is most prevalent among children. Within the five largest towns of the State during 2001-2005 combined, 42% of hospitalizations and emergency room visits were for asthma-related conditions (M. Mohamed, DPH, *personal communication*). An astounding 53% of all deaths to children were either directly or indirectly related to asthma. Connecticut residents of Hispanic ethnicity or Black/African American race were more likely to suffer from asthma. Three out of four asthma hospitalizations related to asthma were paid by public insurance. The Asthma program within DPH manages a program that offers home visiting services, and this program needs to be coordinated with other home visiting programs in the State.

Another public health hazard that can be severely detrimental to childhood development is high blood lead levels. These high levels are usually associated with older homes containing indoor or outdoor lead-based paint. Within Connecticut in calendar year 2007, 50,430 children were tested for high blood lead levels (CDC, 2010). Of these, 764 (1.5%) had elevated levels of intravenous lead. Among the counties of Connecticut, 2.1% of children living in New Haven County had high blood lead levels. Litchfield County also had a higher than overall percent of tested children with high blood lead levels (1.7%), followed by Fairfield, Hartford, and Windham Counties, each with 1.2% of children tested with elevated blood lead levels. New London County (1.0%), Tolland County (0.9%), and Middlesex County (0.6%) had a smaller percentage tested children with high blood levels. These data indicate that high blood lead levels are a concern in both urban and rural counties of the State, and suggest that home visiting programs need to include a component that encourages lead screening in young children, as well as the physical environments within which children live.

Children with Developmental Delays

In Connecticut, approximately 9,600 of eligible children are served annually through the Connecticut Birth to Three System (http://www.birth23.org/index.html), managed by the DDS. Data for the past seven birth cohorts shows that 10-11% of the children in each cohort received services at some time prior to their third birthday. Services by the Birth to Three program are predominantly provided by licensed or certified professionals in the home. Eligibility for the program is limited to children who are either screened for a significant developmental delay, or who have been diagnosed with a condition that has a high probability of resulting in significant developmental delays. Test screening for developmental delays are measured by a standardized assessment tool. With these rigorous eligibility criteria, approximately 40% of the children referred are found not to be eligible.

A total of 9,126 children were referred to the Connecticut Birth to Three program for test screening during fiscal year 2010 (July 1, 2009 – June 30, 2010; **Table VIII**). Of this total, 50% (5,590) children were found to have a significant delay in their development, which made them eligible to receive services under Part C of Individuals with Disabilities Education Act (IDEA). Of the remaining 3,536 children, 551 were not evaluated, either because the family declined, or because the family could not be located. Forty-two percent (3,804) of the children referred for evaluation were residents of one of these top ten towns: Bridgeport, Bristol, Danbury, Hartford, Meriden, New Britain, New Haven, Norwalk, Stamford, or Waterbury. Of all children statewide referred for evaluation, 21% of White/Caucasian referrals were from these top 10 towns, while 50% of Black/African American and Asian/Pacific Islander referrals, and 50% of Hispanic referrals were from these top towns. Compared to birth records for calendar year 2008, these data suggest that a disproportionate percent of children referred into the program lived in large urban areas of the State. Further, a greater than expected percent of statewide referrals were for children of minority race/ethnicity. Intervention strategies for children with special needs need to be culturally-sensitive and available to these communities.

Table VIII
Children with Developmental Delays
Eligibility to the Connecticut Birth To Three Program, 2010

	Refered for Evaluation		Not Eligible/ Not Evaluated	
Race/Ethnicity	Statewide	Top 10 Towns	Statewide	Top 10 Towns
White/Caucasian	3,986	822	1,774	406
Black/African American	809	473	299	200
Hispanic	2,076	1,444	779	550
Asian/Pacific Islander	809	473	85	24
Native American	19	6	11	1
Unknown	1,427	586	588	336
Total	**9,126**	**3,804**	**3,536**	**1,517**

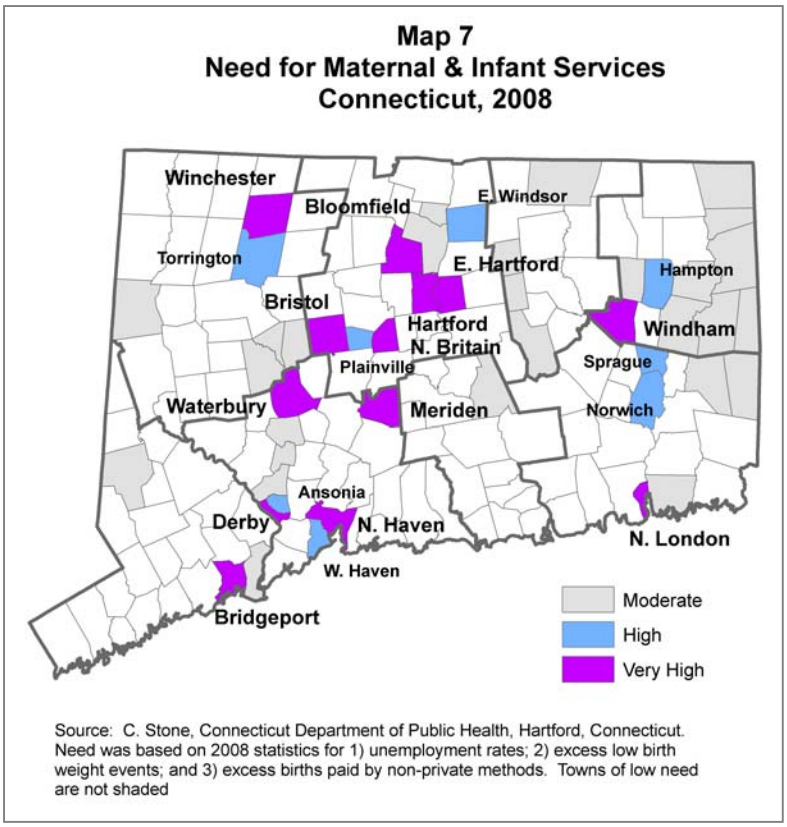
Source: L. Johnson & L. Goodman (2010) DDS, Hartford, Connecticut.

Need for Maternal, Infant, and Early Childhood Services

Maternal and Infant Services

Data available on maternal and infant health collectively indicate that pregnant women and infants living in urban areas of the State are at increased risk of poor maternal, birth, and infant outcomes (**Map 7 and Appendix 1**). Towns of smaller population size, as well as rural areas, however, are also in need of services. Fourteen areas of *very high need* for maternal and infant services include the 11 urban towns of Bloomfield, Bridgeport, Bristol, East Hartford, Hartford, Meriden, New Britain, New Haven, New London, Waterbury, and Windham, as well as the smaller town of Derby and the rural town of Winchester. Eight areas of *high need* for maternal and infant services include the three urban towns of Norwich, Torrington, and West Haven, the three smaller towns of Ansonia, East Windsor, and Plainville, and the two rural towns of Hampton and Sprague. Twenty-seven towns within the State have a *moderate need* for maternal and infant services. They include the six urban towns of Danbury, Naugatuck, Stratford, Vernon, Watertown, and Windsor; the eight smaller towns of East Hampton, Griswold, Groton, Hebron, Killingly, Seymour, Stafford, and Windsor Locks, and the 13 rural towns of Beacon Falls, Bolton, Brooklyn, Canterbury, Chaplin, Kent, Plainfield, Plymouth, Putnam, Sterling, Thomaston, Thompson, and Voluntown.

Towns with a moderate, high, or very high need in Connecticut for maternal and infant services are distributed broadly across the State (**Map 7**). A total of three towns of need are located in Fairfield County, nine towns are located in Hartford County, six towns are located in Litchfield County, one town is located in Middlesex County, nine towns are located in New Haven County, and six towns are located in New London County. Ten of the 15 towns in Windham County have a need for maternal and infant services.



The results obtained here are based on 2008 population-based statistics, and reflect only the initial stages of the economic recession, which began officially in December 2007 (Rampell, 2008). A general increase in public insurance across the decade (**Table IV**), as well as the continued recession, suggest that the need within the State may have increased. For this reason, and because of migration dynamics in Connecticut, needs within Connecticut for maternal and

infant services should be evaluated at periodic intervals, ideally on an annual basis.

Early Childhood Services

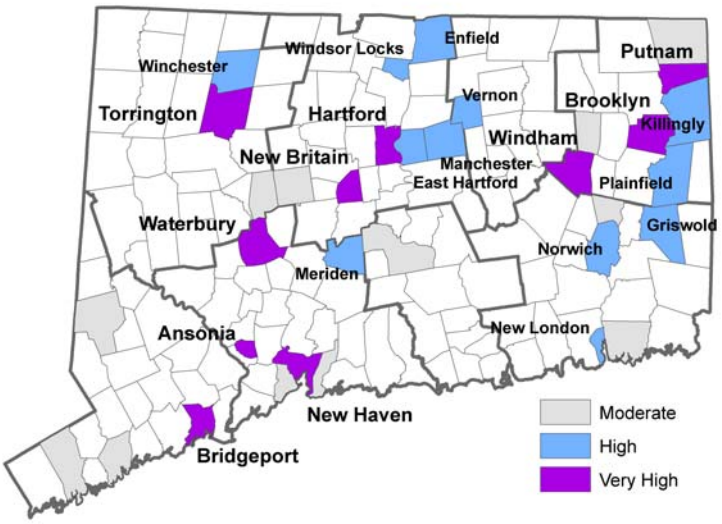
Data available on early childhood health and development collectively indicate that children living in urban areas of Connecticut, as well as more rural parts of the State, are at increased risk of poor developmental outcomes. (**Map 8 and Appendix 2**). Ten towns of *very high need* for early childhood services include the urban areas of Bridgeport, Hartford, New Britain, New Haven, Torrington, Waterbury, and Windham, as well as the smaller town of Ansonia, and the rural towns of Brooklyn, and Putnam. Twelve towns of *high need* for early childhood services include the seven urban towns of East Hartford, Enfield, Manchester, Meriden, New London, Norwich, and Vernon, as well as the three smaller towns of Griswold, Killingly, and Windsor Locks, and the two rural towns of Plainfield and Winchester. Twelve towns of *moderate need* for services include Bristol, Chaplin, Danbury, East Haven, Groton, Middletown, Norwalk, Plymouth, Sprague, Stamford, Thompson, and West Haven.

Towns identified with a moderate, high, or very high need are scattered across the State. Seven towns each are located in Hartford and Windham Counties, and six towns are located in New Haven County. Five towns are located in New London County, four towns are located in Fairfield County, three towns are located in Litchfield County, and one town is located in Tolland County.

These data rely heavily on existing information from other state agencies, such as DCF and SDE. Strong collaborative inter-agency relationships are needed to ensure that estimates such as childhood abuse and neglect, low school achievement, and high school dropout rates can be regularly monitored.

Only county level population estimates are available from the U.S. Census Bureau for children aged 0-4 and 5-17, and for children of these age groups who are living in poverty. It is these figures at the statewide level that were used by HRSA to allocate state-specific funding for the ACA Maternal, Infant, and Early Childhood Home Visiting program. Town-level population estimates of infants rely on birth records and the linked Medicaid status of those records. Town-specific population estimates for children, grouped into ages 0-4 and 5-17 years, were developed for this report using the distribution of

Map 8
Need for Early Childhood Services
Connecticut, 2008



Need was based on 2008 statistics for 1) percent young children in poverty; 2) excess childhood abuse/neglect; 3) low third grade CMT scores; and 4) high school dropout rates. Towns of low need are not shaded.

Source: C. Stone, Connecticut Department of Public Health, Hartford, Connecticut.

Medicaid status at birth for each town, capped to county-level estimates from the U.S. Census Bureau. These estimates should be prepared annually, with available county-level estimates from the U.S. Census Bureau, and are necessary to properly monitor young children in need of services across the State.

Composite Need

A comparison of town needs for either maternal and infant, or early childhood services, described above, reveals that 16 towns are of very high need for either maternal and infant, or early childhood services, or both (**Table IX**). Most of these towns have been identified repeatedly throughout this assessment, and include the twelve large urban towns of Bloomfield, Bridgeport, Bristol, East Hartford, Hartford, New Britain, Meriden, New Haven, New London, Torrington, Waterbury, and Windham. The two smaller towns of Ansonia and Derby are also in very high need of services, as well as the two rural towns of Putnam and Winchester. Five towns each are located in Hartford and New Haven Counties, two towns each are located in Litchfield

Table IX
Need for Maternal, Infant, and Early Childhood Services
Connecticut, 2008

Fairfield County	Hartford County	Litchfield County	Middlesex County	New Haven County	New London County	Tolland County	Windham County
Very High Need for Maternal & Infant AND/OR Early Childhood Services [1]							
Bridgeport**	Bloomfield** Bristol** East Hartford** Hartford** New Britain**	Torrington* Winchester*		Ansonia** Derby* Meriden** New Haven** Waterbury**	New London**		Putnam** Windham**
High Need for Maternal & Infant AND/OR Early Childhood Services [2]							
	East Windsor Enfield* Manchester* Plainville Windsor Locks			East Haven* West Haven**	Griswold* Norwich** Sprague*	Vernon*	Killingly* Plainfield*
Moderate Need for Maternal & Infant AND Early Childhood Services [3]							
Danbury**		Plymouth*			Groton*		Chaplin* Thompson*

[1] - Towns identified as very high need for either Maternal & Infant or Early Childhood services.

[2] - Towns identified as high need for either Maternal & Infant or Early Childhood services.

[3] - Towns identified as moderate need for both Maternal & Infant and Early Childhood services.

Towns identified by the Governor's Early Childhood Research & Policy Council as a priority (**) or competitive (*) town are shown.

and Windham Counties, and one town each is located in Fairfield and New London Counties.

An additional 13 towns were identified as being of high need for services, based on a comparison of high need either for maternal and infant services, or for early childhood services. These areas included the six urban towns of East Haven, Enfield, Manchester, Norwich, Vernon, and West Haven, as well as the five smaller towns of East Windsor, Griswold, Killingly, Plainville, and Windsor Locks, and the two rural towns of Sprague and Plainfield. Five of these towns were located in Hartford County, three were located in New London County, and two each were located in New Haven and Windham Counties. One town was located in Tolland County.

Of the total number of 169 towns in Connecticut, 28 (17%) were identified as being either of very high or high need for maternal, infant, and early childhood services. An additional five towns shared a moderate need of maternal and infant, as well as early childhood, services, and included the urban towns of Danbury and Groton, and the rural towns of Chaplin, Plymouth, and Thompson.

The Governor's Early Childhood Research & Policy Council, which has as a goal to increase school readiness among the State's young children, recently published a set of priority and competitive districts for early childhood interventions (2007). Most of the towns identified by the Council are also identified as high or very high need in this assessment. Only East Windsor, Plainville, and Windsor Locks identified by this needs assessment were not identified by the Council. Several towns identified by the Council as being of priority need for early childhood services did not meet the criteria for very high, high, or moderate need for services, and included the towns of Middletown, Norwalk, and Stamford. The reasons for this difference need to be further studied.

Population-based and town-specific information can provide a wealth of information about towns in need for maternal, infant, and early childhood services. These data represent the most current extent of the problem, in the presence of all the programs currently working to reduce poor outcomes. As programs expand and shrink in response to unstable local, state, and federal funding, it is important to closely monitor changes in outcomes to this population.

The classification of town need identified in this assessment relied on available town-specific information. Rates and excess measures were used whenever possible, so town size was less of a factor in determining town need. These need classifications, therefore, may not match the magnitude of services needed for each town. Further, although weights for large towns were minimized in this assessment, very small or rural towns were also not weighted. Very small towns, therefore, may not have had enough people to create rates that accurately represented their need. Conversely, some small towns, such as Putnam, with a high need for services but with a limited number of potential clients, may need to be considered with adjacent, larger towns.

The criteria used to assess town need for maternal and infant services (unemployment rate, excess low birth weight, and excess non-private insurance) and early childhood services (percent children in poverty, low third grade CMT scores, and high school dropout rates) may overlap. Therefore, although no criteria for either maternal and infant, or early childhood services correlated by more than 78% (C. Stone, DPH, *personal communication*), some degree of confounding is likely. An effort was made in this assessment to use criteria that are known contributors to maternal, infant, and early childhood poor outcomes, but the criteria are not

exhaustive. Additional study is needed to explore other, and better, measures for determining need, and to identify available data that measure town need. For instance, additional measures for early childhood health development that could be explored include social/emotional development indicators, such as children asked to leave child care and nursery schools because of behavioral problems (P. Langer, SERC, *personal communication*). This and other indicators need to be explored.

Male Involvement

Historically, maternal and child health interventions in Connecticut have focused only on the mother and child. Until recently, strategies that included the father, or male support, were not a focus. Within the past few years, the Maternal and Child Health Block Grant within DPH has implemented a variety of pilot strategies that focus on fathers. In partnership with DPH, which was funded by a technical assistance grant from the HRSA Maternal and Child Health Bureau, a curriculum for fathers and instructors of fatherhood curricula has been developed by Real Dads Forever, Inc. (Doug Edwards, founder) in Connecticut. The curriculum is being evaluated in a few local areas of the State, and is slated for implementation within Hartford by the federal Hartford Healthy Start program. The curriculum needs to be more fully evaluated, and then implemented in maternal and child health programs across the State.

The DCF also recognizes the need for father involvement in child welfare systems (D. Howard, 2010). Specifically, the agency seeks to answer the following questions as it develops a Connecticut Child Welfare Fatherhood Initiative: 1) What are the attitudes, perceptions, and beliefs about fathers and how do they influence practice? 2) What is the demographic make-up of Connecticut fathers involved in child welfare? 3) What are the needs of Connecticut's fathers involved in the child welfare system? 4) What services are available at the community, regional, and statewide level to meet the specific needs of Connecticut's fathers involved in the child welfare system? 5) What factors specific to gender, culture, and socio-economic status influence the agency's ability to serve fathers?

Recognizing a similar need for fatherhood involvement in mother and child relationships, DSS has established a Fatherhood Initiative of Connecticut (http://www.fatherhoodinitiative.state.ct.us/index2.htm). This program seeks to involve fathers in social services managed by the agency, and across the State. The agency is also piloting a fatherhood component for its Nurturing Families Network program. Male involvement has long been a component of Head Start programs in the Northeast region of the country (G. Whitney, DSS, *personal communication*). Thirty-one of 33 Head Start and Early Head Start programs in Connecticut (94%) have fatherhood and male involvement components, and last year, 1,975 children in Head Start had fathers participating in component activities. Although state agencies in Connecticut are moving quickly to strategies that involve fathers in their public initiatives, these efforts are currently limited and lack coordination. A broader statewide emphasis of father involvement is needed, and methods to track implementation, utilization, and outcomes associated with fatherhood programs are needed.

A number of fatherhood programs exist in Connecticut for incarcerated fathers and are offered through DOC (M. Hayward, *personal communication*). Some programs are available at all correctional institutions, while others are limited to one or several institutions. These programs

include: Embracing Fatherhood; Fatherhood; Read to Your Child; Family Matters; Family Re-entry: Bridgeport Community Re-Entry Center; Family Time Program; Fatherhood Initiative Program; the Family, Education, Aids Transition Skills Program; Inside/Out Dad; Marriage/Family Relationships; Men's Corner (Garner Correctional Institute only); Parenting: The Extended You Project Free; and Building Bridges –New Day Program. In addition, last year in Head Start and Early Head Start programs, 358 (4.5%) received assistance related to incarcerated individuals (G. Whitney, DSS, *personal communication*). These programs need broader implementation across the State.

II. Maternal, Infant, and Early Childhood Home Visiting Services in Connecticut

Existing Home Visiting Program Services [7]

A wide variety of maternal, infant, and early childhood programs with a home visiting component currently exist across Connecticut. Some of these programs are managed by state agencies, while others are managed by municipal agencies, as well as private organizations at the national, state, and local levels. Funding for these programs is also diverse, and includes federal, state, municipal, and private sources.

To better understand the scope and breadth of home existing services available Connecticut, and to assess the need for additional services, a survey of current service programs was conducted in June, 2010. During a very quick four-week time period, twenty-eight voluntary programs responded to the survey with detailed information about general program characteristics, program eligibility and exclusion criteria, types of services offered and the range of clients served, outcomes monitored, and degree of evidence-base (**Appendix 3**).

Programs funded by community-based organizations, such as the Visiting Nurses Association and small private nonprofit organizations, as well as municipal entities, either were not recruited or were unable to respond quickly with needed information. In addition, some programs responded with incomplete information. This suggests that smaller, yet perhaps significant programs, currently embedded in the communities they service, may not have been able to respond quickly to the detailed grid components required of the survey. The results of this survey, therefore, represent services offered by larger, more organized programs. The results are not exhaustive and do not fully characterize the home visiting services available in individual communities. Further, the survey was conducted of programs in the State with a home visiting component, and did not distinguish between programs that offer only home visiting from programs that offer a range of customized services based on each family's degree of need. Individual community-based assessments are needed to fully understand the complex and diverse needs for home visiting services in local areas of the State.

Number and Management of Home Visiting Programs

Of the 28 programs that responded to the survey, all but two are managed by State agencies (**Appendix 4**). Only one program is funded entirely with private foundation funding (Mind the Baby), while the others are funded by either state of federal sources, alone, in combination, or with supplemental funding from private sources. Ten full programs and three intensive programs are managed by the DCF. Five full programs are offered by DPH, and four full programs and two pilot programs are managed by the DSS. One program each is managed by DDS, SDE, and

[7] Early childhood home visiting programs in Connecticut are those that offer services on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children from birth to kindergarten entry, focusing on outcomes that may include: improved maternal and infant health; prevention of child injuries, abuse, or maltreatment; reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic abuse; improved family economic status; improved coordination and referral services; or improved parenting skills related to child development.

DMHAS. One programs is offered by a private organization, Yale University, and one program is offered by a public/private partnership with DCF and SDE (The Children's Fund of Connecticut). A total of $183.8 million annually is spent for families and children aged 0-17, inclusive, across Connecticut, for services to 94,347 children aged 0-17 who were living in poverty during calendar year 2008 (U.S. Census Bureau, 2010). The average funding spent per child in poverty within Connecticut is, therefore, about $2,000 annually. Of the total number of children aged 0-17 living in poverty, however, only about one-third are actually served by the program. There were an estimated 32,937 children of early ages (0-4 years, inclusive) in 2008, and of these, an estimated 13,786 were less than one year of age. It is unclear from the survey responses what percentage of young children are served by the home visiting programs. It is also unclear from the survey how much of this funding is spent on actual home visiting services, and how much is spent on other services such as care coordination, ancillary activities, and infrastructure. This needs to be more fully explored, so that additional funds added into the system of home visiting care are used most efficiently. Discussions about the use of additional funds must include the state agencies that manage home visiting programs, and these state agencies must work cooperatively to ensure that funds are used wisely.

Towns Served by Home Visiting Programs

Programs with home visiting services are scattered across Connecticut (**Table X; Appendix 4**). Hartford has the largest number of programs, with a total of fifteen. This is followed by New

Table X
Connecticut Programs with Maternal, Infant, and Early Childhood Home Visiting Services, 2008

Fairfield County	Hartford County	Litchfield County	Middlesex County	New Haven County	New London County	Tolland County	Windham County
Very High Need for Maternal & Infant AND/OR Early Childhood Services [1]							
Bridgeport (8)	Bloomfield (1) Bristol (5) East Hartford (1) Hartford (15) New Britain (7)	Torrington (9) Winchester (1)		Ansonia (0) Derby (0) Meriden (3) New Haven (13) Waterbury (13)	New London (5)		Putnam (3) Windham (7)
High Need for Maternal & Infant AND/OR Early Childhood Services [2]							
	East Windsor (2) Enfield (3) Manchester (8) Plainville (3) Windsor Locks (0)			East Haven (2) West Haven (1)	Griswold (2) Norwich (11) Sprague (0)	Vernon (1)	Killingly (0) Plainfield (0)
Moderate Need for Maternal & Infant AND Early Childhood Services [3]							
Danbury (7)		Plymouth (0)			Groton (4)		Chaplin (0) Thompson (0)

Categories of need extracted from **Table IX**.
Values in parentheses are the number of programs with a home visiting component, obtained from a survey of 28 existing programs in the state (**Appendix 3 and 4**).

Haven and Waterbury (13), Torrington (9), and Bridgeport (8). All of these towns are categorized as being of very high need for maternal, infant, and early childhood services (**Table IX**). Other towns of this very high need category with existing home services are New Britain (7), Windham (7), Bristol (5), New London (5), Meriden (3), Putnam (2), and East Hartford, Bloomfield, and Winchester (1). Derby and Ansonia have no existing services.

Among towns with a high need for maternal, infant, and early childhood services, Norwich has the highest number of programs (11), followed by Manchester (8), Groton (4), and Enfield and Plainville (3). East Windsor, Griswold and East Haven each have two programs, and Vernon has one program. Four towns in this category have no programs. Among towns categorized as having a moderate need for maternal, infant, and early childhood services, Danbury has the highest number of programs (7), followed by Groton, with four programs. The other three towns have no programs.

At the county level, a total of 45 separate programs exist through the Hartford County, followed by 33 in New Haven County, 22 in New London County, and 15 in Fairfield County. Litchfield County has ten programs, Windham County has nine programs, and Middlesex County has eight programs. Tolland County has 2 programs. This compares to an estimated 9,962 young children (0-4 years old, inclusive) living in poverty within Hartford County, followed by New Haven (9,735 children), Fairfield (7,201), New London (2,078), Windham (1,457), Litchfield (982), Middlesex (882), and Tolland (640). The number of services generally agrees with the number of young children in need. New London and Litchfield Counties, however, have slightly more programs than expected, and Fairfield and Windham Counties have slightly less programs than expected.

These data suggest that, whereas the number of programs generally matches the population of children living in poverty, some geographic areas of the State are receiving a disproportionate amount of services. Responses from the survey did not distinguish between large and small towns, and it is possible that some smaller towns are serviced by programs in nearby, larger, towns. Also, within individual programs, it is not known if the distribution of services varies with town size. It is possible that, among all children of need in the State, some receive duplicated services, while others lack services. Due to the large number of separate programs that exist in some geographic areas, a coordinated system of care is needed that allows existing services to function in a seamless way that maximizes services, with equity, to all children in need. This requires a systems approach to home visiting services in Connecticut that includes group discussions within key geographic locations. Discussions should involve all programs that exist in local areas.

The specific services offered by any single program can vary from town to town. For instance, with the exception of the sites in Hartford and New Haven that provide intensive home visiting, the State Healthy Start program provides limited home visitation (LV. Barrera, DSS, *personal communication*). This occurs because available resources do not support home visitation for all towns in each region. Other programs may have similar limitations.

Ages Served by Home Visiting Programs

Programs with a home visiting component in Connecticut serve a variety of ages during early childhood and even before birth (**Appendix 4**). Some programs serve children only after birth, while others enroll mothers before a baby is born, during either the preconception or inter-conception time period during a woman's reproductive years. Some serve only infants and toddlers, while others serve children up to age five and beyond, and some enroll children, as needed, across a range of ages. A total of 10 programs in the State initiate enrollment before a baby is born (prenatal time period), while six initiate enrollment during infancy, and four initiate enrollment even before a women is pregnant. Among services to children, one program only serves infants, and three programs serve children up to age two. Four programs serve children up to age three, and another four programs serve children up to age five. Ten programs serve children beyond age five. For children requiring a continuum of care throughout early childhood, and even throughout childhood, programs within Connecticut need to cooperate to form a seamless referral mechanism. Alternatively, some programs could be expanded to include a broader range of ages.

Outcomes Monitored by Home Visiting Programs

Maternal, infant, and early childhood programs serve at-risk families to reduce factors that contribute to poor family outcomes, and an indication of any program's effectiveness is improvement toward its objectives. Outcome measures that provide each program's progress toward objectives are monitored regularly by programs within Connecticut that have a home visiting component (**Appendix 4**). Some programs within Connecticut with a home visiting component focus on health concerns, while other programs focus on social or behavioral concerns. A majority of programs (16) monitor parenting stress and parenting skills outcomes, as well as the mother's health and behavior. Fourteen programs monitor infant and child health, and 13 programs monitor child development and behavior. Eight programs each monitor school readiness and indicators of crime or domestic abuse. Seven programs monitor family economic well-being, and six programs monitor child abuse or neglect. These data indicate that a variety of risk factors can be addressed by programs within Connecticut, but that these programs need to be matched to family need. Some families may only have health or economic concerns, while other families have childhood behavior and development concerns. Some families may have multiple concerns. Programs in Connecticut must be coordinated to match individual family need with services offered by programs. This suggests that a variety of programs need to be available in a wide range of geographic areas, and that program staff in these geographic areas need to be in regular communication.

Degree of Evidence Base in Home Visiting Programs

Home visiting services in Connecticut are based on a diverse set of models, with a range of evidence base (**Appendix 4**). Some of these programs are described below.

1) Six programs are unique, and have either a strong evidence base with peer-reviewed journals or are pending publication. These programs are: Early Childhood Consultation Partnership (http://www.clasp.org/admin/site/publications_states/files/

map030707ct_eccp_summary.pdf); Child FIRST (http://www.ChildFIRSTCT.org); Intensive In-Home Child and Adolescent Psychiatric Services (http://www.fcaweb.org/inhomeservices.htm); Minding the Baby (http://childstudycenter.yale.edu/services/baby.html), which is based in part on the Nurse Family Partnership model of home visiting (http://www.nursefamilypartnership.org/); and Family Reunification Services (DCF). The Family-Based Recovery program (DCF) is pending publication.

2) Nine programs in Connecticut with a home visiting component fully replicate existing evidence-based models. The Birth To Three (http://www.birth23.org/) program uses its national model. The Head Start (http://www.acf.hhs.gov/programs/ohs/), Early Head Start (http://eclkc.ohs.acf.hhs.gov/hslc/Early%20Head%20Start), Family Resource Centers (http://www.ctfrc.org/), and Nurturing Families Network (http://www.ct.gov/ctf/cwp/view.asp?a=1786&q=296678) programs replicate the Parents as Teachers model of home visiting (http://www.parentsasteachers.org/). One program, AIRS, is based on a model developed by the Centers for Disease Control and Prevention (http://www.thecommunityguide.org/asthma/multicomponent.html). The Building Blocks program (http://buildingblocksct.org/) replicates the Child FIRST model of home visiting care (see item 2). Two programs replicate the Healthy Start model (http://mchb.hrsa.gov/healthystart/phase1report/; State Healthy Start and Hartford Healthy Start). The State Healthy Start program is well known as an essential resource for pregnant and post partum women and their families, and has a history of offering home visitation. The program is currently embedded in the community, engages its clients effectively, and is capable of expansion (LV. Barrera, DSS, *personal communication*). In addition, the federal Healthy Start programs, with funded programs in New Haven and Hartford, are well-positioned within the community to expand their quality home visiting systems to improve health outcomes (Berry et. al., 2010).

3) Fifteen programs budget for external evaluations to provide an objective set of analyses that support program effectiveness, and 11 of those programs have received evaluation reports.

4) Eleven programs perform evaluations using data made available to program staff.

These results suggest that there is wide variation in the degree of evidence base among maternal, infant, and early childhood programs in Connecticut, and varying outcomes of interest for each program. Those programs that replicate nationally-recognized evidence-based models, and those with strong evidence worthy of peer-review publication, have a high likelihood of being considered evidence-based programs. Other programs that lack this level of evidence, but that are well-established within the community, may be able to incorporate evidence-based models. There are a few programs in the State that may not be able to achieve a level of evidence-base. Programs of these three types need to be compiled and assessed for their impact on services to Connecticut residents.

Maternal and Child Health Block Grant Needs Assessment

Semi-decennial needs assessments are a requirement of the Maternal and Child Health Block Grant, funded through the U.S. Title V Social Security Act. Its most recent needs assessment in Connecticut was completed in June, 2010, and identified a set of nine state priorities. These

priorities are: 1) enhance child health data systems; 2) improve mental/behavioral health services; 3) enhance oral health services; 4) reduce obesity; 5) enhance early identification of developmental delays, including autism; 6) improve the health status of women, including depression; 7) improve linkages to services and access to care; 8) integrate lifecourse theory throughout state priorities; and 9) reduce health disparities. All of these state priorities could be addressed with home visiting services. Close collaboration and data sharing between state agencies would enhance data systems. Home visiting services to women and young children and their families would directly affect mental/behavioral health services, oral health services, services to address or treat obesity, and childhood developmental screening. A coordinated system of home visiting services would improve the overall health status of women and children, and a seamless referral system of home visiting services would improve linkage to an array of physical, social and emotional services. Further, the provision of services in areas of the State with high concentrations of families of minority race/ethnicity would help to address health disparities. Finally, by focusing on the health and well-being of young children, a variety of adverse developmental, social, and health outcomes could be prevented in adulthood, consistent with lifecourse theory.

Local Assessments

Head Start Plans

Thirty-three Head Start and Early Head Start programs exist in Connecticut, with funding through the U.S. Head Start Act. Each program has developed a local document of community strengths and needs. Each document consists of varying components, such as demographics, and needs perceived by parents, community members, and service providers. Each needs assessment concludes with identification and prioritization of issues and problems. Among all these documents, however, none currently considers home visitation programs in the community. A foundation of Head Start community assessments would be a starting point for an additional focus on home visiting programs, and could help to highlight the great need for these programs among families with some of the highest risk for adverse outcomes. To date, four local needs assessment documents have been compiled by DPH. With the exception of East Hartford, community needs assessments for towns of very high need were not available to inform this needs assessment document. These documents will be important for future activities within the communities of need.

Childhood Abuse Prevention and Treatment Program Assessments

The Children's Trust Fund is funded to address childhood abuse through section 205(3) of the U.S. Child Abuse Prevention and Treatment Act. It has worked with the United Way of Connecticut through its Help Me Grow program to develop an inventory of programs and services that support families and children, and to identify unmet needs (K. Foley-Schain, DSS, *personal communication*). The inventory includes: 4,557 agencies, 14,124 service sites, 1,756 unique services, and a total of 47,627 services among sites.

The inventory of available services is extensive, however gaps and barriers to services exist in key areas of prevention programming. The gaps and barriers information was developed

primarily from the experiences of 3,000 families calling the Children's Trust Fund's Help Me Grow program in 2008. A key finding of the inventory was that requests for parenting and family support programs of all kinds out pace available programs including services for: 1) Home visiting and other services for pregnant and new families; 2) Parenting groups particularly those offered in Spanish; 3) Community-based mental health and addiction services that accept Medicaid reimbursements; 4) Respite and crisis services; 5) Adequate programs for fathers and men in parenting programs; 6) School based programs for children and parents - including after school and family support services; and 7) Programs to support grandparents raising grandchildren.

In addition, other needs identified were: 1) Bi-lingual and multi-lingual staff, especially in the area of agency intake; 2) Financial support for and/or the availability of basic needs resources; 3) Behavioral health providers for young children; 4) A transition of health care coverage for Medicaid enrolled children when they reach their 19th year; 5) Services/supports for youth with special health care needs who are transitioning from youth to adult services; 6) and Child care and after school care for children with special health care needs.

Community Comprehensive Early Childhood Plans

In January 2009, twenty-three (23) communities were selected to receive public-private partnership grants (J. Meyers, CHDI, *personal communication*). The Early Childhood Education Cabinet allocated $525,000 in each year of the 2008-2009 biennial budget for building local capacity grants that was matched by an allocation of $300,000 each year by the William Caspar Graustein Memorial Fund (http://www.wcgmf.org). The co-investment was an opportunity to create a public-private partnership that would support the development of comprehensive community plans for young children that aligned with the *Ready by 5 & Fine by 9* framework (Connecticut Early Childhood Education Cabinet, 2006).

Community capacity has been further enhanced by the addition of private/public partnerships. The Children's Fund of Connecticut and the Graustein Memorial Fund in partnership provided $100,000 each to support community efforts to engage the health sector in the community planning process. Twelve of the Building Local Capacity grant communities applied for funding. Eight communities were awarded $15,000 - $20,000 health addendum grants that were administered through the Child Health and Development Institute. A collaborative management team comprised of staff from these three organizations, as well as the Connecticut Early Childhood Cabinet, was established to jointly oversee the implementation. The twenty-three communities receiving a public-private partnership grant included 14 Priority School Districts and nine Competitive School Districts. All 14 of the Priority School District planning grant communities have been designated by the SDE as "in need of improvement" within the context of federal No Child Left Behind (NCLB) laws.

Through the community planning process, it was anticipated that communities would begin to develop an early care and education system responsive to the varying needs of young children and their families. Communities were encouraged to collect and analyze data to develop a community-wide understanding of what was contributing to poor outcomes. From this needs assessment, communities identified a range of strategies and sub-strategies that would move them toward achieving the results they specified for their young children. Despite the unique

characteristics and needs of the communities, common strategies emerged within each major domain.

In addition to strategies in the domains of health, early education and family support, cross system strategies that connect multiple programs and streamline access were also proposed. Home visiting was one such cross system strategy that emerged from a review of the 23 community plans, linking and integrating behavioral health, primary health care, and early education.

Although some plans are working drafts and others are complete, all the communities see the plans as the first step in a continuous process. Funding from both the public and private sectors is now available for continuation of this work. Fifteen communities have received grants to implement their plans. Four additional communities have received grants to enhance specific elements of their plans before receiving full implementation funds. Another 20 communities recently received first time planning grants.

The plans developed by these communities within Connecticut contain items specific to each community. Many communities identified as high or very high need for home visiting are partners with the Memorial Fund and have developed community plans. Some components include home visiting, while others do not. These local plans could be evaluated for their ability to assess community needs for home visiting services. Those lacking this component could be expanded to include home visiting, using the infrastructure developed for the plans.

Substance Abuse Programs; Need and Capacity [8]

Substance abuse is a component of many programs in Connecticut, including programs offered through the State's community health centers. Many programs specific to substance abuse treatment are managed within DMHAS. These substance abuse treatment programs serve a total of 75,000 adults annually, of which 35% are women (T. Nowakowski, DMHAS, *personal communication*). Of all those served, 60 % are Caucasian, 18.2 % are African American and 16.2 % are Hispanic. The programs provide prevention, treatment and support services to children, adolescents and adults. Services are culturally competent, with a focus on the underserved or poorly served populations. The DMHAS focuses increased attention on gender, culture, trauma, and co-occurring disorders.

In calendar year 2009, 21 towns hosted centers by DMHAS for substance abuse treatment of young adults, serving a total of 19,773 young adults. Racial and ethnic disparities exist in young adults treated for substance abuse. Of the 19,779 in active treatment statewide, 48.6% clients were of White/Caucasian race, 5,604 (28.3%) were of Black/African American race, and 4,332 (21.9%) were of Hispanic origin. Towns with a higher than average percent of Black/African Americans in treatment were: New Haven (46.8%), Bridgeport (41.3%), Stamford (37.8%), Hartford (36.0%), and Norwalk (33.0%). Towns with a higher than average percent of Hispanic

[8] Substance abuse treatment and counseling services may include treatment and/or counseling services for abuse of alcohol, illegal substances, prescription drugs, inhalants, over-the-counter medications and/or other products. These services are not limited to home visiting.

clients were: Hartford (39.1%), Bridgeport (32.1%), New Britain (31.7%), Waterbury (24.8%), and Windham (22.8%).

Recent information from the U.S. Substance Abuse and Mental Health Services Administration indicates that the eastern region of Connecticut, which generally includes towns in New London and Windham Counties, has the highest prevalence of illicit drug use among persons 12 years and older, in which over 10% of the population reported using illicit drugs in the past month, and 3.6% reported using drugs other than marijuana (SAMHSA, 2010). This region of the State was also reportedly in need of treatment for other drugs and alcohol; 9.1% of these who responded indicated a need for drug treatment services, and 2.7% reported a need for alcohol treatment services. It is not clear from these results what specific towns are in greatest need for services.

Of all young adults treated in calendar year 2009 for substance abuse, 5,285 (26.7%) were women, and 178 (3.4%) of these women were pregnant at the time of active treatment. Towns with a higher than average percent of pregnant clients included Enfield, Middletown, Waterbury, East Haven, New Haven, Bridgeport, New Britain, Torrington, and Hartford. All but two of these towns were identified as being of very high need for maternal, infant and early childhood services (**Table IX**); Although the towns of Enfield and Middletown did not meet the criteria for very high need, they carry a disproportionate burden of need for substance abuse programs. These results indicate that culturally-appropriate treatment programs are needed in the State, and that the programs must be matched to the areas of greatest need.

In recognition of the unique barriers and experiences that women in need of substance abuse treatment services face, DMHAS funds specialized and comprehensive programs for women and their children. These include residential treatment, outpatient treatment, and specialized care management for women transitioning from a specialized residential setting to community-based recovery services. While programs are located statewide in many communities to allow a woman to remain "local", she is also eligible for programs outside her immediate area, based on availability. Treatment programs are located in both urban and rural settings, thereby offering unique experiences, opportunities and features. A variety of programs specific to women are described below (T. Nowakowski, DMHAS, *personal communication*).

During the period of July 31, 2008 to July 31, 2010, there were 403 admissions to women's and children's residential programs (T. Nowakowski, DMHAS, *personal communication*). The children were primarily under the age of five, because only one program allows children up to the age of ten. Of the total number of admissions, 107 were pregnant at admission, and 49 were pregnant with their first child. Another 239 women were not pregnant, but had other children. Only one woman was neither pregnant nor had any children. During this same time period, of 399 women discharged from the programs, 102 were reunited with their child or children while in the program, and 89 had their children with them during treatment. A total of 192 were not reunited with their children at discharge, and 16 lost custody of their children while in treatment. The potential custodial loss of children during treatment may represent a barrier to services that needs to be further studied.

Women's Services Practice Improvement Collaborative (WSPIC)

In October 2004, DMHAS launched a three-year initiative called WSPIC to enhance the behavioral health service system for women in a way that is trauma-informed, gender-specific, and that promotes self-determination (Nowakowski, 2007). The goal of WSPIC is to improve treatment outcomes and the quality of services for women receiving substance abuse treatment in Connecticut through participation in a recovery-oriented treatment system of care that incorporates best practices in programming.

Women's Behavioral Health Services Program (WBHSP)

The WBHSP is designed to provide additional support to women who either currently reside or who recently resided at one of the Women's Specialty Residential Programs. Three women's recovery specialists provide discharge planning support for women who are discharging from residential services. The goals of WBHSP are to: 1) Improve access to recovery-based services for women; 2) maximize the use of existing resources through care management of residential treatment services; 3) improve the measurement and monitoring of treatment outcomes; and 4) identify gaps in services for women. To accomplish these goals, the WBHSP women's recovery specialists provide holistic services to maximize the likelihood of client success upon discharge from residential programs. These specialists assist in successful client treatment outcomes by being a participant in discharge planning efforts, and by improving clinical linkages among treatment providers, community-based supports, and workers from DCF.

Recovery Specialist Voluntary Program (RSVP)

The DMHAS, in partnership with DCF and the Judicial System, developed RSVP to give parents facing permanent separation from their children a chance to bring them back home (http://www.jud.state.ct.us/external/super/StandOrders/Juvenile/RSVP_standing_order.pdf). The program offers hope for recovery and is implemented by reallocating funds from existing programs with less impact. RSVP facilitates a parent's path to recovery and ability to reunite with their children after losing custody due to substance abuse. Parents work with a recovery specialist to: 1) Assist in engagement of substance abuse treatment, 2) Conduct random drug screens to validate the recovery process, and 3) Provide a support structure and "recovery coaching." Parents facing DCF intervention don't always participate in substance abuse treatment as soon as they could. Participating with recovery specialists allows for early treatment help and recovery supports for parents beginning the recovery process. The program was initiated in New Britain in April 2009 and expanded into Bridgeport and Windham the second quarter of 2009. The program is now also offered in Norwich and Middletown, with intention of expanding statewide.

III. Status of Connecticut's Maternal, Infant, and Early Childhood Service System

To maximize the coordination of services within states, a systems approach is often used. An effective and efficiently coordinated system of home visiting programs would be described by a set of ideal characteristics (Coffman & Parker, 2010; Coffman, 2007). These ideal characteristics include: 1) a surrounding environment that is supportive and strong; 2) programs of high quality that produce the desired outcomes; 3) strong and effective linkages; 4) a governance and administrative structure that supports the system, and 5) a comprehensive set of services that meet the needs of high-risk communities.

To assess the baseline for systems building within Connecticut, and to facilitate the development of benchmarks and strategies for building a strong system of home visiting programs in the State, a Systems Self-Assessment developed by the Colorado Trust (Coffman, 2007) was adapted with extracted information from a statewide assessment developed by the organization Zero to Three (Gebhard, 2010), and was piloted among all members of the Needs Assessment Group (**Appendix 5**). A total of 14 members responded to the Self-Assessment. Responses provide only a tentative baseline for the current system of maternal, infant, and early childhood services in Connecticut, and suggest possible strategies to building a strong, sustainable, and effective system. The Self-Assessment should be distributed to a broader and larger audience, including consumers, policy makers, and program staff, as well as early childhood advocates.

A Strong and Supportive System Environment

Results of the piloted Systems Self-Assessment indicate that the current status of this ideal characteristic has a baseline score of 2.1 of 5.0 (**Appendix 5**). Strengths in this area are a somewhat strong public will and a set of policies that support the system. Although additional state policies are needed to strengthen the system of care, the State of Connecticut has active advocates within the legislature for maternal, infant, and early childhood health and well-being. These advocates include the COC (http://www.cga.ct.gov/coc/). The Commission has been instrumental in advocating for four recent public health policies (E. Zimmerman, COC, *personal communication*). Current legislation to support infant and early childhood health and development include the following:

Public Act 10-133, An Act Concerning Children in the Recession: This law makes Connecticut the first state in the nation to take a comprehensive approach to addressing the needs of children harmed by the economic downturn. It requires that whenever the state unemployment rate reaches eight percent or higher, a leadership team from across state agencies will meet regularly to create a unified government response to such matters as hunger and homelessness. The legislation also seeks to improve the delivery of services to families who need them by requiring state agencies to develop a single, streamlined application process for services like food stamps, the Care4Kids child care program, unemployment, and medical assistance and insurance. This will not only simplify the application process for needy residents, but will also make state government more efficient and cost-effective. Under the law, a child nutrition outreach program will be implemented to increase participation in the School Breakfast Program, federal Summer Food Service Program, and the federal Child and Adult Care Food Program. Increased

enrollment could bring in at least $8 million in new federal funds for school breakfast and summer feeding programs for children. The law also: Allows parents receiving TANF (Temporary Assistance for Needy Families) to attend two- or four-year degree programs as one of the program's acceptable work activities, increasing their future productivity; prohibits the DSS from closing the Care4Kids child-care assistance program without 30 days advance notice; ensures essential services for homeless families and those at risk of homelessness; and calls for a greater focus on reducing the incidence of (a) low birth weight, (b) homelessness among children and families, and (c) food insecurity.

Public Act 04-238, An Act Concerning Child Poverty: In 2004, Connecticut became the first state in the nation to enact a law setting a target for reducing child poverty. The law (P.A. 04-238) mandated state planning and implementation to reduce the number of children living in poverty by fifty percent by the year 2014. It also established the Child Poverty Council (now the Child Poverty and Prevention Council), a state entity representing all three branches of government, and charged it with developing and promoting the implementation of a ten-year plan to meet the poverty reduction goal.

Public Act 06-179, An Act Concerning State Investment in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils: A Connecticut prevention law enacted in 2006 encourages investment in proven, cost-effective prevention services that improve outcomes for children, youth, and families. The law promotes prosperity and success for Connecticut's children and families, rather than just crisis management. The law, known formally as An Act Concerning State Investment in Prevention (P.A. 06-179), takes the following steps to strengthen Connecticut's prevention investment: Reactivates the State Prevention Council's work and sharpens its prevention mission; revives the Governor's biennial prevention budget and aligns it with child and family prevention goals already in Connecticut law; requires the Governor to report on the State's progress toward meeting the goal that, by the year 2020, 10 percent of the budgets of State agencies serving children and families will be allocated for prevention services; and directs these State agencies to report annually on the effectiveness of their prevention services and their efforts to improve child outcomes.

An especially weak area of this characteristic is a funding stream that is flexible, diversified, and consistent with need. Funding streams need to be identified that strengthen the system, and mechanisms need to be explored that would allow existing funds to support the system beyond services.

<u>High Quality Programs</u>

Responses to the piloted Self-Assessment indicated an overall score of 3.0 of 5.0 (**Appendix 5**). Identified strengths in this area were the perceived number of programs that are evidence-based, and the extent to which programs reach clients in need. Respondents also generally felt that services matched the needs of the community and were culturally-sensitive.

A commonly used model in use within Connecticut is the Parents as Teachers (http://www.parentsasteachers.org/) model of home visiting. This model is a voluntary parent education and family support program based on the vision that all children will learn, grow and develop to realize their full potential. Trained and certified parent educators provide parents

with timely information on child development the prenatal stage to kindergarten entry, and involve them in parent-child activities that encourage language, intellectual, motor, and social-emotional growth. This program, which has been used in Connecticut for over 20 years, offers training and technical assistance on a regular basis (P. Langer, SERC, personal communication). Programs within Connecticut that include a component of this model are Family Resource Centers, Early Head Start and Head Start programs, Birth To Three, and Nurturing Families Network (see **Section III**).

Other nationally recognized evidence-based models could be explored. A recent study of home visiting models for early childhood outcomes was recently conducted (Kahn et al, 2010). This document performed a meta-analysis of 35 home visiting programs from across the country, and determined that 16 of the programs met its criteria for strong evidence. These programs were evaluated for outcomes such as physical and health development, externalizing behavior, cognitive development, social skills, mental/emotional health, parenting skills, parent-child relationships, child maltreatment, substance abuse, and reproductive health. The study generally found two important components of successful home visiting programs: programs that were high intensity, and programs in which therapists or social workers taught parenting skills. Other home visiting program models that may be evaluated and determined to be of sufficient evidence could be explored (Olds et al, 1999; Lyons-Ruth, 2006). It is important that any replication of existing evidence-base models include a means to monitor fidelity.

An identified weak component of this characteristic is a universal set of outcomes that are monitored by individual programs. Program outcomes that were evaluated in this assessment were: maternal health/behavior, infant/child health, child development/behavior, parenting stress and skills, school readiness, crime/domestic abuse, child abuse/neglect, and family economic well-being (**Section III; Appendix 4**). An additional set of outcomes used by some evidence-based programs in the country include: cognitive development, social skills, mental/emotional health, parent-child relationship, substance use, and reproductive health (Kahm and Moore, 2010). Each maternal, infant, and early childhood program in the State could choose among a list of outcomes it wishes to achieve, and then indicators could be developed to monitor these outcomes.

Strong and Effective Program Linkages

Among responses to the piloted Self-Assessment, this ideal characteristic received an overall score of 1.7 of 5.0 (**Appendix 5**), and was the characteristic that scored lowest of the five ideal characteristics. This suggests that efforts to build strong and effective linkages need to be a priority in the short term. Area strengths in the category included a moderate level of satisfaction with referral systems across programs and cooperation among programs. The DCF, as well as Head Start program have been working together for many years, and partnerships between agencies are readily formed to meet common goals. Some memoranda of agreement exist to formalize these partnerships. Additional work is needed to strengthen these relationships and create a seamless referral system that involves regular communication between programs.

An especially weak area of this characteristic is the existence of data systems to monitor and track program participants. Data systems need to exist that facilitate this function, and data systems available to individual programs need to contain information in common to allow

extraction and compilation of client-level data, with appropriate human investigation approval. Inter-agency data sharing agreements are needed to facilitate this process, and agencies must share a common goal to achieve this objective. A survey of existing interagency data sharing agreements in the State, and associated strategies to build on those agreements, is needed.

A Supportive Governance and Administration

The piloted Self-Assessment revealed an overall score for this ideal characteristic of 2.2 of 5.0 (**Appendix 5**). A moderate area of strength was the existence of education and training to create a competent workforce. Since 2007, a group of 15-20 people interested in developing a competent workforce in infant and early childhood mental health have been meeting as the Competency Planning Consortium (J. Meyers, CHDI, *personal communication*). Upon the recommendation of the Consortium, The Connecticut Association for Infant and Maternal Health (CT-AIMH) purchased the Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice to Promote Infant Mental Health® from the Michigan Association for Infant Mental Health in October 2008. In January 2009, the group received training on the Guidelines from staff in Michigan at MI-AIMH, a professional organization with over 450 members. Since then, the Consortium has worked through committees to introduce the competencies in Connecticut. The Competency Guidelines were developed over a 10-year period by the MI-AIMH, a professional organization with over 450 members. The Guidelines provide a comprehensive set of standards for persons offering services at multiple levels and in many systems to infants, very young children and their families, leading to an endorsement in Infant Mental Health. The standards in the Guidelines include knowledge, skills and reflective practice support, building capacity in the infant and family field, leading to best practice and promoting social and emotional well-being or infant mental health. The Consortium is in the process of identifying a statewide program that serves infants, toddlers and their families as a focus for endorsement. Home visiting staff would be an ideal group of practitioners for this purpose, because their work would greatly benefit from having the skills and knowledge included in the Infant Mental Health Competencies.

In addition, training for the Parents as Teachers model of home visiting care is available through ConnPAT, which offers training to trainers, and CT-PEN (http://ctpen.org/), which offers credentials from Charter Oak College for parenting educators (P. Langer, SERC, *personal communication*). These and other training opportunities would strengthen the workforce involved in maternal, infant, and early childhood home visiting.

A bifurcation in responses occurred in the area of governing entities that oversee and coordinate programs in the system. Although some felt that the existing structure is relatively strong, others felt that the existing structure is weak. Alternative structures for oversight of the system need to be explored. In addition, existing structures that connect the State to communities should be explored, and include local health departments, or the community partnerships created with funding from the Caspar Graustein Memorial Fund. Other possible system structures need to be explored.

Especially weak areas of this characteristic were a consistent set of standards across the system and the involvement of consumers in oversight activities. Existing programs in Connecticut need to develop a set of standards upon which all programs can be assessed, and

programs need to commit resources and strategies that maintain standards. A concerted effort must also be made to encourage and value consumer oversight.

Comprehensive Services for All in Need

The piloted Self-Assessment produced an overall score for this ideal characteristic that was 2.0 of 5.0 (**Appendix 5**). This characteristic ranked second lowest among the five characteristics, suggesting that it needs to be a priority in the short term. An area of moderate strength in the characteristic was the availability of an array of services. A bifurcated response, however, was obtained for the availability of programs in all geographies of need. The results of this assessment highlighted sub-geographies of need within the State (**Table IX**). Some communities report that the need for services greatly overwhelms the availability of resources, and that waiting periods exist for some programs. Community populations are dynamic, however, and change with time, and the needs of any community may also change. These community-based population changes need to be monitored regularly, and health indicators also need to be monitored across Connecticut's population to assess changes in geographic need for services. Regular documents similar to that developed by the Finison (2007), would be a helpful complement to these efforts.

The data presented in this needs assessment report cannot describe the needs of individual communities with detail. Community-based needs assessments are necessary to best understand these needs. Stakeholders who were not surveyed in this needs assessment need to be included in community-based assessments, and include local community-based programs, such as Hartford and New Haven Healthy Start, as well as local municipalities. The Visiting Nurses Association group should also be included in community-based assessments.

Areas of particular weakness in this characteristic include a funding system that is stable and sustainable. If efforts to build a system of maternal, infant, and early childhood home visiting programs is limited only to individual services, then services and outcomes will be completely dependent on funding. As funds wane, services will also diminish, and poor outcomes will increase. Further, intergenerational change will be entirely dependent on the services received. Only with an ecological approach to this public health problem will sustainable and long-lasting change occur in the status of high-risk families. An ecological approach to addressing the needs of at-risk families seeks to simultaneously address the problem, not only at the interpersonal/intrapersonal level of individual and family services, but also at the environment within which that family is embedded. Strategies at the institutional, community, and statewide level are needed to fully address the problem.

IV. Statewide and At-Risk Community Data Report

See **Appendix 6**.

"Community" for the purposes of this report is defined as the 169 towns that exist in the State of Connecticut. Data reports for the State overall, as well as for 16 towns identified as being of very high need communities, are included in the Data Report. Details of each indicator in the Data Report are discussed below. Data from CAPTA and Head Start were not readily available, so other sources of data were used to measure poverty, unemployment, and child maltreatment, as discussed below. Data from SAMHSA are available only at the regional level; a town-level proxy of substance abuse is used, as discussed below.

Premature Birth and Low Birth Weight Rate: The percent of preterm birth, by town, is available and is reported for calendar year 2008 in the Data Report at both the statewide and community levels. The percent of births with a calculated gestational age that was less than 37 weeks is reported. The rate of low birth weight, per 100 births, by town, is also available, and is reported for calendar year 2008. A low birth weight is defined as a birth weight less than 2,500 grams. Premature birth is calculated from a set of data fields in birth records that has variable quality. For this reason, low birth weight alone is used in the body of this report to determine community need. Data are available from vital records within DPH. To balance town size and intra-town magnitude, excess measures of low birth weight are used to identify communities in need (see below).

Infant Mortality Rate: The rate of infant mortality, per 1,000 live births, is available at the town level is reported for calendar years 2003 through 2007, combined. Infant mortality is defined as a death to a live baby that occurs before his/her first birthday, and includes neonatal, as well as post-neonatal deaths. All deaths, including those that result from intentional harm, are included in this measure. Some towns of smaller population size have less than 20 occurrences within the time period, and caution should be used when using those infant mortality rates to establish communities of high need. Infant mortality rates based on a number of occurrences less than six are suppressed. Data are available from vital records within DPH. Infant mortality is not used as a criterion of community need, because it is strongly associated with low birth weight, though it is discussed at the statewide level in **Section I**, *page 11*.

Poverty: Poverty estimates are not available at the town level, but are available from the U.S. Census Bureau at the county level (http://www.census.gov/cgi-gin/saipe/saipe.cgi). For the purposes of this report, town level estimates of percent poverty of children less than 18 years of age are calculated from these county estimates, using the percent of births in calendar year 2008 for each town that were not paid by private insurance. These percentages are obtained from vital records within DPH. Percent poverty is calculated from the estimated number of children living in poverty within each town, relative to the estimated number of children living in that town. Percent poverty for children less than 18 years of age is recorded in the Data Report. Percent poverty estimates for young children less than five years of age are used in the body of this report to identify communities of need (see below).

Crime: Crime statistics at the town level are available within the State from the Connecticut Department of Safety (http://www.dir.ct.gov/dps/ucr/ucr.aspx). These estimates are recorded in the body of this report, and are recorded in the Data Report. Offenses and arrests for murder,

rape, robbery, aggravated assault, burglary, larceny, motor vehicle theft, and arson, per 1,000 residents, are reported for calendar year 2008. Excess measures are used in the body of this report and are discussed in **Section I**, *page 7*.

Domestic Violence: The State of Connecticut Behavioral Risk Factor Surveillance System regularly collects information on a variety of topics. Response estimates, however, are not generated at the town level. A proxy for domestic abuse used within DPH is obtained from hospitalization records made available by the Connecticut Hospital Association. Hospitalization ICD codes 995.50-995.55, 995.59, and 995.80-995.85 are used to obtain a percent of all emergency room visits that are related to domestic violence. These data are available by town of residence and are reported in the body of this report (**Section I**, *page 8*), and the Data Report.

High School Dropout Rates: High school dropout rates are available from SDE at the school district level. Estimates at the town level are imputed from these estimates. The percent of school dropout is calculated from the number of students enrolled in each district for grades nine through twelve who dropped out during the school year. These data are used in the body of this report (**Section I**, *page 19*), and are recorded in the Data Report.

Substance Abuse: Substance abuse is not readily available at the town level within Connecticut. Data by five regions of the State are available from the National Survey on Drug Use and Health (http://oas.samhsa.gov/substate2k10/toc.cfm). Town of residence data among individuals actively treated for substance abuse in 2008 is available from the DMHAS. Active treatment by town of residence is used to identify communities in need for services (**Section II**, *page 38*), and are recorded in the Data Report.

Unemployment: Estimated unemployment rates are available from the Connecticut Economic Resource Center, for calendar year 2008 (http://www.cerc.com/TownProfiles/default.asp). These data are used in the body of the report to identify communities of need (**Section I**, *page 6*), and are recorded in the Data Report.

Child Maltreatment Rate: Estimates of child maltreatment rates are available from DCF at the town level. Child maltreatment is defined as any type of substantiated case and includes educational, medical, physical, or sexual maltreatment cases. The average annual rate is calculated from the number of cases to children less than 18 years of age, by town of residence, relative to the estimated number of children living in the town who were less than 18 years of age, for years 2008-2010 combined. Rates per 1,000 children are recorded in the Data Report. Rates of abuse in towns with a population less than 10,000 are suppressed. The body of this report uses excess measures of child maltreatment to identify communities in need (see below).

Young Children Living in Poverty: One criterion for identifying communities in need is the percent of young children, aged 0-4, inclusive, who were living in poverty in 2008. This estimate is developed using the same method identified above for poverty. Estimates are recorded in the Data Report, and are included in the body of this report to identify communities of need (**Section I**, *page 22*).

Excess Low Birth Weight: Excess measures of low birth weight are used in the body of this report to identify communities of need. These values are recorded in the Data Report, and are discussed in the body of this report (**Section I**, *page 10*).

Excess Non-Private Insurance at Birth: An estimate at birth that is available at the town level and that provides a sense of emerging poverty in the community is deliveries that have not been paid by private insurance. This includes births paid by public forms of insurance, as well as births to individuals who lack insurance. The value is readily available in vital records within DPH. Excess measures of births that were paid by non-private methods are used to evaluate communities in need (**Section I**, *page 14*). These measures are also recorded in the Data Report.

Excess Child Maltreatment: As described above, the body of this report uses excess measures of child maltreatment to identify communities in need (**Section I**, *page 23)*. These values are recorded in the Data Report.

Low Third Grade CMT Scores: The Connecticut Mastery Tests (CMT) are used statewide and within school districts to monitor student achievement. These tests are given to students in third through eighth grade. Three subjects are tested, mathematics, reading, and writing. Each school district is then assessed for the percent of students who achieve proficiency in the three subjects. As a measure of early school achievement, these percentages for third grade students are assessed at the town level. Schools that fail to meet the statewide percent of students who reached proficiency in one, two, or all three of the subjects are identified. These numbers are recorded in the Data Report, and are also discussed in the body of this report to identify communities of need (**Section I**, *page 18*).

Towns were determined to be communities of very high need, high need, or moderate need for maternal and infant services if they had three, two, or one high value(s), respectively, of the following indicators: unemployment rate, excess low birth weight, or excess births paid by non-private sources (**Appendix 1**; **Section I**, *page 25*).

Towns were determined to be communities of very high need, high need, or moderate need for early childhood services if they had four, three, or two high values, respectively, of the following indicators: young children living in poverty, high school dropout rates, excess cases of maltreatment, or two or more low third grade CMT scores (**Appendix 2**; **Section I**, *page 27*).

V. Summary and Next Steps

Summary

A broad and inclusive group of stakeholders from across the State of Connecticut, which included state agencies and advocates, as well as regional groups, was convened in May, 2010 to develop a mandated statewide needs assessment of maternal, infant, and early childhood visiting programs. This activity was initiated in anticipation of future funding through the Patient Protection and Affordable Care Act of 2010. Included in this group were the Directors of Head Start, Title II, Title V, and statewide substance abuse services (see **Letters of Support, Appendix 7**). Additional membership included representatives from the following State agencies: COC, DCF, DOC, DDS, SDE, DMHAS, and CHDI (see **Membership**, *page 2*). Other stakeholders were also involved in the discussions. The group met five times through the month of August, 2010 to oversee, give guidance, share narrative and data, and review material contained in this report. Every effort was made to give voice to all in the group, both individually and collectively.

A geographic analysis of need was conducted in the State for maternal, infant, and early childhood home visiting services. A set of key indicators were identified for which town-level data were available, and an index of need was established. Indicators to establish need for maternal and infant services included unemployment rate, excess low birth weight and excess non-private insurance at birth (**Appendix 1**). Percent young children living in poverty, low third grade school achievement, high school dropout rates, and excess abuse or neglect were used to establish the need for early childhood services (**Appendix 2**). A composite set of needs in the State was then generated (**Table IX**). The statewide assessment of needs for maternal, infant, and early childhood services revealed that some towns in Connecticut are of far greater need than others (**Sections I & II**).

1) Towns of very high need for maternal, infant, and early childhood home visiting services include the 16 towns of: Ansonia, Bloomfield, Bridgeport, Bristol, Derby, East Hartford, Hartford, Meriden, New Britain, New Haven, New London, Putnam, Torrington, Waterbury, Winchester, and Windham. These towns represent the first tier of need for home visiting services, and supporting data are recorded in **Section IV**. The homeless in Connecticut are another subgroup in very high need for services that are not reflected in the town-level data.

2) Thirteen towns of high need for maternal, infant, and early childhood services in the State include: East Haven, East Windsor, Enfield, Griswold, Killingly, Manchester, Norwich, Plainfield, Plainville, Sprague, West Haven, Windsor Locks, and Vernon. These towns represent the second tier of need for home visiting services in the State.

3) An additional five towns of moderate need for maternal, infant, and early childhood home visiting services include: Chaplin, Danbury, Groton, Plymouth, and Thompson. These towns represent the third tier of need for home visiting services in Connecticut. Continued surveillance is needed to monitor towns for emerging need.

Of the 16 towns identified above as very high need, six have early head start programs and all have community comprehensive early childhood community plans. None of the head start plans currently include a component on home visiting. These existing plans, where available, may be

useful as community-level assessments are conducted to evaluate the specific needs for home visiting within each of the communities.

To assess available services in Connecticut, a survey was conducted and compiled that included a variety of very detailed information about 28 programs in the State (**Appendix 3**). Results of this survey indicated that, although town-level services across Connecticut's counties generally reflect the estimated population of children living in poverty and in need of services, some counties receive disproportionately more services and others receive disproportionately fewer services (**Section III**; **Tables IX and X**). Summary analysis of the survey also indicated that home visiting services in Connecticut are managed by multiple agencies, operating multiple programs that serve a variety of subpopulations across the State (**Appendix 4**). Programs currently operate separately with a loose and informal networking structure.

A piloted Self-Assessment was conducted among the members of the Home Visiting Needs Assessment Group to evaluate the current statewide system of programs that offer home visiting services. The survey revealed that, although some work has been done to achieve an ideal service system in Connecticut, more work is needed to achieve a strong and sustainable system of care in the State (**Section IV**; **Appendix 5**).

Racial and Ethnic Disparities

Throughout this needs assessment document, striking disparities among minority race and ethnic groups were documented, and are summarized in **Table XI**. Relative to the population distribution of race and ethnicity among residents of Connecticut in 2008, a disproportionate

Table XI
Selected Maternal, Infant, and Early Childhood Indicators of Need by Race/Ethnicity, Connecticut, 2008

Indicator	Race/Ethnicity		
	White/ Caucasian	Black/ African Am	Hispanic
Population (%)	74	10	12
Births (%)	58	12	21
Births in Large Urban Communities (%)	9	54	48
Active Treatment of Substance Abuse (%)	49	28	22
Emergency Room Visits for Domestic Violence (%)	5	17	13
Births Paid by Public Insurance (%)	18	57	55
Late Prenatal Care (%)	8	20	20
Third Grade CMT Reading Scores (% not at goal)	21	73	76
Singleton Low Birth Weight Rate (per 100)	4.3	10.7	6.3
Feto-Infant Mortality Rate (per 1,000)	5.2	13.1	8.1
Teen Birth Rate (per 1,000)	8.5	41.8	78.0

Summary table is generated from previous sections. Racial/ethnic distribution is recorded at the statewide level.

burden of poor maternal, infant, and early childhood outcomes and risk factors exists among families within Black/African American and Hispanic communities. Further, a disproportionate distribution of minority race/ethnicities live in urban areas of the State and comprise the 2008 birth cohort. These data collectively indicate that minority racial and ethnic communities are in very high need of home visiting services. During a recent forum to examine persistent disparities in perinatal services within Connecticut (Lipkind, 2010), a diverse group of State and local leaders identified a set of positive and negative ecological determinants that impact service disparities. Many of these determinants could be addressed with home visiting services, and at the intrapersonal/interpersonal level include life skills training, food and housing insecurity, poverty, domestic violence, access to care, reproductive education, and breastfeeding support. Other determinants at the institutional, community, and federal/state levels could be addressed with a strong system of care that offers successful home visiting programs focused on families of minority race and ethnicity. These successful programs would have the ability to attract, retain, and address poor outcomes and risk factors among minority participants.

Next Steps

This needs assessment document identified three tiers of towns in need for maternal, infant, and early childhood home visiting services (**Table IX**). In the months ahead, DPH will individually assess the specific home visiting service needs within the sixteen tier one communities. The DPH will work with existing programs in the tier one communities to identify gaps and duplications in services. Needed outcomes and associated service needs will be identified to effectively supplement existing services. Gaps in services, as well as duplications, will be corrected with local plans to create cohesive and well-coordinated program services in the towns. Material contained in existing local assessments (**Section II**), and the key local stakeholders who developed these assessments**,** will facilitate the process. Included among these stakeholders will be community-based health centers and the local Visiting Nurses Assocaition. Consumer participation in the community-level assessments will be an important part of this process. These local area assessments will be submitted as supplemental information in early 2011.

In addition to local area assessments, and also with a target date of early 2011, DPH will build on this needs assessment document to develop a statewide plan of activities that expands home visiting services to communities of need. Key stakeholders will be important contributors, and the group will meet regularly during fall and early winter to complete the statewide plan. To plan a strong system of home visiting programs in Connecticut, the following set of questions need to be considered during this next, planning phase. Organized by the five broad characteristics of an ideal service system described in **Section IV**, they include:

A Strong & Comprehensive System

1) How can current public policy best support the system, and what additional policies are needed?
2) How can federal, state, and local resources support the system?

High Quality Programs

1) What is the capacity of existing programs with a home visiting component in communities of need, and by what mechanism will these programs be brought to a standard level of competence? Components such as staff training and certification, program management and supervision, and fidelity should be considered, and should include programs not are not represented in this assessment. Related questions include:
    a. How will existing programs with evidence-based models be supported and monitored for quality assurance, and
    b. How will programs embedded in the community but working without an evidence-base replicate effective models of home visiting, and how will the quality and fidelity of replicated models be assured?
2) How will existing programs be evaluated to ensure that they are cost effective?
3) How will culturally and linguistically competent models be incorporated into the system to address racial and ethnic disparities in program services?
4) How will programs incorporate evidence-based service models to address interconception/preconception maternal health?
5) How will quality assurance be monitored, and how will this process ensure input from program staff and consumers? Related to this question is what standard measures will be used to monitor desired outcomes.
6) How will a seamless system providing a continuum of home visiting services be ensured? The type and length of services need to be customized for each family, at the appropriate intensity, with supports directed to their unique needs.
7) How will services reach the most fragile within Connecticut? Services should reach families living in homeless shelters, or with food insecurity; families living with substance abuse; families living with domestic violence, neglect, or abuse; and families in which the mother or father is incarcerated.

Strong Linkages

1) How will horizontal and vertical connections among existing home visiting programs, community organizations, and State agencies be strengthened?
2) How will regular statewide data be captured to monitor needs, breadth of service delivery, and outcomes? Related to this question is what existing data can be combined and mined effectively with inter-agency data sharing agreements.
3) How will medical homes be integrated into the home visiting system?
4) How will service providers who serve high-risk families be fully engaged in the system? These service providers include community-based clinics and other community-based

organizations, food pantries and soup kitchens, faith-based organizations, homeless shelters, and domestic abuse shelters.

5) How will male involvement be encouraged across the system?

Supportive Governance

1) What regular mechanism will capture input from key stakeholders, and especially consumers?
2) What should the governance structure look like? Related to this question is if there will be an oversight entity, and if so, what will be its role. Also related to this question is how involvement by consumers will be ensured.
3) Are all services offered by home visiting programs eligible to receive a Medicaid match, and if not, what specific services are eligible for a Medicaid match, and could others become eligible in the future?
4) How can a flexible, non-categorical funding stream be built into the system to support a continuum of high quality home-visiting services? Related to this question is how funds will be used for sustainable change in the community.
5) How can early efforts in systems building within the State be furthered?
6) How can maternal and infant home visiting advocates partner with early childhood home visiting advocates to build a strong system?
7) How will a universal set of practice guidelines and standards of performance be created and implemented, without at the same time masking the unique aspects of individual programs?
8) What kind of surveillance strategy will exist to monitor the system and its programs?

Comprehensive Services

1) How will individual communities of high need assess detailed gaps in services and needs for services, and how will these needs be translated into action within the system? Related to this question is by what mechanism families of very high need who live in communities of moderate or low need will receive services.
2) How will the system ensure that community needs are met, and how will these needs be prioritized? Related to this question is how home visiting services will identify and serve pregnant women, children and families of the highest need. Also related to this question is how high-risk families who are wary of social serves will be engaged.
3) How will substance abuse treatment and behavioral health programs for pregnant women and parents of young children be ensured?
4) What range of services will be provided, and how will continued high school, job skills and job training be included to improve economic status?

Funding made available through the Patient Protection and Affordable Care Act of 2010 will supplement exiting home visiting services in communities of need within Connecticut. The funds, however, are conditional on continuation of State funds for existing programs. This permits a 5-year opportunity to establish a strong and vibrant system of maternal, infant, and early childhood programs that work effectively, and that use funds efficiently. It allows the State to work with local communities at risk for poor family outcomes. It provides a rare opportunity for existing programs, communities, and State agencies to work cooperatively to: 1) coordinate existing home visiting services to provide a continuum of care for families in need, 2) empower communities to actively participate to develop supporting environments of positive change, and 3) develop State policies and processes that support Connecticut's most vulnerable communities and that allows continued progress toward optimum health throughout the lifespan and across generations.

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APPENDICES

Appendix 1. Need for Maternal & Infant Home Visiting Services, by Town, Connecticut, 2008

Appendix 2. Need for Early Childhood Home Visiting Services, by Town, Connecticut, 2008

Appendix 3. Grid Responses to Survey of Home Visiting Programs in Connecticut, June, 2008

Appendix 4. Summary Results of Existing Home Visiting Programs

Appendix 5. Results of Home Visiting Systems Self Assessment

Appendix 6. Statewide and At-Risk Community Data Reports

Appendix 7. Letters of Support

Appendix 1
Need for Maternal and Infant Home Visiting Services
By Town, Connecticut, 2008

Town	Rural/ Urban [1]	Population	Unemployment Rate [2]	Excess LBW [3]	Excess Non-Private Insurance at Birth [4]	Need [5]
Andover	R	3,183	4	-1	-7	Low
Ansonia		18,503	**7.1**	0	**21**	**High**
Ashford	R	4,467	4.7	-1	-9	Low
Avon		17,328	3.6	-1	-38	Low
Barkhamsted	R	3,662	4.8	0	-1	Low
Beacon Falls	R	5,807	**5.8**	-1	-10	Moderate
Berlin		20,364	4.7	-4	-36	Low
Bethany	R	5,575	4.3	-1	-11	Low
Bethel		18,438	4.3	-2	-30	Low
Bethlehem	R	3,560	4.6	-2	-3	Low
Bloomfield	u	20,727	**6.5**	**7**	**4**	**Very High**
Bolton	R	5,117	4.2	**3**	-8	Moderate
Bozrah	R	2,452	5.4	-1	-2	Low
Branford	u	28,969	4.9	-1	-36	Low
Bridgeport	U	136,405	**8.8**	**53**	**806**	**Very High**
Bridgewater	R	1,873	3.7	0	-2	Low
Bristol	U	60,927	**6.2**	**6**	**26**	**Very High**
Brookfield		16,657	4.5	-2	-38	Low
Brooklyn	R	7,949	**6.8**	-3	-7	Moderate
Burlington		9,150	4.3	-3	-21	Low
Canaan	R	1,095	4.6	-1	-2	Low
Canterbury	R	5,118	**5.9**	0	-1	Moderate
Canton		10,104	3.9	-2	-19	Low
Chaplin	R	2,556	5.6	-1	**6**	Moderate
Cheshire	u	29,066	4.4	-4	-57	Low
Chester	R	3,811	4.2	-2	-4	Low
Clinton		13,554	4.7	-1	-26	Low
Colchester		15,578	5	-3	-27	Low
Colebrook	R	1,520	3.1	0	0	Low
Columbia	R	5,315	4.6	0	-10	Low
Cornwall	R	1,481	3.8	0	1	Low
Coventry		12,207	4.9	-5	-31	Low
Cromwell		13,600	4.9	-3	-37	Low
Danbury	U	79,256	4.7	-18	**75**	Moderate
Darien		20,177	3.8	-5	-77	Low
Deep River	R	4,668	4.7	-2	-6	Low
Derby		12,393	**6.7**	**2**	**6**	**Very High**
Durham	R	7,456	3.9	-2	-17	Low

Town	Rural/ Urban [1]	Population	Unemployment Rate [2]	Excess LBW [3]	Excess Non-Private Insurance at Birth [4]	Need [5]
East Granby	R	5,155	4.2	-1	-17	Low
East Haddam		8,896	4.4	1	-24	Low
East Hampton		12,685	5.8	-2	-34	Moderate
East Hartford	U	48,571	7.2	25	110	Very High
East Haven	u	28,590	6.1	3	-20	High
East Lyme		19,022	4.7	-2	-24	Low
East Windsor		10,822	6.2	3	1	High
Eastford	R	1,798	4.6	0	-4	Low
Easton		7,340	4.2	0	-15	Low
Ellington		14,568	4.7	-3	-45	Low
Enfield	u	44,895	5.7	0	-26	Low
Essex	R	6,784	4.2	-1	-12	Low
Fairfield	U	57,345	4.6	-15	-158	Low
Farmington	u	25,116	4.3	0	-54	Low
Franklin	R	1,893	5.2	0	-1	Low
Glastonbury	u	33,263	3.9	-7	-83	Low
Goshen	R	3,203	4.5	-1	-2	Low
Granby		11,219	3.9	-5	-24	Low
Greenwich	U	61,937	4	-13	-183	Low
Griswold		11,398	6	0	0	Moderate
Groton	u	39,167	5.5	3	-70	Moderate
Guilford	u	22,398	4.1	-4	-36	Low
Haddam		7,885	4	-2	-20	Low
Hamden	U	57,862	5.5	-5	-68	Low
Hampton	R	2,149	6.1	0	2	High
Hartford	U	124,062	10.9	83	821	Very High
Hartland	R	2,079	3.9	-1	-1	Low
Harwinton	R	5,560	4.9	1	-10	Low
Hebron		9,228	4.3	2	-19	Moderate
Kent	R	2,944	4.1	2	-5	Moderate
Killingly		17,826	7.5	-3	-9	Moderate
Killingworth	R	6,463	4	-2	-14	Low
Lebanon	R	7,358	5.1	0	-9	Low
Ledyard		15,078	4.6	-4	-31	Low
Lisbon	R	4,210	5.3	0	-1	Low
Litchfield	R	8,625	4.7	-1	-11	Low
Lyme	R	2,077	3.9	-1	-2	Low
Madison		18,803	3.8	-2	-28	Low
Manchester	U	56,385	5.6	-3	-46	Low
Mansfield	u	24,622	4.6	-1	-13	Low
Marlborough	R	6,360	4.3	-1	-14	Low
Meriden	U	59,186	7	6	36	Very High

Town	Rural/ Urban [1]	Population	Unemployment Rate [2]	Excess LBW [3]	Excess Non-Private Insurance at Birth [4]	Need [5]
Middlebury	R	7,343	4.4	-1	-17	Low
Middlefield	R	4,249	4.7	0	-6	Low
Middletown	U	48,030	5.4	1	-52	Low
Milford	U	55,907	4.8	-4	-99	Low
Monroe		19,359	4.7	-6	-34	Low
Montville		19,612	5.4	-5	-15	Low
Morris	R	2,329	5.3	0	-1	Low
Naugatuck	u	31,931	7	-6	-20	Moderate
New Britain	U	70,486	**8.5**	**32**	**323**	**Very High**
New Canaan		19,912	3.8	-4	-44	Low
New Fairfield		14,059	4.3	-3	-27	Low
New Hartford	R	6,728	4.8	-2	-15	Low
New Haven	U	123,669	**8.5**	**54**	**557**	**Very High**
New London	u	25,891	**7.1**	**6**	**119**	**Very High**
New Milford	u	28,338	4.5	-5	-54	Low
Newington	u	29,699	4.9	-6	-51	Low
Newtown	u	26,737	4.1	-9	-62	Low
Norfolk	R	1,647	4.2	-1	-2	Low
North Branford		14,374	4.9	-2	-32	Low
North Canaan	R	3,347	5.3	0	1	Moderate
North Haven	u	23,961	4.9	-3	-45	Low
North Stonington	R	5,233	5	-1	-8	Low
Norwalk	U	83,185	4.8	-16	-51	Low
Norwich	u	36,388	**6.5**	1	**93**	**High**
Old Lyme		7,357	4.1	1	-9	Low
Old Saybrook		10,521	4.6	-3	-9	Low
Orange		13,781	4.2	-1	-24	Low
Oxford		12,734	4.6	-2	-26	Low
Plainfield	R	15,430	**7.5**	-2	-9	Moderate
Plainville		17,221	**5.9**	**2**	-19	**High**
Plymouth	R	11,969	**6.7**	1	-9	Moderate
Pomfret	R	4,168	4.9	1	-8	Low
Portland		9,551	4.9	-3	-17	Low
Preston	R	4,931	4.8	-1	-6	Low
Prospect		9,353	5.2	-3	-24	Low
Putnam	R	9,307	**6.9**	-2	-2	Moderate
Redding		8,798	3.7	-3	-21	Low
Ridgefield	u	24,011	3.8	-8	-56	Low
Rocky Hill		18,852	4.8	-6	-40	Low
Roxbury	R	2,311	3.9	-1	-3	Low
Salem	R	4,110	4.6	-2	-8	Low
Salisbury	R	3,958	3.7	0	-3	Low

Town	Rural/ Urban [1]	Population	Unemployment Rate [2]	Excess LBW [3]	Excess Non-Private Insurance at Birth [4]	Need [5]
Scotland	R	1,722	3.6	0	-2	Low
Seymour		16,251	5.8	-2	-30	Moderate
Sharon	R	3,014	3.6	-1	0	Low
Shelton	u	39,991	5.1	-7	-66	Low
Sherman	R	4,106	3.5	-1	-5	Low
Simsbury	u	23,615	3.9	-4	-47	Low
Somers		10,984	5.4	-2	-5	Low
South Windsor	u	25,966	4.2	-7	-58	Low
Southbury		19,702	4.6	1	-29	Low
Southington	u	42,250	4.7	-4	-71	Low
Sprague	R	2,980	6.8	-1	3	**High**
Stafford		11,773	5.8	-2	-13	Moderate
Stamford	U	119,303	4.7	-12	-57	Low
Sterling	R	3,748	6.6	0	-6	Moderate
Stonington		18,371	4.3	-3	-2	Low
Stratford	U	48,853	6.1	-3	-43	Moderate
Suffield		15,136	4.7	-4	-16	Low
Thomaston	R	7,766	6.2	-2	-3	Moderate
Thompson	R	9,269	6.3	-2	-5	Moderate
Tolland		14,705	4.1	1	-31	Low
Torrington	u	35,312	6.4	-5	58	**High**
Trumbull	u	34,688	4.5	-2	-89	Low
Union	R	751	4	1	-2	Low
Vernon	u	29,839	5.3	6	-33	Moderate
Voluntown	R	2,619	6.5	-1	0	Moderate
Wallingford	u	44,859	5	-3	-77	Low
Warren	R	1,385	4.1	0	-3	Low
Washington	R	3,657	4.2	1	-2	Low
Waterbury	U	107,037	9.3	44	560	**Very High**
Waterford		18,794	5.2	-3	-26	Low
Watertown	u	22,095	5.8	-1	-24	Moderate
West Hartford	U	60,495	5	-7	-124	Low
West Haven	U	52,420	6.4	-1	81	**High**
Westbrook	R	6,641	4.6	-3	-8	Low
Weston		10,183	3.5	-2	-21	Low
Westport	u	26,592	4	-5	-64	Low
Wethersfield	u	25,719	5.1	-4	-56	Low
Willington	R	6,114	4.3	0	-8	Low
Wilton		17,698	4.1	-3	-40	Low
Winchester	R	10,716	6.5	2	5	**Very High**
Windham	u	23,609	7.6	3	87	**Very High**
Windsor	u	28,851	5.3	4	-29	Moderate

Town	Rural/ Urban [1]	Population	Unemployment Rate [2]	Excess LBW [3]	Excess Non-Private Insurance at Birth [4]	Need [5]
Windsor Locks		12,495	5.9	-2	-1	Moderate
Wolcott		16,434	5.6	-1	-27	Low
Woodbridge		9,193	3.7	0	-14	Low
Woodbury	R	9,650	4.3	0	-18	Low
Woodstock	R	8,229	5.1	1	-9	Low

[1] - U - town size greater than statewide average of at least 2 standard deviations (45,193); u - town size greater than the statewide average of 10,717; R - designated as a rural town by the Office of Rural Health (http://www.ruralhealthct.org/towns.htm).

[2] - Red - greater than statewide average of 5.7%

[3] - Red - at least two excess low birth weight birth events.

[4] - Red - at least two excess births paid by non-private insurance sources.

[5] - Number of high values for 1) unemployment rate, 2) excess low birth weight events, and 3) excess births paid by nonprivate sources. Very High - three high values; High - two high values; Moderate - one high value; Low - no high values.

Appendix 2
Need for Early Childhood Home Visiting Services
By Town, Connecticut, 2008

Town	% Children 0-4 yrs in Poverty [1]	High School Dropout Rates [2] *per 100 students*	Excess Abuse/Neglect [3]	Number Low CMT Scores [4]	Need [5]
Andover	1.7	1.8	-10	0	Low
Ansonia	**20.7**	**2.2**	**28**	**2**	**Very High**
Ashford	8.4	1.7	1	**3**	Low
Avon	2.6	0.1	-23	0	Low
Barkhamsted	7.4	0.7	-6	0	Low
Beacon Falls	7.9	1.5	-17	0	Low
Berlin	4.5	1.1	-24	0	Low
Bethany	2.5	0.8	-13	0	Low
Bethel	7.9	0.1	-35	0	Low
Bethlehem	2.9	0.6	-14	0	Low
Bloomfield	**17.7**	1.7	-14	1	Low
Bolton	4.9	0.3	-15	0	Low
Bozrah	12.1	na	2	1	Low
Branford	8.2	1	-19	0	Low
Bridgeport	**29.9**	**6.8**	**260**	**3**	**Very High**
Bridgewater	3.9	0.6	-4	0	Low
Bristol	**18.7**	1	**129**	0	Moderate
Brookfield	2.9	0.1	-45	0	Low
Brooklyn	**17.4**	na	**10**	**2**	**Very High**
Burlington	3.7	0.8	-15	0	Low
Canaan	2.7	**2.2**	-1	0	Low
Canterbury	**17.5**	na	-1	1	Low
Canton	7.6	0.6	-10	0	Low
Chaplin	**44.9**	1.6	-1	**3**	Moderate
Cheshire	2.9	0.8	-61	0	Low
Chester	12.2	1.9	-7	0	Low
Clinton	7.5	1.4	-12	0	Low
Colchester	5.6	0.6	-11	0	Low
Colebrook	4.2	0.7	-4	0	Low
Columbia	5.1	na	-6	0	Low
Cornwall	14.5	**2.2**	-3	0	Low
Coventry	6.1	0.6	-7	0	Low
Cromwell	6.0	0.6	-16	**2**	Low
Danbury	9.7	**2.3**	-56	**3**	Moderate
Darien	0.8	0.2	-65	0	Low
Deep River	7.8	1.9	1	1	Low
Derby	13.4	1.3	-4	**3**	Low
Durham	2.9	0.2	-12	0	Low
East Granby	4.4	0.6	**10**	0	Low
East Haddam	1.9	1.2	-1	0	Low
East Hampton	5.1	0.4	-9	0	Low
East Hartford	8.0	**2.6**	**196**	**3**	**High**
East Haven	**25.9**	0.4	-61	**2**	Moderate
East Lyme	11.9	1.1	-67	0	Low
East Windsor	6.8	1.8	-11	**3**	Low
Eastford	0.8	na	-21	0	Low

Town	% Children 0-4 yrs in Poverty [1]	High School Dropout Rates [2] *per 100 students*	Excess Abuse/Neglect [3]	Number Low CMT Scores [4]	Need [5]
Easton	20.3	0.4	-18	0	Low
Ellington	5.5	0.9	-26	0	Low
Enfield	11.0	2.4	37	2	**High**
Essex	2.3	1.9	-11	0	Low
Fairfield	3.1	0.8	-123	0	Low
Farmington	3.3	0.8	-49	0	Low
Franklin	2.8	na	-6	0	Low
Glastonbury	3.2	0.3	-67	0	Low
Goshen	4.5	0.8	1	0	Low
Granby	5.5	0.4	-16	0	Low
Greenwich	1.3	0.8	-143	0	Low
Griswold	14.6	3.3	17	2	**High**
Groton	9.4	0.8	38	3	Moderate
Guilford	2.5	0.5	-45	0	Low
Haddam	3.5	0.1	-10	1	Low
Hamden	12.2	1.2	-59	3	Low
Hampton	24.0	1.6	-2	0	Low
Hartford	36.9	4.6	434	3	**Very High**
Hartland	12.7	na	-4	0	Low
Harwinton	5.9	0.8	-16	0	Low
Hebron	3.9	1.8	-14	0	Low
Kent	5.6	2.2	-6	0	Low
Killingly	18.3	5.3	-2	3	**High**
Killingworth	3.6	0.1	-13	0	Low
Lebanon	4.5	0.7	0	0	Low
Ledyard	7.1	1.1	-18	0	Low
Lisbon	13.3	na	-4	0	Low
Litchfield	1.6	1.2	-27	0	Low
Lyme	8.7	0.7	-11	0	Low
Madison	3.0	0.2	-49	0	Low
Manchester	16.4	1.4	73	2	**High**
Mansfield	10.5	1.7	-15	0	Low
Marlborough	4.8	1.8	-14	0	Low
Meriden	21.4	1.9	270	3	**High**
Middlebury	4.1	1.3	-24	0	Low
Middlefield	2.0	0.2	-22	0	Low
Middletown	18.2	0.9	34	1	Moderate
Milford	6.3	1.7	-14	0	Low
Monroe	5.9	0.2	-46	0	Low
Montville	11.6	1.6	7	0	Low
Morris	2.6	0.8	0	0	Low
Naugatuck	13.0	1.8	-15	3	Low
New Britain	31.6	5.4	259	3	**Very High**
New Canaan	1.7	0.2	-59	0	Low
New Fairfield	4.6	0.5	-30	0	Low
New Hartford	1.8	0.7	-12	0	Low
New Haven	28.9	5.4	544	3	**Very High**
New London	7.4	4	70	3	**High**
New Milford	26.8	1	-27	0	Low
Newington	5.7	0.4	-43	0	Low

Town	% Children 0-4 yrs in Poverty [1]	High School Dropout Rates [2] *per 100 students*	Excess Abuse/Neglect [3]	Number Low CMT Scores [4]	Need [5]
Newtown	1.2	1.2	-72	0	Low
Norfolk	3.1	0.7	0	1	Low
North Branford	5.6	1.3	-22	1	Low
North Canaan	4.2	2.2	-7	0	Low
North Haven	4.6	0.7	-38	0	Low
North Stonington	1.6	1.9	-8	0	Low
Norwalk	9.5	0.9	11	3	Moderate
Norwich	23.6	16	123	3	**High**
Old Lyme	4.8	0.7	-11	0	Low
Old Saybrook	10.5	0.1	-14	0	Low
Orange	2.0	0.8	-28	0	Low
Oxford	5.6	na	-23	0	Low
Plainfield	18.8	4.3	38	1	**High**
Plainville	12.5	1.3	0	2	Low
Plymouth	11.9	3	6	2	Moderate
Pomfret	2.0	na	-7	0	Low
Portland	6.3	0.5	-9	0	Low
Preston	4.8	na	-3	0	Low
Prospect	0.6	1.5	-9	0	Low
Putnam	26.7	3.8	29	3	**Very High**
Redding	0.8	0.4	-19	0	Low
Ridgefield	0.7	0.4	-71	0	Low
Rocky Hill	6.7	1	-25	0	Low
Roxbury	2.9	0.6	-5	0	Low
Salem	4.5	na	-9	0	Low
Salisbury	7.0	2.2	-8	0	Low
Scotland	12.4	1.6	-2	0	Low
Seymour	8.7	2.5	-20	0	Low
Sharon	9.6	2.2	-3	1	Low
Shelton	8.5	2.1	-40	0	Low
Sherman	6.7	na	-10	0	Low
Simsbury	2.8	0.4	-50	0	Low
Somers	10.2	0.8	-20	1	Low
South Windsor	3.3	0.9	-11	0	Low
Southbury	8.3	1.3	-105	0	Low
Southington	3.8	1.4	-5	0	Low
Sprague	17.4	na	2	2	Moderate
Stafford	12.7	2.4	-3	0	Low
Stamford	15.6	2.2	-75	3	Moderate
Sterling	5.2	na	-4	0	Low
Stonington	7.1	1.8	-14	0	Low
Stratford	13.7	1.3	-37	1	Low
Suffield	5.9	0.8	-19	0	Low
Thomaston	12.2	1.9	-10	0	Low
Thompson	9.9	2.5	-5	2	Moderate
Tolland	6.7	0.4	-33	0	Low
Torrington	19.3	4.8	80	3	**Very High**
Trumbull	3.4	0.1	-69	0	Low
Union	0.0	na	-2	0	Low
Vernon	15.1	2.7	35	3	**High**

Town	% Children 0-4 yrs in Poverty [1]	High School Dropout Rates [2] *per 100 students*	Excess Abuse/Neglect [3]	Number Low CMT Scores [4]	Need [5]
Voluntown	10.8	na	0	0	Low
Wallingford	8.0	1.3	-21	0	Low
Warren	6.3	0.8	0	0	Low
Washington	9.4	0.6	-4	0	Low
Waterbury	**34.5**	**2.4**	**153**	**3**	**Very High**
Waterford	6.4	1.3	-10	0	Low
Watertown	8.5	1.2	-30	0	Low
West Hartford	9.3	1.2	**63**	0	Low
West Haven	7.8	1.4	**25**	**3**	Moderate
Westbrook	**19.6**	0.3	-150	0	Low
Weston	0.7	0	-29	0	Low
Westport	1.7	0.1	-64	0	Low
Wethersfield	6.4	1.7	-25	0	Low
Willington	7.7	1.7	-3	**2**	Low
Wilton	1.7	0.2	-57	0	Low
Winchester	**18.4**	**10.9**	**38**	1	**High**
Windham	**38.6**	**3.7**	**150**	**3**	**Very High**
Windsor	12.6	1	-34	**3**	Low
Windsor Locks	**16.6**	**2.3**	6	**3**	**High**
Wolcott	6.7	1.7	-19	0	Low
Woodbridge	3.0	0.8	-23	0	Low
Woodbury	3.8	0.6	-13	0	Low
Woodstock	4.6	1.8	-12	0	Low

[1] - Estimated population figures were calculated from county-level estimates produced by the U.S. Census Bureau (Estimates for Connecticut School Districts, 2008 (http://www.census.gov/cgi-bin/saipe/saipe.cgi). Town-level estimates for children 5-17 were developed from the school district estimates from same source. Town-level estimates for children 0-4 years old were developed from the proportion of births, by town, for calendar years 2004-2008. Red - greater than the statewide average of 15.6%.

[2] - Estimates of high school dropout rates, per 100 students, were prepared from town district drop out rates (Data Bulletin: High School Dropout Rates in Connecticut, November, 2009, State of Connecticut Department of Education). Estimates did not include Area Cooperative Educational Service, Capitol Region Education Council, Common Ground High School, Connecticut Technical High School, Exploration, Norwich Free Academy, Stamford Academy, The Bridge Academy, and The Gilbert schools. na - not available. Red - greater than the statewide average of 1.9%.

[3] - Annual excess cases of substantiated abuse or neglect of the following types: medical, physical, sexual, or educational. Data provided courtesy of the State Department of Children and Families. Red - more than 10 excess substantiated cases.

[4] - Percent of third grade students who met the criteria for the Connecticut Mastery Tests (CMT) during 2008 in three areas (Reading, Writing and Mathematics) were provided by the State Department of Education (http://www.ctreports.com/). The number of areas for which the percent was below the statewide averages of (68.4%, 82.9%, and 80.7%) are shown. Red - at least two tests below avearge.

[5] - Number of high values for 1) young children living in poverty, 2) high school dropout rates, 3) excess cases of maltreatment, and 4) number of CMT tests below the state average. Very High - four high values; High - three high values; Moderate - two high value; Low - no more than one high value.

Program Information

Program Name	Administrative Agency	Funding Source	Annual Funding Amount	Number of Program Sites	Serve: Foster homes? Family shelters? DV shelters? Safe homes?	Location of Program Sites (towns)	Number of Trained Home Visitors	Qualifications of Home Visitors	Qualifications of Supervisor	Number of Families Served Annually
Healthy Start (SHS)	DSS	State & Federal	$1.49 million of DSS state & $200,000 of Title V MCH funds from the DPH.	15	The State Healthy Start serves pregnant & postnatal women, & their families.	State Healthy Start provides services out of 15 locations in the following CT. towns: New Haven, Bridgeport, Hartford & Seymour (at local health depart or social services depart); Middletown, Stamford, Windham, Waterbury & Norwich (at community health centers); Torrington, Norwalk, Greater Hartford & Bristol (at community-based organizations) & New London & Putnam (at hospitals).	For the three sites that do more intensive home visiting: 20. For the sites that do occasional, limited home visitation: there are between 25-35 staff with different educational backgrounds.	Home visitors are from diverse backgrounds that reflect the community served: their education range from high school to some college, associate & bachelor degrees.	For the three sites that do intensive home visitation, masters degrees.	For the 3 sites with intensive home visitation: 440 per mth. For the sites with limited home visitation: about 12-20 visits per mth; for women who are in bed rest, fear domestic violence or who miss most of their prenatal appointments.
Head Start (HS)	USDHHS, ACF, Office of Head Start NOTE: All funds flow from the federal government directly to local programs. THERE IS NO STATE PASS THROUGH AGENCY.	Federal	$53,966,600 (FFY 08-09; represents 80% of total program costs matched with 20% nonfederal share)	24	All	Statewide	12 Home-based visitors 160 Family Workers	Most with BA Half with BA	BA Most with BA	7,934 (08-09)
Early Head Start (EHS)	USDHHS, ACF, Office of Head Start NOTE: All funds flow from the federal government directly to local programs. THERE IS NO STATE PASS THROUGH AGENCY.	Federal	$8,169,990 (FFY 08-09; represents 80% of total program costs matched with 20% nonfederal share)	9	All	Bridgeport, Colchester, Danbury, Griswold, Groton, Manchester, Middletown, Montville, New Haven, New London, Norwich, Stamford, Torrington, Vernon, Waterbury, Windham	16 Home-based visitors	Most with BA	Half with Advanced Degrees	653 (08-09)
Nurturing Families Home Visiting Program (NFN)	DSS	State	$9 million	41	Pregnant or parenting foster children & their families are eligible for home visiting services.	Bridgeport, New London, Bristol, New Milford, Danbury, Norwalk, Enfield, Norwich, Farmington, Putnam, Greenwich, Vernon, Hartford,	125	Home visitors are usually from the community they serve - have background & experience in child	Master degree required - clinical supervisor. Knowledgeable of the community they serve - 20% bi-lingual, 20%	7,200 screened 2,039 home visiting

					Services are offered where ever the parent is residing – including shelters & residential settings, friend's house, hospital when stay is extended, & other locations. Services are offered to grandparents if they are the primary caregiver.	Stamford, Manchester, Torrington, Middletown, Waterbury, New Britain, Windham, New Haven *sites serve catchment area of hospitals in those locations		development & human services. 6% are high school grads; 70% have college credits, including 14% with Assoc. degrees, 32% with BA degrees. 24% have graduate credits & 8% have graduate degrees. Home visitors are required to complete a 200 hr training program when they are hired.	have received public assistance, 20% single parents.	
NFN Fathers Pilot (NFN-F)	DSS	State	$250,000	5	Same as NFN	New Haven Torrington	3 FTEs	Same as NFN – but all men	Same as NFN (same supervisor)	33
Family School Connection Demonstration Project (NFN-S)	DSS	State	$935,000	5	Same as NFN	Hartford Middletown Windham Norwich New Haven	10	Same as NFN	Same as NFN	106
Family Resource Centers (FRC)	SDE	State	$92,325 in FY10; 30% minimum set-aside for the PAT service delivery.	Sixty-two (62) FRCs located throughout forty (41) Connecticut school districts		Bloomfield (1) Branford (1) Bridgeport(4) Bristol(2) Danbury(2) East Hartford(2) East Haven(1) East Windsor(1) Enfield(1) Groton(1) Hamden(1) Hartford(5) Hebron(1) Killingly(1) Manchester(1) Meriden(2) Middletown(2) Milford(1) New Britain(2) New Haven(3) New London(2) North Branford(1) Norwalk(3) Norwich(1) Plainfield(1) Plainville(1) Plymouth(1) Putnam(1) Stafford (1) Stamford(2) Stonington(1) Stratford(1) Toll&(1) Torrington(1) Vernon(1) Waterbury(2) West Hartford(1) West Haven(1) Windham(2) Windsor(1) Winchester(1)	87; avg. 1.4 PAT certified Parent Educators per site	PAT Certification w/ minimum of H.S. or GED. Most have at least an associates degree & over half have bachelors or masters degrees/55% with BA or higher: (27 less than AA/17 with AA/36 with BA/16 with MA/3 higher than MA)		1601 Families serviced
Minding the Baby Home Visiting Program (MB)	Yale School of Nursing; Yale Child Study Center	Irving B. Harris Foundation, the Anne E. Casey Foundation, Pilot Study NIH/NINR (P30NR08999), The Patrick & Catherine Weldon Donaghue Foundation, The Edlow Family, The Schneider Family, NIH/NICHD	Amounts vary from year to year. 09-10 $636,723.00 (includes research support)	2 Fair Haven Community Health Center (FHCHC Cornell Scott Hill Health Center (CSHHC)	Pregnant women who meet our inclusion criteria & who attend FHCHC or CSHHC Pregnant foster children & their families are eligible for home visiting services. Services are offered where ever the parent is	New Haven	6	Master's prepared & licensed clinical social workers & pediatric or family nurse practitioners	PhD prepared psychologists & nurse practitioners	Range 29-37- per year. Intervention families only

		(R21HD048591), The FAR Fund, The Pritzker Foundation, The Seedlings Foundation, & NIH/NICHD (RO1HD057947)			residing – including shelters & residential settings, friend's house, hospital when stay is extended, & other locations. Services are offered to grandparents & family members as needed.					
Birth to Three (BT3)	DDS	State/ Federal/ Medicaid/ Insurance/ Parent Fees	$50 million	44	Wherever child & caregiver are living.	Statewide	1,000	See CT Birth to Three Personnel Standards at http://www.birth23.org/Proviiders/CurrentProcedures/Personnel_St&ards.DOC		9,600
Healthy Choices for Women & Children (HCWC)	DPH	State funding, Children's Health Initiative	$179,966	1	All of the above	Office in Waterbury servicing the Greater Waterbury area.	3	B.S. in Social Work or related field, exper. in substance abuse & domestic violence areas. At least one case manager is bilingual.	B.S. in Social Work or related field. Experience in substance abuse & domestic violence areas. Management experience.	Capacity for 40-50 families.
Case Management for Pregnant Women (CMPW)	DPH	MCHBG	$349,074	3	Not collected. Can potentially serve women in these locations.	Waterbury, New Haven & Hartford	~6 (Referred to as Case Managers)	"Qualified" is determined by contractor & is not specified under contract. All have a minimum of a BA/BS degree	Not specified under contract, but all three Program Directors have Master degrees	~200
Hartford Healthy Start (HHS)	DPH	Federal	$750,000	1	Services are offered wherever a parent lives	Hartford	2	From within the community they serve, with a background in human services; bilingual preferable.	Knowledge of community, public assistance programs, bilingual preferable	1,000 total, 500 home visiting
Putting on AIRS Asthma Program (AIRS)	DPH	CDC EPA	$160,000	6	Visits would be made to the address of record at the time of patient referral. This would include a foster home. Safe homes, DV shelters or Family shelters could be visited if these homes allowed the visit.	Andover, Ansonia, Ashford, Avon, Barkhamsted, Beacon Falls, Berlin, Bethany, Bethel Bolton, Bozrah, Bridgeport, Brooklyn, Canterbury, Canton, Chaplin, Cheshire, Colebrook, Colchester, Columbia, Coventry, Danbury, Derby, East Granby, East Haven, East Lyme, East Windsor, Eastford, Ellington, Enfield, Fairfield, Farmington, Franklin, Granby, Greenwich, Griswold, Hamden, Hampton, Hartford, Hartland, Killingly, Lebanon, Ledyard, Lisbon, Lyme, Mansfield, Meriden, Milford, Monroe, Montville, Naugatuck, New Britain, New Hartford, New Haven, New	12-15	Home visitors are trained public health staff from six local health departments or districts & include: Registered Nurses, Respiratory Therapists, Health Educators, Registered Sanitarians, & Environmental Health Staff	Director of Health would have a master's degree (MPH), Medical Doctor (MD) & sometimes both. Knowledgeable of the population served, has conducted previous needs assessments & identified resources for their populations.	172 families were served for the last complete funding cycle 9/1/08 – 8/31/09

						London, New Milford, Newington, North Branford, North Haven, North Stonington, Norwich, Old Lyme, Orange, Oxford, Plainfield, Plainville, Pomfret, Preston, Prospect, Putnam, Rocky Hill, Salem, Scotland, Seymour, Shelton, Southbury, Sprague, Stafford, Stamford, Stonington, Voluntown, Stratford, Suffield, Trumbull, Vernon, West Haven, Weston, Westport, Wethersfield, Windham, Windsor Locks, Wolcott, Woodbridge, Woodbury				
Young Adult Services Young Parents Program (YAS)	DMHAS	State	0 We currently do not receive additional funding to serve this specialized population.	15 19 Bed In-Pt. Unit	Pregnant or parenting Young Adults. Services are offered where ever the young parent is residing; including shelters & residential settings, friend's house, hospital when stay is extended, & other locations.	Bridgeport East Windsor Bristol Norwich Hartford Stamford Manchester Torrington Middletown Waterbury New Britain Windham New Haven West Haven			Master degree required - clinical supervisor. Knowledgeable of the specific needs of Young Adults with a Major Mental Illness.	75-80
Building Blocks (BB)	DCF	Federal	$1 million ending Sept 2011	1	All families with children 0-6 who are experiencing challenging behaviors are eligible for services. In-home services have been provided in shelters, foster homes, & other locations determined by the family.	Norwich, New London, Groton, Stonington, N. Stonington, Voluntown, Griswold, Salem, East Lyme, Waterford, Old Lyme, Colchester, Montville, Lyme	7	Home visitors include early childhood mental health clinicians (3 are licensed) & two are care coordinators. All have experience & education in child development, family-focused care, & in-home services.	Program Administrator holds a Ph.D. in Early Childhood Development; Clinicians who hold a minimum of a Master's Degree, & are licensed or license eligible in Social Work, Psychology, Education, or other appropriate degree, with at least three years' experience working with children from birth to six & their families; Family Partners/Case Coordinators are family members who have received services from Building Blocks & hold a minimum of an Associates Degree; Clinical Supervisor holds an MSW & has a minimum of five years clinical experience with	75

									Birth-5 population	
Child FIRST (CF)	DCF & Children's Fund of CT	RWJF & 12 other foundations DCF, Head Start & other contracts, Medicaid, federal	$2.8 million ($292,000 from DCF)	6 current. Intention is to create a site serving each DCF area = 14	Serve wherever a child & family lives – foster home, Safe Home, family shelter, DV shelter. (Will also provide services wherever a family is most comfortable in the community, e.g. pediatric primary care, early care, family resource center, work, etc.)	Bridgeport, Hartford, New Haven, Norwalk, Waterbury, New London County (Building Blocks using Child FIRST model)	Currently: 6 Clinical Directors, 21 Mental Health & Developmental Clinicians, 15 Care Coordinators	Mental Health & Developmental Clinicians: Masters degree in social work, psychology, marriage & family therapy with license (or eligible) & 5 years clinical experience with very young children; Care Coordinator: Bachelors degree & 3 years experience with young, ethnically diverse families; At least 50% of staff bilingual; Training through Learning Collaborative with total of 155 hours of direct training & weekly small group supervision meetings with Child FIRST Training Director.	Masters or doctoral level, licensed clinician with over five years experience with parent-child psychotherapy, ethnically diverse populations, & provision of reflective, clinical supervision. One Clinical Director/ Supervisor for each site. Weekly clinical individual & group supervision; biweekly team supervision.	Projected annual numbers served in the home with current staffing: 500
Early Childhood - Parents in Partnership (ECP)	DCF	State	$300,000	2	Pregnant women, and parents of infants (ages 0 – 24 months), toddlers (24-36 month), and preschool children (36-60 months) who are at risk of less than optimal development due to the presence of one or more of the following risk factors: maternal depression, exposure to domestic violence, exposure to parental substance, parents at-risk of referral to DCF, homelessness, teen parenting, caregiver cognitive limitations, caregiver mental illness, families with multi-agency involvement and families who have failed to benefit from traditional parenting programs. Of the targeted population, it is expected that at least 50% of these families will have current or past experience with	Norwich, Hartford	Clinical Supervisor - .34 FTE In-Home Professionals / Paraprofessionals - 2.5 FTE	All staff must be culturally linguistically competent to the needs of families in the identified geographic area. Professional staff requirem include a minimum of a Ma Degree license or certificat either Human Services, Pu Health, Social Work, Educ Psychology or a related fie a minimum of five years of experience working with ch from birth to six and their fa An advanced degree at the of Doctor of Philosophy in the above mentioned area be substituted for some ye experience. Paraprofessionals must possess either an Associate Degree on early childhood education or a Child Development Associate (CDA) certificate or training as Parent Educators and three years of experience working with children and families birth to six	The Contractor will provide supervision in accordance with the best practice standards set by Zero to Three, the National Center for Infants, Toddlers, and Families. Supervision will include on-going individual (1 hour) and group (2 hours) reflective supervision on a weekly basis. Team supervision will be offered quarterly and on an as-needed basis. Ad hoc supervision will always be available. Plans will be developed to strengthen the skills of all staff members.	Norwich: 45-65 children and their families annually. Hartford: 32-47 children and their families annually.

					DCF. DCF is particularly interested in focusing on underserved populations of families and their children, such as parents with cognitive challenges, homeless parents, fathers, and women suffering from maternal depression.			years old.		
Family Enrichment Services (FES)	DCF	State	4.8 Million	30	This service provides a range of in-home teaching, modeling & support services to parents in order to enhance parenting competencies & to improve the parent's overall functioning & ability to care for their children.	Bridgeport, Norwalk, Bristol, Norwich, Danbury, Plainville, Enfield, Stamford, Hartford, Torrington, Manchester, Waterbury, Meriden, Plainfield, Middletown, Windham, New Britain, New Haven * catchment area consists of entire State	61	Minimum of a high school degree (college preferred)	Minimum of a Bachelor Degree (Masters Degree preferred) in social work, counseling, marriage & family therapy, psychology or similar field.	2,406
Family Reunification Services (FRS)	DCF	State	$2.8 mil	11 providers	DCF children (birth to age 17) who were removed from home due to CPS concerns with a viable plan for reunification or Transfer of Guardianship, who still require supervised visitation; Services available to biological parents or relative caretakers; Consideration given to families whose children are likely to remain in care greater than 6 months.	Norwalk, Waterbury, New Haven, Bridgeport, Hartford, Norwich, Danbury, Torrington, Meriden, New Britain, Plainville, Manchester. Statewide access.	35.5	BA level	Masters level	456 families
Family Support Team (FST)	DCF	State	Approx $7,500,000	9	Services are offered in the family home, & this can be the home of a bio family, a foster home, or home of other caregiver. Services are typically not delivered to clients whose residence is non-home or transitional settings, e.g., SAFE homes or shelters. If a family in the program were to temporarily require residence in a shelter, the service	Statewide	60	Half are Master's-prepared licensed or license-eligible clinicians. Half are Bachelor's level paraprofessionals with experience in community services, case management, etc. Each case is served by a Master's-level & a Bachelor's-level staff member working as a team.	A licensed mental health professional (typically Psychologist, Social Worker or Marriage & Family Therapist) supervises the program. In addition, a Child & Adolescent psychiatrist provides program oversight & clinical consultation.	Approx. 515

					would be expected to follow them there & help transition them to a more permanent setting.					
Foster & Adoptive Support Team (FAST)	DCF	State	1,665,020	4	The Foster & Adoption Support Teams (FAST) provide assessment, behavioral management, support, respite & other therapeutic services to foster & adoptive children, their caretakers &/or parents in order to stabilize the living situation & avoid disruption. The primary target population includes children involved in all types of foster family care & pre-adoptive care, excluding children placed in private agency specialized foster care. The secondary target population includes adopted children.	Community Health Resources; Hartford & Manchester, Windsor Community Mental Health Affiliates; New Britain, Torrington, & Waterbury United Community & Family Services Norwich; Middletown, Windham, & Norwich Boys & Girls Village; Milford, Bridgeport, Danbury, Norwalk & Stamford	10	**Behavior Support Workers**: Provide in-home services to families (i.e., assessment, parent training & support). The position requires: a Bachelor in Social Work (BSW) preferred or a Bachelors degree in a social service area <u>At least one behavior support worker in every program must be bilingual, English-Spanish</u>. of FTEs of Behavioral Support Workers to serve the minimum in-home target number of children/annum. **Respite Support Workers**: Staff providing therapeutic respite, at a minimum, will have a high school diploma or equivalency certificate & three years of childcare experience.	**Program Director/Supervisor**: This individual will be required to <u>hold the ABH Behavior Management staff credential.</u> Individual must have experience working with children from the child welfare system, foster & adoptive care & should have a strong knowledge base in child development; the impact of trauma; attachment; & separation & loss. At least one FTE is required per program.	250 foster families served
Intensive Home Based Services: Family-Based Recovery (FBR)	DCF	State	$1,959,119	6	Clinical Behavioral Health Services are delivered in the home with the parent & infant	The following DCF Area Offices: New Britain, New Haven, Bridgeport, Windham, Norwich, Waterbury		2 Master's Level Licensed behavioral health clinicians or above & a bachelor level behavioral health specialists per one FBR team	Master Level & Licensed in Behavioral Health	133 Family cases 240 Individuals
Intensive Home Based Services: Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS)	DCF	State	Approx. $22,000,000	19	Services are offered in the family home, & this can be the home of a bio family, a foster home, or home of other caregiver. Services are typically not delivered to clients whose residence is non-home or transitional settings, e.g., SAFE homes or shelters. If a family in the program were to temporarily	Statewide	210	Half are Master's-prepared licensed or license-eligible clinicians. Half are Bachelor's level paraprofessionals with experience in community services, case management, etc. Each case is served by a Master's-level & a Bachelor's-level staff member, both working	A licensed mental health professional (typically Psychologist, Social Worker or Marriage & Family Therapist) supervises the program. In addition, a Child & Adolescent psychiatrist provides program oversight & clinical consultation.	Approx. 2,000

					require residence in a shelter, the service would be expected to follow them there & help transition them to a more permanent setting.			as a team.		
Integrated Family Violence Services (FVS)	DCF	State	$940,000	6	This primarily in-home service for families where domestic violence has been identified focuses on all family members including the child, the parent who is the survivor of domestic violence & the batterer.	Bridgeport, Groton, Hartford, Manchester, New Haven, Waterbury	15	Full time equivalents will be at the Masters level.	Does not Specify	360
Intensive Community Family Support Services (ICFSS)	DCF	State	Approx. $375,000	1	Services are offered in the family home, & this can be the home of a bio family, a foster home, or home of other caregiver. Services are typically not delivered to clients whose residence is non-home or transitional settings, e.g., SAFE homes or shelters. If a family in the program were to temporarily require residence in a shelter, the service would be expected to follow them there & help transition them to a more permanent setting.	Hartford	4	Half are Master's-prepared licensed or license-eligible clinicians. Half are Bachelor's level paraprofessionals with experience in community services, case management, etc. Each case is served by a Master's-level & a Bachelor's-level staff member working as a team	A licensed mental health professional (typically Psychologist, Social Worker or Marriage & Family Therapist) supervises the program. In addition, a Child & Adolescent psychiatrist provides program oversight & clinical consultation.	Approx. 40
Intensive Family Preservation (FP)	DCF	State	5.8 Million	21	This is a short-term, intensive, in-home service designed to intervene quickly in order to reduce immediate safety factors, the risk of future abuse &/or neglect & the need for out of home placement. This service is delivered to families with children at high risk of out of home care or families with children just reunified following a period of time spent in out of home care.	Bridgeport, Norwalk, Columbia, Norwich, Danbury, Plainville, Essex, Stamford, Hartford, Torrington, Manchester, Middletown, Milford, New Britain, New Haven, New London, Waterbury, Wauregan * catchment area consists of entire State	59	Direct service staff providing intensive family preservation services must possess a minimum of a bachelor's degree with experience providing services to this target population.	The IFP supervisor must possess a minimum of a Master's degree in social work, counseling, marriage & family therapy or psychology & have experience in the delivery of intensive, home-based services, as well as in supervision of direct service staff.	1,122
Parent Assessment &	DCF	State	$121,209	1	Provides home based parent & child	Meriden	2.5	Parent Educators who provide services under	The Parent Educator Supervisor will have the	75

Clinical Education Services – Meriden (PA)					assessment, clinical services, parenting education & skill building services for families with children ages 12 & younger.			this contract are required to be proficient in the following core competencies: Minimum of a MA level or vary experienced BA level; Demonstrated experience parenting &/or direct work with children & families; Solid problem solving skills; Ability to conduct strengths-based assessments of children &/or families; Ability to communicate effectively; An understanding of basic child care & child development issues; An understanding of effective communication, de-escalation & behavior management techniques; An understanding of issues related to child abuse & neglect; Ability to engage individuals in a culturally responsive & respectful manner; Ability to both work independently & to accept supervision; Ability to work effectively in a crisis	following core competencies: Minimum of a MA degree in social work, counseling, marriage & family therapy, psychology or similar field; Demonstrated experience in the management & delivery of home based & onsite parenting education programs & services to children & families; Ability to conduct, & train staff in the appropriate method for conducting strengths-based assessments & developing a strengths-based Family & Child Action Plan; Ability to assess staff strengths, limitations & to train effectively; Ability to collaborate effectively & coordinate service delivery with other community providers; Ability to problem solve	
Early Childhood Consultation Partnership (ECCP)	DCF	State	$2,600,000	15 different office locations for Subcontractors	Services are available to all children birth through five, regardless of where they reside, Bio Family homes, Foster Homes, Shelters, SA residential, Safe Homes, Grandparents or extended family homes, etc.	Bridgeport, New London, Plainville, New Milford, Danbury, Norwalk, Manchester, Norwich, Hartford, Stamford, Manchester, Torrington, Meriden, Waterbury, Windham, Shelton, New Haven All sites serve a specific catchment area **Full statewide coverage provided**	21	Consultant Home visitors typically from & representing the community culture where they serve. !00% Masters level professionals in Mental Health, Early Childhood development or other Human services field. Approx 50% Licensed. 2 years post grad Experience in the field. All Consultants extensively trained & supervised in ECCP Model to include Home Visiting Component.	Masters Degree & Licensure in Mental Health Field Required. 10 Years Post Graduate Experience in the Mental Health/Early Childhood Field. 3 to 5 Years supervisory experience.	Approx 400 served at Child-Specific Level of service. Classroom & Center level of service not included here.

Target Population, Eligibility Requirements, & Duration

Program Name	Ages of Eligible Children at enrollment	Percentage of children enrolled prenatal, 0-3; 3-5; 5+	Eligibility Requirements i.e. age of child, DCF-involved, disability, income level)	Program Serves a High Risk Population Only	Total Duration of Services	Services Offered only on a Voluntary Basis (parents not mandated - can choose to participate or not)	Special Populations (military, Native American, etc.)	Percentage of Families Enrolled Prenatally	Exclusion Criteria (DCF-involved, at least 3 months old, etc)	Other
SHS	Prenatal thru age 2.	Most due to criteria for participation.	Pregnant and postpartum woman & her children under three years of age. Healthy Start provides services to pregnant or postpartum woman in incomes < 185% of federal poverty level, by contract. Sites offer services to women with family incomes < 250% of FPL.	The state Healthy Start program serves pregnant or post partum women of all risk levels. The home visitation component only serves high risk women in most sites. Only two Healthy Start sites offers home visitation on a regular basis. Those sites have dedicated intensive case management as funding allows. Other sites had to drop that part of the program due funding for the program.	On average some families participate for a brief period of time: three months to one year.	All Healthy Start services are voluntary. Clients can refuse to specific parts of the program.	All special populations are welcome into the program.	Between 80 to 90%.	Family refused to be part of program.	
HS	3 to 5	100% ages 3 to 5	At least 90% with incomes at or below federal poverty, children in foster care or children experiencing homelessness; & at least 10% with identified disability; If can demonstrate that eligible populations are served may serve families up to 135% of federal poverty.	Yes	Until kindergarten entry	Voluntary	See eligibility criteria	None	Over income	
EHS	Prenatal to 3	Approx 6% prenatal	At least 90% with incomes at or below federal poverty, children in foster care or children experiencing homelessness; & at least 10% with identified disability; If can demonstrate that eligible populations are served may serve families up to 135% of federal poverty.	Yes	Until age 3	Voluntary	See eligibility criteria	Often but not required	Over income	
NFN	Pre-natal to 3 months	As of the end of December 2009, 12% prenatal, 77% ages 0-3, 11% ages 3-5, 1% over the age of 5.	Screened for social & economic risk factors including poor maternal & child health & development outcomes– child abuse & neglect - parental & financial stress, social isolation, history of abuse or neglect, substance or mental health problems, multiple stressors. First born – up to 3 months	Yes – a high risk population However - The NFN offers Parenting groups are available for the community at large & Connections, a less intensive service for low risk families; In 2008, 584 parents participated in groups. In 2009, 1,743 low risk & 390 high risk families participated in Connections -	Up to 5 years	Yes – always voluntary	Mothers diagnosed with major depression Fathers & men significant to the child Nurturing Parenting Groups are offered to the community at-large	43%	NFN is a voluntary prevention program. Families already involved with DCF due to child abuse or neglect are not eligible. However, if a family becomes DCF involved due to child abuse or	About 50% of the mothers are under 18.

				2,133 total; If a families in Connections becomes high risk they are eligible for home visiting any time up until the child's 5th birthday.					neglect while they are in the NFN program they remain eligible for services.	
NFN-F	Up to 6 months after father became aware that he was a father or anytime a father or man becomes significantly involved with a mother in the program	16% prenatal, 84% 0-3 years	Same as NFN – however point of entry is broader	Yes – high risk 63% not employed; 25% employed PT or occasionally; 48% high school grads; 17% some vocational school or college; 30% arrest history; 60% score at a high level of risk for abuse & neglect on the CAPI -R	Up to 5 years	Yes- always voluntary	Fathers & men significant in the life of a child in the program	Prenatal(?)	Same as NFN	20% of the fathers were under 20 when their baby was born Most risk seen in history of child abuse an neglect
NFN-S	Age of child in the participating school – range from 3 to 12 years	100% over the age of 5	Same as NFN point of entry is broader	Yes – high risk 30% unemployed. 8% of families earn more that $35,000 –the rest earn less	Until the child graduates or leaves the school	Yes- always voluntary	Families whose children are truant – otherwise disconnected form school	None	Same as NFN	67% of the children in the families referred are boys
FRC	Pre-natal to K. Entry	95%; 2111 children serviced - about 5% were 5+ years (103)	Living in Service Area/School community	Not a requirement - priority is recommended for at-risk population	Up to 5 years	Yes - Voluntary			Home-based child care providers & "Kith –n-Kin" (families, friends, neighbors)	
MB	Pre-natal	100% prenatal enrollment	Women between 14-15 having first child & receiving health care from FHCHC or CSHHC Must speak & understand English Exclusion Criteria Psychosis or terminal illness in mother; prenatal drug abuse is screened out by FHCHC	Yes – a high risk population- urban low income families with multiple social, economic & health stressors	27 months	Yes – always voluntary	All welcome	100%	MTB is a voluntary prevention program. Families already involved with DCF due to child abuse or neglect are always eligible. If a family becomes DCF involved due to child abuse or neglect while they are in the program they remain eligible for services. To date we have had no families newly referred to DCF while under our care.	Mean age of our mothers at intake is 19.5 yr.
BT3	Birth to age 3	100% are 0-3	1) Age must be 0-3 & 2) Child must have a significant delay in development or a	Yes	Up till third birthday	Yes	NA	0	Age must be 0-3 & Child must have a significant delay in	

			condition that leads to a significant delay.						development or a condition that leads to a significant delay	
HCWC	Prenatal; Infancy through 3 years of age	100%	Pregnant & at risk for substance abuse &/or domestic violence	At risk for substance abuse &/or domestic violence	Pregnancy up to the child's third birthday	Voluntary involvement	Pregnant women & their families	100% Must be pregnant for eligibility	Must be pregnant to enroll	
CMPW	Prenatal	100% are 0-3	Women during the perinatal & interconceptional period &/or parenting women & men. At least 30% of the clients to be served must be pregnant &/or parenting teenagers (females & males), under the age of 20.	No	Prenatally through 1-4 weeks post partum	It is always voluntary	At least 30% of the clients to be served must be pregnant &/or parenting teenagers (females & males), under the age of 20.	100%	Can not be eligible for other Case Management Programs	78% are under the age of 18. (27% are between the ages of 10-16)
HHS	Preconception , prenatal-2		Low-income women, postpartum to 2 yrs, child to 2 yrs	Serves low, moderate, high risk	Child: up to 2 yrs; mother: 2 yrs postpartum	Yes, always	Health awareness and education is offered to the community; outreach occurs to women in the Afr Am community	90%		
AIRS	Program serves both adults & children of any age	Ages 0-2 N=22 or 12.8% Ages 3-4 N=21 or 12.2% Ages 5-17 N=101 or 58.7% Ages 18+ N=28 or 16.3% 26 were women of childbearing age	A diagnosis of asthma of someone in the family	No- the program is free & accepts referrals from schools, healthcare providers & self-referrals	2-hour patient education & home environmental assessment. Initial phone intake, visit scheduling, phone follow-up after the home visit at 2 weeks, 3 months & 6 months with the avg contact with client being 4-6 total hours	Yes- always voluntary	Town selection for regional coverage for each of the six programs includes a major urban area that asthma surveillance has identified as disproportionally burdened by asthma & has the highest rates of emergency department visits & hospitalizations. Children, adult women, Hispanics, & non-Hispanic blacks experience higher rates of asthma morbidity in the five large cities.	N/A Not captured	None	
YAS	All ages	Data not available	Young Adults ages 18-25 with a Major Mental Illness & frequently exhibiting severe co-occurring problems related to trauma, including persistent & profound neglect, physical &/or sexual abuse.	Yes – a high risk population	18-25 years old	Yes – always voluntary	Mothers/fathers diagnosed with major mental illness, trauma/attachment symptomology.	Data not available	N/A	
BB	Birth to six	0-1 yr < 1% 1 yr 5% 2yr 23% 3 yrs 22 %	Child with an emotional behavioral or mental disorder according to the Diagnostic & Statistical Manual IV (DSMIV) or its ICD-9-CM	Yes, very young children diagnosed with a serious mental health problem	Average Length of stay = 195 days Maximum	All services are voluntary Services offered include Positive Behavioral	Targeted populations include Native Americans, Military Personnel, Spanish-	Not applicable child must have a	Child must have a mental health diagnosis	

		4 yrs 33% 5 yrs 16%	equivalents. For children three years of age or younger, the Diagnostic Classification of Mental Health & Developmental Disorder of Infancy & Early Childhood DC: 0-3 will be used for diagnosis. For children four years of age & older, the DISC may be used as an alternative to DSM-IV.		length of stay to date = 524 days Median Length of Stay = 183 days	Support Individual & dyadic psychotherapy Wrap Around Support Family empowerment & advocacy	Speaking families, women experiencing Domestic Violence Women experiencing Maternal Depression	diagnosed mental health condition		
CF	Prenatal to age 6 yrs (to 8 yrs in Bridgeport)	Prenatal= 1% 0-35 months= 26% 36-59 months = 45% 60 + months = 28% (Bridgeport data)	Child emotional or behavioral problems, developmental or learning problems, or high risk environment (e.g., DCF involvement, maternal depression or psychiatric problems, parental substance abuse, domestic violence, teen parent, homelessness, cognitive limitations, etc.) About 95% have evidence of poverty. No exclusion criteria.	Serves almost exclusively high risk population -98% with socio-demographic risk, (but have served children with significant behavioral problems from middle class homes); Population in randomized trial: Ethnicity: 59% Latino, 30% Black, & 7% Caucasian; Risk factors: 93% receiving public assistance, 64% unemployed, 53% without high school diploma or GED, 67% unmarried, 54% with depression, 44% family history of substance abuse, 25% history of homelessness.	Typical range of 4-12 months, but based on child & family needs. (combination of short term Child FIRST Family Stabilization Program & long term Child FIRST Family Treatment Program – seamless for families.)	Only voluntary.	Children with emotional & behavioral problems or coming from high risk environments, e.g., substance abuse, mental health problems (maternal depression), domestic violence, homeless, history of abuse & neglect (DCF involvement). We also serve children who present with developmental problems (e.g., language delay); many of these children have multiple other complex needs.	About 1% currently. We are increasing prenatal screening for maternal depression & anticipate this number will rise significantly.	None DCF families, parents with substance abuse or mental health problems, undocumented, live in DV or family shelter, etc all eligible.	Child FIRST receives Medicaid reimburse ment for home-based services for children with mental health diagnoses.
ECP	Prenatal to age 6 yr.	N/A	Pregnant women, & parents of infants (ages 0 – 24 months), toddlers (24-36 month), & preschool children (36-60 months) at risk of less than optimal development due to one or more of the following risk factors: maternal depression, exposure to domestic violence, exposure to parental substance, parents at-risk of referral to DCF, homelessness, teen parenting, caregiver cognitive limitations, caregiver mental illness, families with multi-agency involvement & families who have failed to benefit from traditional parenting programs. Of the targeted population, it is expected that at least 50% will have current or past experience with DCF. Focus on underserved populations, such as parents with cognitive challenges, homeless parents, fathers, & women suffering from maternal depression.	Yes	Services will last an average of six to nine months, but will be based on the unique needs of the child & family.	Yes	N/A	N/A	None	N/A
FES	Birth to 17		DCF Involved	No- addresses parenting	4 months	Yes – always voluntary	None	None	DCF Involved	

				basic living needs						
FST	Up to age 18	We track ages according to the following breakdown (percentages are cases served year-to-date): 0-3: 0% 4-7: 10% 8+: 90%	Program serves children & youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	Program serves children & youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	No maximum time limit. Average length of service is approx 8-12 mths. Some cases are served for 18-24 months. A few are longer than 24 mths.	Yes	Serves children & youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	0%	Given the nature of the intervention, child should live in a home setting that is not transitional.	
FBR	0-2		The program uses a variety of standardized clinical screening, assessment & treatment tools are used. Pre & post measures for changes in parental substance abuse, adult mental health, attachment & bonding, & infant mental health. A positive toxicology screen at birth or within 90days is required to be eligible for the service. Social economic, housing & vocational issues are assessed. Age 2 & under	Substance exposure at birth Parental factors include substance abuse, psychiatric illness, victimization, trauma, & child risk factors are drug & alcohol exposure at birth. Cognitive Limitations 3% Mental Illness 29% Alcohol/Substance Abuse 98% Domestic Violence 21% Phys Illness/Med Condition 6% Criminality 8% Poverty 25% Parental Unemployment 38% Housing Problems 25%	Up to 18 months	Yes	Substance Exposed Newborns & parents with substance abuse & mental health issues. The	0	95% are referred by DCF protective services	CAPTA requirements are reporting requirement for newborns are be to reported to protective services if infants are exposed to illicit drugs
IICAPS	Up to age 18	We track ages according to the following breakdown (percentages are cases served year-to-date): 0-3: 2% 4-7: 15% 8+: 83%	Program serves children & youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	Program serves children & youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	No maximum time limit. Average length of service is approx 5-7 months.	Yes	Serves children & youth with Serious Emotional Disturbance at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	0%	Given the nature of the intervention, child should live in a home setting that is not transitional.	
ICFSS	Up to age 18	We track ages according to the following breakdown (percentages are cases served year-	Program serves children & youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	Program serves children & youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are	No maximum time limit. Average length of service is approx 6 months.	Yes	Serves children & youth with Serious Emotional Disturbance at risk of requiring out-of-home treatment (e.g., psychiatric hospital or	0%	Given the nature of the intervention, child should live in a home setting that is not transitional.	

		to-date): 0-3: 0% 4-7: 0% 8+: 100%		returning home from an out-of-home treatment setting.	Some cases are served for up to 12 months.		residential treatment facility), or who are returning home from an out-of-home treatment setting.			
ECCP	Ages Birth Through Five	20 to 25% Birth through Three 75% Three through Five.	All children birth through five eligible where there are social, emotional or behavioral concerns.	ECCP services children who may be considered high risk & those who are at risk to a lesser degree.	Ave length of Child-Specific Service: 8 wks. Ave length of Classroom-based Service: 14 wks. Ave length of center wide service: 10 mths.	Yes – ECCP services are voluntary	Yes-ECCP services a variety of special populations with no exclusionary criteria.	0%	All children birth through five eligible where there are social, emotional or behavioral concerns. No exclusionary criteria.	

Services Offered

Program Name	Average Number of Actual Home Visits Per Month	Average Length of Participation	Types of Education Provided	Type of Curriculum	Types of Services Provided	Types of Screening & Assessment Services Conducted	Types & Numbers of Referrals to Other Services	Tracking to Ensure Receipt of Referral Services?	Life Skills & Life Action Planning	Case Management or Care Coordination ?	Other (services for child or wraparound to child & family)
SHS	Depending on the site none to about 30 per month.	About a year.	Breastfeeding support, child safety, appropriate use of heath services, smoking cessation & secondary smoking.	No specific curricula used. Family is involved in determining the agenda of the home intervention.	Risk assessment, case management, perinatal focus health education & HUSKY application assistance.	Healthy Start risk assessment to determined risk & screening for perinatal depression.	Referrals to WIC, Nurturing Families, food pantries, breastfeeding support, dental. medical & mental health services, free bed funds, legal services.	Yes, WIC, health care providers,	Healthy Start specific case management.	Case coordination for low & medium risk clients & case management for high risk mothers.	
HS	Center-based Option: Twice per year by teacher & ongoing contact with family service staff; (99% of capacity) Home-based Option: weekly visits plus monthly socialization groups. (< 1% of capacity) Combination Option: both center-based & home visiting services (< 1% of capacity)	Typically ages 3 to 5	Education for children & their families	Center-based Option: 75% Creative Curriculum 17% CT PCF 8% Locally designed Home-based Option: 33% CT PCF 33% Creative Curriculum 33% PAT	Education plus comprehensive child development services including health, mental health, oral health, ,family support & education, fatherhood & grandparent supports, community resources.	Screening Tools: 33% ESI 29% ASQ 25% DECA 17% Brigance 17% DIAL 8% Battelle 4% SSRS 4% LAP-D 4% Gesell Assessment Tools: 58% Creative Curriculum 25% CT PAF 17% Other	72% of families receive at least one family service: 49% health education 48% parenting education 35% emergency/crisis intervention 30% housing assistance 26% adult education 20% job training 17% mental health 10% ESL 6% CAN 4% supports related to incarcerated 3% child support assistance 2% substance abuse related services 2% DV related services 2% marriage related assistance	Yes	Family Partnership Agreement	Family Service Workers & Family Advocates; Fatherhood Initiatives; Some gr&parent & foster family supports	Additional services & supports available depending on sponsoring agency, e.g., CAP agencies provide social service supports; & on identified needs resulting from ongoing community assessments, Policy Council, health advisory, family engagement, community partnerships, etc. Extensive collaboration with child care & School Readiness; Statewide partnership with DCF.
EHS	Center-based Option: Twice per year by teacher &	Typically first three years	Education for children & their families	Center-based Option: 100% Creative curriculum	Education plus comprehensive prenatal & child development	Screening Tools: 100% ASQ 11% DECA 11% Denver	83% of families receive at least one family service:	Yes	Family Partnership Agreement	Family Service Workers & Family	Additional services & supports available depending on

	ongoing contact with family service staff; (50% of capacity) <u>Home-based Option</u>: weekly visits plus monthly socialization groups. (50% of capacity) <u>Combination Option</u>: both center-based & home visiting services (0%)			<u>Hone-based Option</u>: * 57% Creative Curriculum 43% PAT 14% locally designed <u>Pregnant Women</u>: 50% PAT 22% Partners for a Healthy Baby 11% March of Dimes 11% HV for Expectant Families	services including health, mental health, oral health, ,family support & education, fatherhood & grandparent supports, community resources.	<u>Assessment Tools</u>: 67% Creative Curriculum 33% ASQ 11% HELP 11% PAT	68% parenting education 66% health education 41% emergency/ crisis intervention 36% housing assistance 24% CAN 15% ESL 14% mental health 13% adult education 10% job training 9% child support assistance 6% supports related to incarcerated 4% DV related services 3% marriage related assistance 2% substance abuse related services			Advocates; Fatherhood Initiatives; Some gr&parent & foster family supports	sponsoring agency, e.g., CAP agencies provide social service supports; & on identified needs resulting from ongoing community assessments, Policy Council, health advisory, family engagement, community partnerships, etc. Extensive collaboration with Birth to 3; Statewide partnership with DCF.
NFN	2.3	22 months 33% complete 2 years	Nurturing Parenting; Child Development, Family Literacy, Maternal & Child Health & Wellness, Community Resources	Required – Nurturing Parenting –Bavolek; Parents as Teachers; Partners for a Healthy Baby. Supplemental – Itsy – Bitsy, San Angelo's, other	Parenting education including skills, info & activities for child development & school readiness; health information & referrals, parent life course, parent leadership skills, & case management.	Revised Early Identification Scale The Kempe Family Stress Checklist – assessment Ages & Stages Child Monitoring Questionnaire Maternal Depression – Edinburgh Child Abuse Potential Inventory Community Life Skills Scale Smoking, alcohol, drug use during pregnancy Baseline For children – the Ages & Stages Child Monitoring	WIC- 29 DSS programs- 106 Social security- 10 Food needs- 216 Doctor/medical - 98 Housing needs- 189 Legal needs- 36 Early intervention/Child care- 86 Mental health/counseling- 38 Crisis intervention- 0 Parenting classes- 27 Domestic Violence- 14 Substance abuse- 2 Education & Employment- 124 DCF- 9 Cultural/religious- 2 Other- 148 Total- 1460 (2008 data for Hartford & New Haven sites only)	Yes Also - mothers show more knowledge & use of community resources based on the Community Life Skills scale in the areas of transportation, budgeting, accessing support services, accepting & involving support from others, & personal interests & hobbies.	Yes – parents develop *A Life Plan* to work toward life goals including education, employment, housing, child spacing, other	Both - plus	Activities to break social isolation & foster family development; family activities, celebrations, events, educational trips. Wrap around services for child & family.

						Questionnaire – development & social & emotional					
NFN-F	2.0	Too soon to determine	Same as NFN with focus on paternal health fathering	Same as NFN plus - Nurturing Fathers –Pearlman & 24-7 Dads	Same as NFN	Same as NFN					
NFN-S	2.8	Too soon to determine	Same as NFN with focus on family health & school connections.	Nurturing Parenting – Bavolek – others under review	Same as NFN	Same as NFN plus the Parent/School Involvement Survey					
FRC	AVG 10.7 visits per site		Child Development; Parenting Education	Parents as Teachers Curriculum & Model	Home Visits, Groups, Screening, Resources	Ages & Stages Dev. Screening, PATNC Health Forms	Community Social Services Agencies; to Birth to Three	Recommended but not required	No	No	
MB	4.5	27 months	Reflective Parenting; Child Development, Pediatric Anticipatory Guidance; Maternal & Child Health & Wellness, Maternal reproductive health; Community Resources	Minding the Baby Treatment Manual; Bright Futures; Health Steps: Circle of Security also used	Parental reflective functioning coaching & parent education including skills, info & activities for enhancing attachment, child development. Direct mental health care provided for mothers & infant/parent dyadic care provided for family. health care & information & referrals, parent life course, parent self efficacy skills, & case management.	Clinical interviews & psychosocial & health assessments at baseline & monthly. Ages & Stages Child Monitoring Questionnaire Maternal Depression – CESD Maternal anxiety & PTSS Smoking, alcohol, drug use during pregnancy & ongoing	Data not available	All referrals are followed up with parents & if appropriate with providers or agencies	Yes – including education, employment, housing, relationships & delaying rapid subsequent childbearing	Both - plus	Direct mental health treatment provided in home when needed.
BT3	4.6 per month	11 months	Child Development, Parent Training,	Hawaii Early Learning Profile (HELP), Carolina Curriculum for Infants & Toddlers, Assessment, Evaluation & Programming System for Infants	17 services required under Part C of IDEA. Services Procedure at http://www.birth23.org/providers/Procedures.html	Multi-disciplinary evaluation & assessment of cognitive, physical, communication, social & emotional development & adaptive skills. Screening for autism spectrum disorders for	Social & Financial Services, Preschool Special Education	Most referrals are documented & tracked on the Individualized Family Service Plan (IFSP)		Each family is assigned a service coordinator	Family support groups & parent to parent support.

				& Toddlers (AEPS)		children 16 months & older.					
HCWC		2.5 - 3 years	Child development, nutrition, breast feeding, child safety, health related information, birth control/family planning, public assistance information	Varies	Comprehensive case management to at risk pregnant women & their families for substance abuse & domestic violence	Ages & Stages, perinatal/post partum depression, tobacco, substance abuse, housing, mental health needs, basic needs,	Referrals to DSS, food banks, adult educ, subst abuse/domestic violence couns/rehab, Birth to 3, shelters, energy assist, housing, employment services (DOL), WIC, daycare/child develop programs, CT legal aide, med providers, educl institutions, crisis interv, infoline, transport services, childbirth classes.	Follow up with home visits & telephone calls to referral services	Life action planning included in client's goals & reviewed every 3 months.	Part of case manager's role is care coordination	Health education to parents on site; community events; materials provided regarding breastfeeding, car seats, safety planning, etc.
CMPW	At least monthly for each child	Do not collect this, but it's prenatal through postpartum	Education related to maternal health, childbirth, nutrition, baby care, parenting, community services available, interconception & family planning, life skills, etc, etc, etc	Varies. All use Parent's as Teachers, all have social workers on staff	Varies with program. Case Management with home visitation, medical appt, referrals to WIC, food stamps provide support & education, assist with basic needs food, diapers, clothing, School-based program assists with monitoring truancy, college applications, financial aid forms, day care, transport to & from school.	Full assessment at time of referral to CM program. Screened for tobacco, substance abuse, housing, education, basic needs, support, perinatal depression (w/referrals as needed). Individual detailed assessment results not collected through contract reporting	160 referred for crisis or emergency services. Specific referral sources not collected.	Done by individual case management contractor	Yes	Part of case manager's role is care coordination	Family activities, father's group, community events, one offers prepared childbirth education
HHS	4.0	36 mths	Maternal and child health and wellness; maternal depression, smoking cessation, nutrition		Health information, care coordination, co-enrollment in WIC, HUSKY A, other social services	Screening, referral, tracking for depression, tobacco cessation, medical risk factors	WIC, HUSKY A, doctor/medical, housing needs, mental health, domestic violence, substance abuse, education,	yes	Yes – care plan	Care coordination	
AIRS	12	6-8 months	Pathophysiology of asthma & that asthma can be controlled Patient/family asthma self-	Patient education based on the NIH, National Asthma Education Prevention Program's (NAEPP) EPR3	One-on-one patient /family education, pre & posttest, Asthma Control Test (ACT) to identify actual asthma	ACT administered to determine patient's current level of asthma control & control for the previous month on day of home visit Pre & post tests to	Only anecdotal information available, actual numbers & types not captured. Visits are time consuming & about half have additional need for	Follow-up with PCP is done if no AAP Only referrals identified as an action item	An AAP is developed or revised between the Program, patient & PCP to guide the patient in effectively	May happen for specific families that are complex cases over the length of the program	N/A

			management education Asthma environmental triggers identification & reduction /elimination interventions	Guidelines, revised 2007 EPA Healthy Homes checklist	control of symptoms versus patient perceived control	determine patient's level of knowledge of environmental asthma triggers Assesses patient understanding of current Asthma Action Plan (AAP) (written instructions from healthcare provider) Reinforces & clarifies components of AAP Identifies if environmental tobacco smoke (ETS) is an issue	other services. Provides summary of services provided to the primary care provider (PCP) & interaction to get patient needs met for asthma, if indicated Follow-up with PCP if no AAP to obtain a current one, if patient has poorly controlled asthma &/or treatment is not based on NAEPP EPR3 Guidelines Referred to 1-800-quit-now for smokers	will be followed-up in phone calls at 2 weeks, 3 mos. & 6 mos.	self-managing their asthma (e.g. what medications to take when symptoms increase, when to call the PCP, what asthma environmental triggers to avoid)		
YAS	2.3	22 months 33% complete 2 years	Positive Parenting; Child Development, Maternal & Child Health & Wellness, Community Resources	Positive Parenting; Baby Think It Over Baby Simulator (prevention) Realityworks Babies Cry Have A Plan-The Massachusetts Children's Trust Fund The Happiest Baby on the Block-Dr. Harvey Karp	Parenting education including skills, child development DOULA services for expectant & new mothers.	Being Developed	Data being collected	Yes mothers are offered intensive supports with transportation, budgeting, continued education, obtaining jobs, accepting & involving support from others, & personal interests & hobbies, peer supports	Yes – Life Skills Inventory (LSI-Casey Family Services) PAYA Curriculum	Case Management	Activities to break social isolation & foster family development are currently being developed statewide for Young Adults; family activities, celebrations, events, educational trips are currently being developed statewide for Young Adults
BB	4	6.1 months	Parenting, Community Resources, Relationship development	Positive Behavior Supports (required)	Mental health services, care coordination	Caregiver Strain Questionnaire; Caregiver Information Questionnaire; Family Life Questionnaire; Living Situation Questionnaire; Parenting Stress Index; CES Depression Scale; Alcohol Severity Index; Traumatic Events Screening Inventory; Child Behavior Checklist; Vineland Screener; Columbia Impairment Scale;		Yes- Care Coordinators maintain contact with families to provide support & additional assistance as needed until families are comfortable obtaining services on their own.	Goals are set with the family with a plan to reach the goals set in place. A safety plan is also developed	Care Coordination	Wraparound services for child & family.

						BITSEA; Devereaux Early Childhood Assessment- SE; TABS; Educational Questionnaire; Multi Sector Service Contacts; Youth Service Survey for Families; Cultural Competence & Service Provision Questionnaire					
CF	Average of 3.0 visits. 4 visits per month scheduled. (Length of visit often up to 2 hours.) May increase to several visits/wk if needed acutely by the family	Average of 4-12 months, but entirely family-driven, so range of 1-18 months. (This is a combination of our short term Child FIRST Family Stabilization Program & our more long term Child FIRST Family Treatment Program. They are seamlessly connected for the family.)	Child development, especially around social-emotional & language development; parenting; impact of environmental risks on child; parental self-sufficiency; community resources	Child FIRST Training Manual & Toolkit. Training through Learning Collaborative with 16 training days, & weekly group consultation by Training Director with each site. Intervention in home is driven by needs of child & family. No set parenting curriculum. Family-driven intervention to promote nurturing relationship & secure attachment. Use of reflective functioning, Circle of Security, & parent-child psycho-therapy. Content & materials individualized for each family.	1) <u>Screening & mental health consultation:</u> early care, education, pediatrics; other community providers 2) <u>Home visiting intervention:</u> Comprehensive child & family assessment; Family-driven Child & Family Plan of Care; Parent guidance & parent-child psycho-therapy; Observations & mental health consultation & strategies within early care & education; Referral to community-based services & hands-on care coordination & case management for all members of family.	<u>Screening:</u> Parent Risk Questionnaire; Brief Infant-Toddler Social-Emotional Assessment (BITSEA); Devereux Early Childhood Assessment (DECA); Preschool-Kindergarten Behavioral Scale (PKBS) <u>Assessments:</u> Family Demographic Questionnaire; Child & Family Clinical Assessment; Service Needs Inventory for Families (SNIFF); Ages & Stages Developmental Questionnaire; CT Infant-Toddler Developmental Assessment (IDA) – Language; Infant-Toddler Social & Emotional Assessment (ITSEA); M-CHAT; Short Sensory Profile; Traumatic Events Screening Inventory-Brief (TESI); Observation of Caregiver-Child Relationship (OCCR); Life Stress Questionnaire – modified; Parenting Stress Index (PSI); Center for Epidemiology Scale-Depression (CES-D); Edinburgh Depression Scale; Youth Service Satisfaction for	Referrals to community-based services for child, parents, & others in family is very broad with the following examples: Child Development (e.g., Birth to Three); Early Care & Education (e.g., special education); Child Mental Health (e.g., IICAPS for sib); Child Health (e.g., Medical Home); Parent Mental Health & Substance Abuse (e.g., substance abuse, mental health, & DV services); Parent Health (e.g., health specialists); Family Support (e.g., family resource centers, Nurturing Home Visiting, parenting groups); Concrete Supports (e.g., WIC, HUSKY, SSI, DV shelter, housing, training, food) <u>Research data:</u> SAMHSA randomized trial showed that 92% of desired services were accessed in Intervention as compared to 33% of Controls. On average, 15 new services were accessed per family. Safe Start evaluation of children exposed to violence showed that 84% of services were accessed within 3	Yes, Care Coordinators are directly involved in helping families connect to services, & tracking barriers to service access & successful engagement. This is tracked on the Family Service Plan.	Yes, this is an integral part of working with families - helping them reflect on & understand the barriers to their meeting their goals & the skills that they want to develop to do so. A Child & Family Plan of Care is developed by the families & clinical staff (family-driven). This is a dynamic document that reflects families' current needs. Families review & sign at least every 3 mos.	Intensive care coordination & case management provided by the Child FIRST care coordinator.	Connects child & all family members with comprehensive, wrap-around services & supports. Provides home-based parent-child psychotherapy, as needed. Within each community, the Early Childhood Council or Collaborative is responsible for oversight of Child FIRST early childhood system of care.

						Families (YSSF); (Some of above are discretionary)	months, with families receiving an average of 20 new services.				
ECP	<u>Norwich</u> 1x/wk = 21 families .5-.9 x/wk = 8 families <.5 x/wk = 6 families (4th quarter, 2009) Hartford - N/A due to recent start	6-9 months; longer as needed	Comprehensive education related to child development & parenting provided	Promoting First Relationships	Individual & Family Plan of Care Home-based visits Family Support Services Care Coordination/Case Management Services Transition Planning Services	Child & Family Assessment; Service Needs Inventory for Families (SNIFF); Family Demographic Information; Ages & Stages; Ages & Stages Social-Emotional Screen (ASQ-SE); Observation of Caregiver-Child Relationship (OCCR); Abadin Parenting Stress Index (PSI); Center for Epidemiology – Depression scale (CES-D); Edinburgh Depression Scale; Home Observation of the Physical Environment (HOPE)	Referrals are made for employment, housing, food, health care, educational, social networking, & other needs. # - N/A	Yes	Child & Family Plan of Care is developed	Both	See previous column on types of referrals.
FST	This varies by level of clinical acuity. On average it is expected to be 2-3 visits per week, which is 8-12 visits per month.	Average length of service is approx 8-12 months. Some cases are served for 18-24 months. A few are longer than 24 months	Multifaceted intervention addressing child & family need on several levels within the family ecology, including child behavior, family functioning, parental distress, school performance, concrete needs (housing, etc.), & system collaboration. Emphasis varies from case to case; often include skill building in affect regulation & behavior management, parent authority & reinforcement of appropriate child behavior, preparation for	Multifaceted intervention addressing child & family need on several levels within the family ecology, including child behavior, family functioning, parental distress, school performance, concrete needs (housing, etc.), & system collaboration. Emphasis varies from case to case; often include skill building in affect regulation & behavior management, parent authority & reinforcement of appropriate child behavior, preparation for collaboration with school, psycho-	Multifaceted intervention addressing child & family need on several levels within the family ecology, including child behavior, family functioning, parental distress, school performance, concrete needs (housing, etc.), & system collaboration. Emphasis varies from case to case; often include skill building in affect regulation & behavior management, parent authority & reinforcement of appropriate child behavior, preparation for	Psychiatric assessment, comprehensive psychosocial evaluation, Ohio Scales (Ohio Youth Problems, Functioning & Satisfaction Scales).	Percentage of cases receiving various service referrals for cases discharged year-to-date: Inpatient Hospital: 9% Residential Treatment: 13% Group Home: 7% Partial Hospital Program: 2% Intensive Outpatient Program: 2% Intensive In-Home Services: 3% Extended Day Treatment: 4% Outpatient Services: 29% Care Coordination: 1% Other: Out-of-Home: 8% Other: Community-Based: 5%	It is expected that cases will be transitioned to the services as part of the intervention. No systematic follow-up is performed post-discharge to assess participation in follow-up services.	As appropriate, particularly with older children, the intervention includes life skills coaching, vocational assessment, etc.	Yes, both.	It is intended to be a multifaceted intervention that addresses child & family need on several levels within the family ecology, including child behavior, family functioning, parental distress, school performance, concrete needs (housing, etc.), & system collaboration. The service includes psychiatric assessment, school consultation, connection with recreational supports, etc. (consistent with wraparound approach to care).

			collaboration with school, psycho-education about specific presenting conditions, medication compliance, etc.	education about specific presenting conditions, medication compliance, etc	collaboration with school, psycho-education about specific presenting conditions, medication compliance, etc.						
FBR	Average three visits per week/ 12 visits per month	Mean Length of Service is 7.2 months	Uses everyday moments—feeding, bathing, reciprocal play, singing, talking, touch-- to help parents make connections between feelings, action, & consequences of acting on feelings in the parent-child relationship. Uses the opportunity of a baby to help parents resolve issues with early caregivers ("Ghosts in the Nursery") that are interfering with the capacity to parent & establish secure attachments	Reflective Functioning (seeing from the child's perspective), or making sense of the child's behavior, emotion, feelings Uses natural parent-child interaction as opportunity for intervention: moment of anticipating/understanding a need; moment of shared delight or when parent can soothe child; staying present with child despite stress Substance Abuse under RBT incorporates: Community Reinforcement Approach (Budney & Higgins, 1998) Motivational Interviewing (Miller & Rollnick, 1992).	Integrated treatment; treats parental substance abuse/mental health using Reinforcement Based Therapy with an in-home interactive parent & child therapy developed by Yale Child Study under the Abandoned Infants Project for Substance abuse exposed infants with case management and: Drug testing; Social Club; Vocational; Safety & Substance Abuse Contracting; Quality Assurance	Measures Parent Stress Inventory –Short Form Edinburgh Postnatal Depression Scale Postpartum Bonding Questionnaire Genograms Ages & Stages (ASQ & ASQ- Social Emotional) Questionnaires Global Appraisal of Individual Needs (QUICK) intake & discharge Functional Assessment of substance abuse Graphing of Tox screens & mood	TANF cash Assistance 36% Unemployment 10% Food Stamps 67% Medicaid 74% WIC 70% Housing subsidy 24%	Yes, Family Based Recovery Services tracks each client & provide quarterly data on performance & program indicators of tox screen results, pre-post measures.	Parents are engaged in social club & long term recovery supports which involved life skills, vocational & social supports	Yes, this is included	Linkages to primary care & pediatricians
IICAPS	This varies by level of clinical acuity. On average it is expected to be 3 visits per week, or approx 12 visits per month.	Average length of service is approx 5-7 months.	Multifaceted intervention addressing child & family need on several levels within the family ecology, including child behavior, family functioning,	Uses the model-specific IICAPS intervention, which includes a variety of assessment, treatment planning, service evaluation tools, etc.	Multifaceted intervention addressing child & family need on several levels within the family ecology, including child behavior, family functioning,	Psychiatric assessment, comprehensive psychosocial evaluation, Ohio Scales (Ohio Youth Problems, Functioning & Satisfaction Scales).	Percentage of cases receiving various service referrals for cases discharged year-to-date: Inpatient Hospital:4% Residential Treatment: 7% Group Home: 1% Partial Hospital	It is expected that cases will be transitioned to the services as part of the intervention. No systematic follow-up is performed	As appropriate, particularly with older children, the intervention includes life skills coaching, vocational assessment, etc.	Yes, both.	It is intended to be a multifaceted intervention that addresses child & family need on several levels within the family ecology, including child behavior, family functioning,

			parental distress, school performance, concrete needs (housing, etc.), & system collaboration. Emphasis varies from case to case; includes skill building in affect regulation & behavior management, parent authority & reinforcement of appropriate child behavior, preparation for collaboration with school, psycho-education regarding specific presenting conditions, medication compliance, etc.		parental distress, school performance, concrete needs (housing, etc.), & system collaboration. Emphasis varies from case to case; includes skill building in affect regulation & behavior management, parent authority & reinforcement of appropriate child behavior, preparation for collaboration with school, psycho-education regarding specific presenting conditions, medication compliance, etc		Program: 2% Intensive Outpatient Program: 3% Intensive In-Home Services: 4% Extended Day Treatment :5% Outpatient Services; 55% Care Coordination: 5% Other: Out-of-Home :3% Other: Community-Based: 11%	post-discharge to assess participation in follow-up services			parental distress, school performance, concrete needs (housing, etc.), & system collaboration. The service includes psychiatric assessment, school consultation, connection with recreational supports, etc. (consistent with wraparound approach to care).
ICFSS	This varies by level of clinical acuity. On average it is expected to be 2-3 visits per week, which is 8-12 visits per month.	Average length of service is approx 6 months. Some cases are served for up to 12 months.	Multifaceted intervention addressing child & family need on several levels within the family ecology, including child behavior, family functioning, parental distress, school performance, concrete needs (housing, etc.), & system collaboration. Emphasis varies from case to case; includes skill building in affect regulation & behavior management,	Multifaceted intervention addressing child & family need on several levels within the family ecology, including child behavior, family functioning, parental distress, school performance, concrete needs (housing, etc.), & system collaboration. Emphasis varies from case to case; includes skill building in affect regulation & behavior management, parent authority &	Multifaceted intervention addressing child & family need on several levels within the family ecology, including child behavior, family functioning, parental distress, school performance, concrete needs (housing, etc.), & system collaboration. Emphasis varies from case to case; includes skill building in affect regulation & behavior management,	Psychiatric assessment, comprehensive psychosocial evaluation, Ohio Scales (Ohio Youth Problems, Functioning & Satisfaction Scales).	Percentage of cases receiving various service referrals for cases discharged year-to-date: Outpatient Services: 25%	It is expected that cases will be transitioned to the services as part of the intervention. No systematic follow-up is performed post-discharge to assess participation in follow-up services	As appropriate, particularly with older children, the intervention includes life skills coaching, vocational assessment, etc.	Yes, both.	It is intended to be a multifaceted intervention that addresses child & family need on several levels within the family ecology, including child behavior, family functioning, parental distress, school performance, concrete needs (housing, etc.), & system collaboration. The service includes psychiatric assessment, school consultation, connection with recreational

			parent authority & reinforcement of appropriate child behavior, preparation for collaboration with school, psycho-education regarding specific presenting conditions, medication compliance, etc.	reinforcement of appropriate child behavior, preparation for collaboration with school, psycho-education regarding specific presenting conditions, medication compliance, etc.	parent authority & reinforcement of appropriate child behavior, preparation for collaboration with school, psycho-education regarding specific presenting conditions, medication compliance, etc						supports, etc. (consistent with wraparound approach to care).
ECCP	22 per Consultant or 2 to 3 per Child-Specific Case	2 months	Consultation Provided on Social-Emotional & Behavioral Health, Development & Parenting	Clinical Consultation Provided on Social-Emotional & Behavioral Health, Conscious Discipline. Pyramid Model, ELG, etc. ECCP considered National Best Practice Model Backed by r&om control rigorous research studies.	Early Childhood Mental Health Consultation Provided	CBCL CTR-F Ages & Stages Child Monitoring Questionnaire Ages & Stages Child Social Emotional Monitoring Questionnaire Parenting Stress Index HOME Tool BITSEA Sensory Profile EC & IT	288 referrals made annually to variety of sources such as: Mental Health Child Mental Health Adult Special Education Services Pediatrician Specialty Evaluation Parenting Groups Support Groups Play Groups	Yes. Centralized Data System & Manualized program to include 1 & 6 month Follow Up services. Multiple referrals given to family for services due to waitlists, location of services, etc. 25% of referrals made were accepted.	Action Plans developed for each child/family focus on strengths & strategies to meet social emotional & behavioral needs. Plans developed to cross home & early care/education environments.	Case Management & care coordinate among family/early care & education environments & other early childhood providers involved.	Family/Home & Early Care/Education Based services

Outcome Measures

Program Name	**Maternal Health/Behavioral Outcomes**	**Infant & Child Health & Mortality**	**Child Development** - Child Emotional/ Behavioral Health	**Parenting Stress & Skills**	**School Readiness**	**Crime/ Domestic Violence**	**Child Abuse/ Neglect**	**Family Economic Wellbeing**	**Source for Outcome Measures**
SHS	Statistically significant decrease rate of preterm birth. The proportion of Low Birth Weight is lower than that of CT's newborns corresponding racial & ethnic categories. Most clients, 58% register for the program in first trimester of pregnancy.	Infants born to Healthy Start participants have a statistically significant decrease likelihood of being preterm (major contributor of Infant mortality).	HS staff provided culturally sensitive education that is guided by screening for perinatal depression, oral health needs & related prenatal issues including child development & safety.	Mothers are provided with referrals to parenting resources that are accessible in their community.				Other evaluation outcomes: Serves disproportionally non-white & Hispanic clients; Serves disproportionate number of young mothers; Produces an estimated cost savings of $.35 mil.	Healthy Start Evaluation for 2006-2007 conducted by Beth Osborrn Daponte PhD of Yale University.
HS	* extensive national studies & local level data www.eclkc.ohs.acf.hhs.gov)	Yes	Yes	Yes	Yes			Yes	
EHS	* extensive national studies & local level data www.eclkc.ohs.acf.hhs.gov)	Yes	Yes	Yes	Yes			Yes	
NFN	Rates of preterm & low birth weight babies for the high risk mothers compare favorably with the state & national rates for the general population. Statistically significant increase of mothers receiving food stamps. The majority of families who came into the program with acute risk are no longer acute 3 months later. Statistically significant decrease in social isolation. Statistically significant increase in mothers being connected to others, increased time spent with others, involved in reciprocal relationships with friends – exchanging favors such as babysitting. Randomized control study of maternal depression underway.	Low birth weight – 9% for high risk compared to 7.7% for general population Pre-term births for high risk mothers the same as for the state average for the general population – 10% 96% of children were fully immunized 98% of children had a pediatric care physician	Ages & Stages Monitoring Questionnaire showed 5% of children with a developmental or social – emotional delay. The delays were considered significant in 3% of the cases & were referred for further evaluation. The NFN children had fewer social & emotional & developmental problems than would be expected. The National Center for Children in Poverty found between 9.5% & 14.2 % of children have developmental delays or social & emotional problems.	Mothers show a statistically significant decrease for risk of child abuse & neglect on the CAPI –including less parenting stress & less rigid parenting styles.	*Source - Parents as Teachers Second Wave Study - found that poor preschool children whose families participated in a home visiting program scored significantly higher on all measures of intelligence, achievement, & language ability than children in the comparison group whose families did not receive home visiting services. The children did as well as the national norm for children their age - with roughly 15%	The DV rate dropped significantly from program entry- 2.4% to 1% at one year. All mothers who reported DV at program entry were not in DV relationships 1 year later. The group at 1 year who reported DV did not report it at entry.	Mothers reduced risk for abuse & neglect -statistically significant decreases on the Child Abuse Potential Rigidity Subscale. The annual rate of abuse & neglect is 2% for 2009. In all but two cases, the family was substantiated for physical neglect. There was one case of medical neglect & one case of physical abuse. The 2% finding compares favorably to the rates of abuse & neglect rate in other comparable programs nationally; several studies show rates of 4% to 8%. 2% is very low when compared with rates of 20-25%	Statistically significant increases in budgeting, families with a bank account, more families financially secure. Mothers made statistically significant progress in rates of high school completion employment, independent living & increased state support.	2010 annual evaluation report of the NFN home visiting program conducted by the University of Hartford Center for Social Research. Information for school readiness outcomes was drawn form the Parents as Teachers Second Wave Study. This study & others studies on PAT are available Referral & group enrollment information was taken from the 2009 NFN Evaluation Report. Rates of developmental & social & emotional problems from the

					exceeding the national norm.		reported in studies with similarly high-risk mothers who did not receive home visitation services.		National center for Children in Poverty –*Social Emotional Development in Children, Aug., 2009*
NFN-F	Outcome data is not yet available								
NFN-S	Outcome data still preliminary – sites began working with families less than a year ago.								
FRC	Improved home environment, opportunities to interact with other parents, awareness of resources & so increased fulfillment of basic needs, reduction of stress, & family support.	Improved identification of & referral for possible delays; lower rate of low birth rate; decreased child abuse/neglect; better nutrition & health care 99% of children in these programs were fully immunized by age 2	Improved skills in language, motor, social-emotional & cognitive abilities; improved relationships to family & peers. Fewer unidentified & un-remediated delays or unaddressed health/vision/hearing issues.	Improved knowledge of & ability to facilitate age-appropriate development. Increased connection with other parents & with schools & community.	Enhanced cognitive abilities & general knowledge, language & literacy skills, social-emotional dev., motor skills, phys well-being, ability to learn, academic achievement	With more competence & confidence as parents & a support system family stress is reduced.	With parents' improved knowledge of realistic expectations, positive discipline techniques, better attachment to the child, & support system child are less likely to be abused or neglected	Not addressed specifically other than in referrals	PAT National Center Logic Model & Annual Program Reports
MB	Mothers more likely to start & continue breastfeeding through first 12 months 1(N=65) mother in MTB group *vs* 6 (N=57) in Control group experienced rapid subsequent childbearing (within 24 months of first childbirth)	100% Children fully immunized & receiving regular pediatric visits *vs* 80% of control group	Mothers & toddlers with more secure attachment & less disorganized attachment *vs* control group children & mothers	Mothers report significantly less total stress on Parenting Stress Index- short form	Follow up school age data not available yet	No mothers arrested or involved with justice system; no statistics currently available for DV	0% of families involved with DCF 2% of control families referred to DCF for child removal into foster care	No statistics currently available	Ongoing data collection; Randomized clinical trial with control group from same settings
BT3	No	No	Yes	Yes	No	No	No	No	1. Developmental Assessment updated annually 2. Report to OSEP on 3 outcomes for each child enrolled for at least 6 months
HCWC	Measured with number of women enrolled in substance abuse programs, individual therapy & review of individual client goals/progress.	Measured with number of low/very low birth weights, premature births, age appropriate immunizations & ages & stages questionnaire completed at specific ages.	No outcome measure	No outcome measure	No outcome measure	Number of women referred to domestic violence shelters/programs; Documentation of safety plan for individual clients; Review of	No outcome measure	No outcome measure	Quarterly & Annual Report

						individual client's goals/objectives relating to domestic violence.			
CMPW	Improved birth outcomes, Decreased repeat pregnancy, Improved parenting skills, Decreased DCF involvement	0.05% rate of preterm births	Not collected	100% of all mother's receive parenting classes, father's can participate as well.	N/A	Assessed for during initial assessments. Not measured	Assessed for during assessments & ongoing case management. Not measured. Required by State law to report.	Not measured	Annual & quarterly program reports
HHS	yes	Yes	No	No	No	No	No	No	No
AIRS	A) In 2009, 15.4 % of CT's adult population were current cigarette smokers. The rate for men was 16.2 %, for women 14.7% with the highest prevalence among 18-24 year-olds at 24%. This could impact women in their child-bearing years & caring for young children that are exposed to ETS. B) Based on 2006-2007 Behavior Risk Factor Surveillance Survey (BRFSS) data, those who currently smoked were significantly more likely to have severe asthma (32%) than those who smoked in the past (20%) or never smoked (13 %). Not only do smokers have a higher risk for severe asthma than former smokers & nonsmokers, but smokers also have different environmental risk factors for severe asthma than former smokers & nonsmokers. C) Out of 172 families, 43 families (25%) had current smokers identified during Putting on AIRS visits	D) From 1996-2005 among children 0-17 years old, the average death rate was 2.3 per 1,000,000 & 0.8 per 1,000,000 with asthma as the underlying & contributing cause, respectively (rates may be unstable due to small number of deaths & thus should be interpreted with caution). Asthma is a controllable disease & no one should die from asthma.	The # of days absent from school due to asthma at the 6-month follow-up after the home visit decreased by 8 days compared to the prior 3 months on the day the intervention began	Parent empowerment to advocate for their child & family for appropriate medical diagnosis & management of asthma as a controllable disease increased anecdotally in most cases. Patient /parent can identify signs & symptoms of an asthma exacerbation & the steps they should take to decrease symptoms & when to call their PCP. By the end of the visit, the patient/family demonstrated correct inhalation technique & was able to verbalize the difference in a controller versus rescue medication & the appropriate time of when each should be used Another visit was scheduled to ensure patient/family understanding if this was not accomplished during the initial visit. Parents demonstrated increased knowledge regarding asthma triggers on the posttest compared to the pretest.	N/A	N/A	N/A	N/A	A) 2009 Behavior Risk Factor Surveillance Survey (BRFSS) data Tobacco Program B) 2006-2007 BRFSS Asthma Program C) 2009 Putting on AIRS Program Data D) Mortality data (1996-2005) – CT DPH Office of Vital Records
BB	Statistically significant reduction in internalizing & externalizing behaviors Significant increase in child's ability to exercise self control 68% of children live in a home with someone who is			Statistically significant reduction in parental stress, decrease maintained at 18 months.	Decrease in suspension & expulsion rates after 6 months of services. At 18 months rate continues to decrease.	42% of children live in a home where they have experienced domestic violence. 41% of children live with someone who has been		62% of children live at or below the poverty level.	Taken from 2009 Clinical Outcomes Evaluation report

	depressed. Of that 32% are the caregiver. Decrease in caregiver depression reported. Decrease in problem behaviors with change sustained over 18- month period.					convicted of a crime.			
CF	Depression & Mental Health Problems: SAMHSA randomized trial: Mothers participating at baseline: 54% with depression & 44% with substance abuse. 12-month follow-up showed Child FIRST Intervention group with statistically significant decrease in maternal depressive symptoms (Center for Epidemiology – Depression Scale – CES-D) & mental health problems (Brief Symptom Inventory - BSI), with 4 fold reduction compared to Controls. Reflects both decrease in existing symptoms & prevention of new symptoms.	Immunization status, medical home, lead level, acute/chronic diseases, prenatal	Social-Emotional & Language: SAMHSA randomized trial: Children at baseline: 52% with social-emotional or behavioral problems (Infant-Toddler Social-Emotional Assessment – ITSEA) ; 12 month follow-up showed children in Child FIRST Intervention were 4.7 times less likely to have aggression & defiance (externalizing symptoms). 20% of children had language delays at baseline. 12 month follow-up, Child FIRST Intervention children were 4.4 times less likely to have language problems, representing both catch-up in language (80% in Intervention compared to 36% in Controls) & prevention of new language problems. Parent-child interaction was also measured using the Observation of the Caregiver-Child Relationship (OCCR) with a statistically significant improvement in the relationship. Safe Start: Significant decrease in children's post traumatic stress symptoms.	Stress: SAMHSA: Mothers at baseline: 29% with significant parenting stress. Intervention mothers showed statistically significant decrease in parenting stress (Parenting Stress Index – PSI), with 3.2 fold decrease in scores in clinical range as compared to Controls. Safe Start: Marked decrease in parenting stress on PSI (including changes on all subscales.)	See Child Development outcomes in language & social-emotional development for school readiness outcomes.	SAMHSA: 27% of mothers or spouses had been incarcerated at some time at baseline. No Intervention mothers were incarcerated during the study. Safe Start: Significant decrease in the number of traumatic events that children experienced.	Child Abuse & Neglect: SAMHSA: At baseline: 34% of families had either past or current DCF involvement. 12-month follow-up, mothers in Intervention reported a 4.1 fold decrease in DCF involvement compared to Controls. Using DCF data: Child FIRST Intervention families had a 2.1 decrease in DCF involvement at 3 year follow-up.	Data on employment not analyzed.	Outcomes come from both the Starting Early Starting Smart – Prototype (SAMHSA) randomized trial and from the evaluation of the Safe Start Initiative (OJJDP). OTHER: Multiple measures used at baseline and outcome. Parent Satisfaction Questionnaire demonstrated very high satisfaction in both SAMHSA and Safe Start studies (4.6 on scale of 1-5.) Child FIRST developed extensive Fidelity Metrics and Measures for use by replicating communities.
ECP	Norwich Depression Above cut-off Pre - 7/18	Norwich DCF Involvement Pre - 32/40 Post - 19/34	Norwich OCCR ≥ 41 (at risk) Pre - 16/35	Norwich PSI-SF ≥ 91(at risk) Pre - 7/35	N/A	N/A	N/A	N/A	Annual report (10/2008 - 9/2009)

	Post - 1/7 *Hartford - N/A due to recent start*	*Hartford - N/A due to recent start*	Post - 6/23 <u>Ages & Stages</u> Below cut-off Pre - 4/18 Post - 2/5 <u>Ages & Stages - SE</u> Below cut-off Pre - 13/16 Post - 3/3 *Hartford - N/A due to recent start*	Post - 2/12 *Hartford - N/A due to recent start*					
FST		Ohio Scales measures of child problem severity & child functioning as reported at intake & discharge by parent & clinician; Emergency room visits 6 months prior to admission & during episode of care; Psychiatric hospitalizations lifetime & 6 months prior to admission & during episode of care; Residence at intake & discharge (outcome is ability to remain in community versus institutional care); DSM-IV Global Assessment of Functioning (GAF Axis V) at intake & discharge.	Parent report of their ability to manage child's needs at intake & discharge; Parent satisfaction & degree to which they report treatment plan reflective of their concerns, at discharge;	Parent report of school attendance at intake & discharge;	Arrest 6 months prior to admission & during episode of care;	Substance problem lifetime, 6 months prior to admission & during episode of care;			
FBR	FBR Services Pre-post **Measures** / **Change Score & Significance** Edinburgh N=255 Depression Scale Total Score -0.90 ** Parental Bonding Questionnaire N=100 Total Score -1.85 ** Impaired Bonding -1.04 ** Rejection-Anger -0.24 NS Anxiety-Care -0.55 ** Risk of Abuse -0.04 NS UConn Health Center Matched comparison Evaluation Design being	FBR Services Child Risk / **Mean** / **Range** Gest Age: 37.9 wks sd=3.1 wks; 27-42 s Birth Weight: 6.3 lbs sd=1.3 lbs; 2.2-9.4		Measures Parenting Stress Index-Short Form N=112 Total Score -6.73 ** Parenting Distress -3.75 ** Parent-Child Dysfunctional Interaction -1.93 ** Difficult Child -1.26 NS (p=.06)		43% percent report Domestic Violence at admission Over 30% report being worried about being victimized 60% have had an internalizing & externalizing disorders. Pre/post of parental risk factors are being conducted	FBR cases are risk for DCF placement FBR at discharge 72% are with the parent & 12% placed with relatives Evaluation is being conducted.	RBT studies have shown increase in self sufficiency & self efficacy & significant reductions in substance abuse FBR has shown a decrease in substance abuse.	FBR Services Report. Presentations at National Summit Exposed Infants 2010 sponsored by ACF, NIDA & National center on Substance Abuse & Child Welfare DCF PSDRS DCF GAIN Data

	conducted RBT published by Johns Hopkins as an evidence-based substance abuse intervention for opiated addicted pregnant & post partum women								
IICAPS		Emergency room visits 6 months prior to admission & during episode of care; Psychiatric hospitalizations lifetime & 6 months prior to admission & during episode of care; Residence at intake & discharge (outcome is ability to remain in community versus institutional care); DSM-IV Global Assessment of Functioning (GAF Axis V) at intake & discharge.	Ohio Scales measures of child problem severity & child functioning as reported at intake & discharge by parent & clinician	Parent report of their ability to manage child's needs at intake & discharge; Parent satisfaction & degree to which they report treatment plan reflective of their concerns, at discharge; Arrest 6 months prior to admission & during episode of care;	Parent report of school attendance at intake & discharge;	Substance problem lifetime, 6 months prior to admission & during episode of care;			
ICFSS		Emergency room visits 6 months prior to admission & during episode of care; Psychiatric hospitalizations lifetime & 6 months prior to admission & during episode of care; Residence at intake & discharge (outcome is ability to remain in community versus institutional care); DSM-IV Global Assessment of Functioning (GAF Axis V) at intake & discharge.	Ohio Scales measures of child problem severity & child functioning as reported at intake & discharge by parent & clinician;	Parent report of their ability to manage child's needs at intake & discharge; Parent satisfaction & degree to which they report treatment plan reflective of their concerns, at discharge;	Parent report of school attendance at intake & discharge; Arrest 6 months prior to admission & during episode of care;	Substance problem lifetime, 6 months prior to admission & during episode of care;			
ECCP	% of Children Maintained in their early care or education setting	% improved on CBCL	% improved on CTR-F	% Classrooms Improved using CLASS Tool	Goals established in Child-Specific Action Plan				DCF ECCP Quarterly Reports Annual RBA Reports

Evidence Base

Program Name	Unique or Replicated Program?	Model used for Replication	Data system for tracking outcomes	Source of Documented Internal Evaluation	Source of Documented Independent Evaluation	Evaluation Design (randomized, quasi-experimental, etc)	Most Recent Evaluation Report Available	Peer Review Journal – Outcomes Published	Other
SHS	Unique		yes.	Program staff does quality checks, not real evaluation of program.	Healthy Start Evaluation for 2006-2007 conducted by Beth Osborrn Daponte PhD of Yale University.	Quasi experimental design for evaluation.	Healthy Start Evaluation for 2006-2007 conducted by Beth Osborrn Daponte PhD of Yale University.	No	
HS	National Early Childhood Laboratory	Federal Head Start Act; Head Start Program Performance St&ards; etc.	Extensive internal & external tracking systems	Program level PIR data; program level outcome data; program level community assessment data, ongoing federal program monitoring, etc.	Program evaluation: External program monitoring. Research: Various sampling strategies utilized for national Head Start & Early Head Start studies & vast number of smaller scale studies by researchers around the country.	Extensive national research & policy agenda with federal funding support		extensive	
EHS	National Early Childhood Laboratory	same	same	same	same				
NFN	Unique & replicated	Nurturing Families Model	yes		University of Hartford University of Connecticut The PAT & Nurturing Parenting curriculum have also been independently	Quasi-experimental	Nurturing Families Network 2010 Evaluation Report Center for Social Research University of Hartford.	In process	2010 annual evaluation conducted by the UConn Center for Social Res. School readiness outcomes from Parents

					evaluated. Several studies & peer review articles are available. Nurturing Parenting has received proven program status from OJJDP.				as Teachers Second Wave Study. Referral & group enrollment information from 2009 NFN Eval Report. Rates of dev, social & emotional problems *Social Emotional Development in Children, Aug., 2009*
NFN-F	Unique – replication based on NFN	Nurturing Families Network Model	yes		University of Hartford conducting a program evaluation	Quasi-experimental	NFN 2010 Evaluation Report; Center for Social Research University of Hartford. An interim study is being conduced by the University of Hartford.		
NFN-S	Unique – replication effort underway	Nurturing Families Model	yes		University of Hartford conducting a program evaluation	Quasi-experimental	2009 Process & Outcome Interim Evaluation Report		
FRC	Replicated nationally & internationally; currently implemented in over 3000 sites.	Parents as Teachers four component model: home visits, group meetings, child screening, & resource network.	Please see table on evidentiary support for each of the outcomes for next three columns. Research is primarily independent.			Most recently listed as an Evidence-Based Program by FRIENDS; listed on the California Evidence-Based Clearinghouse for Child Welfare; pending review on			

						SAMHSA's National Registry of Effective Programs & Practices [1]			
MB	Unique- still in efficacy testing phase of development We based the development of MTB on the Nurse Family Partnership & the work of Peter Fonagy, Alicia Lieberman & Christopher Heineke		Yes- this is a randomized clinical trial	Minding the Baby Research Staff members, biostatistician, PI (L. Sadler) & consultants (J. Robinson & D. Leslie)		Randomized Clinical Trial with Intent to Treat analyses & cost & effectiveness analyses	NICHD R21 Final Progress Report	Currently in preparation, also: Sadler, L.S., et al. (2006). Minding the Baby: A mentalization based parenting program. In J.G. Allen & P. Fonagy (Eds.), *H&book of mentalization-based treatment (pp.271-288)* Chichester, UK: Wiley. Sadler L.S.& Mayes, L.(2005). Mechanisms of change in influencing early attachment processes: Enhancing parental reflective functioning. In L. Berlin, Y. Ziv, L. Amaya-Jackson & M. Greenberg (Eds.), *Enhancing early attachments*.(pp. 152-177) New York: Guilford Publications Inc. Slade, A. etal (2005) *Psychoanalytic Study of the Child, 60,* 74-100.	
BT3	National - IDEA Part C	IDEA Part C	Yes	State RBA, Federal Annual Performance Reports (APR)	NA		February 2010	Garalnick	
HCWC	unique	None	Manual tracking; information reviewed & updated every month; goals reviewed every three months.	Client & provider surveys were conducted.	None	Surveys were sent to all clients.	2008	None	
CMPW	Both	Student Parenting, NF, what contractor outlines in RFP.	No. Manual tracking.	Not required through contract.	Student Parenting-Yale	Descriptive study	2007		
HHS	Replicated	State Healthy Start	yes						
AIRS	Replicated	http://www.thecommunityguide.org/asthma/multicomponent.html Asthma Control: Home-based Multi-trigger, Multicomponent Environmental Interventions	Yes	DPH Asthma Program Evaluation Plan		quasi-experimental	Pending	Planned	
YAS	Unique	N/A	Under development				N/A	N/A	
BB	Unique- currently	Child FIRST	yes		Contract with Yale- The	Quasi experimental	Building Blocks 2009 Clinical	In process	

[1] http://www.friendsnrc.org/download/eb_prog_direct.pdf; http://www.cebc4cw.org/program/95; http://www.nrepp.samhsa.gov/resources-pending.asp

	being adapted to replicate Child FIRST model				Consultation Center to conduct independent evaluation.		Outcomes The Consultation Center Yale		
CF	Unique – Developed in Greater Bridgeport & now replicated in 5 other cities/regions in CT. Plan to exp& to all DCF area offices (14 sites).	Child FIRST Iinformed by work published by A. Lieberman, C. Heinicke, & A. Slade.	Customized cross-site, web-based database developed by CS&O, which incorporates all data needed by PSDCRS (DCF)		University of CT & University of Massachusetts, Boston – funded by SAMHSA as part of the Starting Early / Starting Smart – Prototype (one of five national sites) & by the Robert Wood Johnson Foundation. Yale University Consultation Center – funded by OJJDP.	Randomized, controlled trial, intent to treat design. Quasi-experimental	Lowell, DI, et al "A Randomized Controlled Trial of Child FIRST: A Comprehensive, Home-Based Intervention Translating Research into Early Childhood Practice." Accepted for publication by *Child Development* as part of a special issue: "Raising Healthy Children: Translating Child Development Research into Practice," to be published in 2010. Crusto, C, et al *Best Practices in Mental Health, An International Journal,* 2008	Yes – Accepted for publication in *Child Development, 2010* Published in *Best Practices in Mental Health, An International Journal,* 2008	Cost-benefit analysis currently in process.
ECP	Unique	N/A	Available 2011	N/A	N/A	N/A	N/A	N/A	
FST	Unique	N/A	Yes	N/A	N/A	N/A	N/A	No	
FBR	Unique in CT but based on replications CT has six sites & looking to be replicated elsewhere	Reinforcement Based Therapy (Johns Hopkins) Coordinated Intervention for Infants & Women's (Yale Child Study)	Yes	Yale University: J. Adnopoz, K. Hanson, C. Connell, D. Saul, J. Vanderploeg, J. Radawich, A. Myers Johns Hopkins/U. of	University of Connecticut J. Hawke, K. Steinberg	Matched Comparison RBT Randomized Clinical	In process	In process	

				Maryland: M. Tuten, C. Schaeffer, J. Ertel					
IICAPS	Replicated	IICAPS model	Yes	Yale Child Study Center	N/A	N/A	IICAPS Quarterly Report	No	
ICFSS	Unique	N/A	Yes	N/A	N/A	N/A	N/A	No	
ECCP	Statewide Early Childhood Mental Health Consultation Program; Data driven, manualized & backed by 3 rigorous random control research studies.	ECCP is replicated statewide. ECCP is highlighted in the 2009 Georgetown University "What Works?" Study as one of 6 best practice Early Childhood Mental Health Consultation Programs in the country.	Customized & fully integrated, centralized Information System that is: interactive; produces reports; provides program-wide quality assurance & contract reports	ECCP Information System.	Process Evaluation: UConn, AJ Pappanikou Center, program Start Up in 2003 Research Evaluation: Yale Univ, W. Gilliam, three random control studies.	Rigorous Randomized Blind Rater Research Study. 2007	Research Evaluation Yale University- Dr Walter Gilliam Rigorous Random control	Yes	

* - provide hard copy & location for all documents.

Appendix 4
Towns with Home Visiting Services*
Results of Survey Conducted by Home Visiting Needs Assessment Group
Connecticut, 2010

Home Visiting Programs	
Bloomfield	**Bridgeport**
FRC	SHS, EHS, NFN, FRC, YAS, FBR, FP, CF
Branford	**Bristol**
FRC, CF, FES, FRS, FAST, FVS	SHS, NFN, FRC, YAS, FES
Colchester	**Columbia**
BB, EHS	FP
Danbury	**Enfield**
EHS, NFN, FRC, FES, FRS, FP, FAST	NFN, FRC, FES
East Haven	**East Windsor**
FRC, BB	FRC, YAS
East Hartford	**Essex**
FRC	FP
Farmington	**Greenwich**
NFN	NFN
Griswold	**Groton**
BB, EHS	FRC, BB, FVS, EHS
Hartford	**Hamden**
SHS, NFN, NFN-S, FRC, CMPW, FRS, FAST, CT, FES, FVS, CFS, FP, YAS, CF, HHS	FRC
Hebron	**Lyme**
FRC	BB
Manchester	**Middletown**
EHS, NFN, YAS, FES, FRS, FVS, FAST, FP	SHS, NFN, NFN-S, YAS, FP, FES, FAST, EHS
Meriden	**Milford**
FES, FRS, PA	FAST, FP
New Haven	**Montville**
SHS, EHS, NFN, NFN-F, NFN-S, CMPW, YAS, FVS, FP, FRS, FBR, MB, CF	EHS
New London	**New Britain**
SHS, NFN, BB, FP, EHS	NFN, YAS, FES, FRS, FAST, FBR, FP
New Milford	**North Stonington**
NFN	BB
Norwich	**Norwalk**
SHS, NFN, NFN-S, YAS, BB, FES, FRS, FAST, FBR, FP, EHS	SHS, NFN, CF, FES, FRS, FAST, FP
Plainville	**Old Lyme**
FES, FRS, FP	BB
Salem	**Putnam**
BB	SHS, NFN, FRC
Stamford	**Seymour**
SHS, EHS, NFN, YAS, FP, FES, FAST	SHS
Torrington	**Stonington**
SHS, EHS, NFN, NFN-F, YAS, FES, FRS, FAST, FP	BB
Voluntown	**Vernon**
BB	EHS
Waterbury	**Waterford**
SHS, NFN, HCWC, CMPW, YAS, CF, FES, FVS, FP, FRS, FAST, FBR, EHS	BB
Windham	**West Haven**
EHS, NFN, NFN-S, YAS, FES, FAST, FBR	YAS
Winchester	**Windsor**
FRC	FAST
Statewide	
HS, BT3, IICAPS, ECCP, NFN, AIRS (94 towns)	

* - Information from a survey of known maternal, infant, and early childhood programs in Connecticut, conducted pursuant to the U.S. Patient Protection and Affordable Care Act of 2010.

Appendix 4
Ages Services by Home Visiting Programs *
Results of Survey Conducted by the Hoome Visiting Needs Assessment Group
Connecticut, July 2010

	Maternal/Infant Development Stage							
Program	**Preconception/ Interconception**	**Prenatal**	**0-1 yr**	**1-2 yr**	**2-3 yr**	**3-4 yr**	**4-5 yr**	**5+ yr**
Young Adults Services Young Parents	x	x						
State Healthy Start	x	x	x	x				
Hartford Healthy Start (federal)	x	x	x	x				
Putting on Airs	x	x	x	x	x	x	x	x
Case Management for Pregnant Women		x	(x)					
Minding the Baby		x	x	x	(x)			
Early Head Start		x	x	x	x			
Healthy Choices for Women & Children		x	x	x	x			
Nurtuing Families Network		x	x	x	x	x	x	
Nurturing Families Network Fathers Pilot		x	x	x	x	x	x	
Family Resource Centers		x	x	x	x	x	x	
Child FIRST		x	x	x	x	x	x	x
Early Childhood - Parents in Partnership		x	x	x	x	x	x	x
Intensive Community Family Support Services		x	x	x	x	x	x	x
Family-Based Recovery			x	x				
Birth to Three			x	x	x			
Early Childhood Consultation Partnership			x	x	x	x	x	x
Building Blocks			x	x	x	x	x	x
Family Support Team			x	x	x	x	x	x
Intensive In-Home Child & Adolescent Psychiatric Services			x	x	x	x	x	x
Family Enrichment Services			x	x	x	x	x	x
Head Start						x	x	
Family School Connection Demonstration Project								x

Data not available for Family Reunification Services, Foster & Adoptive Support Team, Integrated Family Violence Services, Intensive Family Preservation, Parent Assessment & Clinical Education Services.

Crosses in parentheses indicate a partial fulfillment of developmental stage.

* - Information obtained from a survey of known maternal, infant, and early childhood home visiting programs in Connecticut, conducted pursuant to the U.S. Patient Protection and Affordable Cared Act of 2010.

Appendix 4
Outcomes Monitored by Home Visiting Programs *
Results of Survey Conducted by the Home Visiting Needs Assessment Group
Connecticut, 2010

Home Visiting Program	Maternal Health/ Behavior	Infant/Child Health	Child Development/ Behavior	Parenting Stress & Skills	School Readiness	Crime/ Domestic Abuse	Child Abuse/Neglect	Family Economic Wellbeing
Intensive In-Home Child & Adolescent Psychiatric Services	x							
Intensive Community Family Support Services	x							
Birth to Three			x	x				
Case Management for Pregnant Women	x	x		x				
Healthy Choices for Women & Children	x	x				x		
Head Start		x	x	x	x			x
Early Head Start	x	x	x	x	x			x
Early Childhood - Parents in Partnership	x	x	x	x				
Putting on Airs	x	x	x	x				
Early Childhood Consultation Partnership	x	x	x	x	x			
Child FIRST	x		x	x	x	x	x	
Building Blocks	x			x	x	x		x
Hartford Healthy Start (federal)	x	x	x	x				x
State Healthy Start	x	x	x	x				x
Minding the Baby	x	x	x	x		x	x	
Intensive Home Based Services: Family-Based Recovery	x	x		x		x	x	x
Family Support Team		x	x	x	x	x	x	
Family Resource Centers	x	x	x	x	x	x	x	
Nurturing Families Network	x	x	x	x	x	x	x	x
Nurturing Families Network Fathers Pilot Family School Connection Demonstration Project	***none***							

Data not available for Young Adult Services: Young Parents Program, Family Enrichment Services, Family Reunification Services, Foster & Adoptive Support Team, Integrated Family Violence Servicdes, Intensive Family Preservation, Parent Assessment & Clinical Education Services.

* - Information from a survey of known maternal, infant, and early childhood home visiting programs in Connecticut, conducted pursuant to the U.S. Patient Protection and Affordable Care Act of 2010.

Appendix 4
Degree of Evidence Base for Home Visiting Programs [1]
Results of Survey Conducted by Home Visiting Needs Assessment Group
Connecticut, 2010

Program	Internal Evaluation	External Evaluation	Peer-Reviewed Publication [2]
Birth to Three	x	x	R
Early Head Start	x	x	R
Head Start	x	x	R
AIRS	x		R
Nurturing Families Network	x	x	R
Building Blocks		x	R
State Healthy Start	x	x	R
Hartford Healthy Start (federal)		pending	R
Family Resource Centers			R
Early Childhood Consultation Partnership	x	x	x
Child FIRST		x	x
Intensive In-Home Child & Adolescent Psychiatric Services		x	x
Minding the Baby	x		x
Family Reunification Services	x		x
Family-Based Recovery	x	x	pending
Case Management for Pregnant Women		x	
Healthy Choices for Women & Children	x		
Nurturing Families Network Fathers Pilot		pending	
Family School Connection Demonstration Project		pending	
Young Adults Services Young Parents		pending	
Early Childhood - Parents in Partnership Family Support Team Intensive Community Family Support Services	*none available*		

R - replicated

Data not availble for Family Enrichment Services, Family Reunification Services, Foster & Adoptive Support Team, Integrated Family Violence Services, Intensive Family Preservation, Parent Assessment & Clinical Education Services.

[1] - Information from survey of known maternal, infant, and early childhood home visiting programs in Connecticut, conducted pursuant to the U.S. Patient Protection and Affordable Care Act of 2010.

[2] - includes peer reviewed publications conducted by the organization for a unique program, or publications available for replicated programs.

Appendix 5

Systems Self Assessment Results, August 2010

Characteristics of an Ideal System of Evidence-based Home Visiting Programs in Connecticut *

Please consider the current system of home visiting programs in Connecticut, and then answer the following question for each ideal characteristic below: HOW WELL ARE WE DOING NOW?
1 = not well at all; 5 = very well.

	Score					Average
1. The environment surrounding the system is strong and supportive.	**1**	**2**	**3**	**4**	**5**	**2.1**
a. State policies support the system.	3	**7**	4	0	0	**2.1**
b. Funding streams into the system are flexible, diversified, and consistent with need.	5	**7**	2	0	0	**1.8**
c. The public will is strong.	3	**5**	4	2	0	**2.4**
d. The political will is strong	4	**5**	2	2	0	**2.2**
2. Programs within the system are of high quality and produce desired	**1**	**2**	**3**	**4**	**5**	**3.0**
a. New programs or services are matched with needs.	1	2	**9**	2	0	**2.9**
b. Existing programs are evidence-based.	0	1	5	**8**	0	**3.5**
c. Programs reach clients in need.	2	0	4	**6**	1	**3.3**
d. Programs are of the highest quality.	0	2	**7**	5	0	**3.2**
e. Programs operate with a high level of efficiency.	0	**6**	4	3	0	**2.8**
f. Programs have a universal set of outcomes of interest.	**5**	4	2	3	0	**2.2**
g. Programs are cost effective.	0	**5**	**5**	3	1	**3.0**
h. Programs are culturally-sensitive and responsive to consumers.	0	3	**8**	2	2	**3.2**
3. Linkages across the system are strong and effective.	**1**	**2**	**3**	**4**	**5**	**1.7**
a. A centralized data system exists to track participants	**10**	2	0	1	1	**1.6**
b. Data maintained by individual programs are shared to track participants.	**8**	5	0	0	0	**1.4**
c. Referrals between programs are seamless and efficient.	**6**	4	3	1	0	**1.9**
d. Programs work together to create joint plans.	**6**	5	2	0	1	**1.9**
e. Eligibility assessments and co-applications are coordinated.	**8**	3	3	0	0	**1.6**
f. MOAs exist to solidify linkages between programs.	**8**	2	1	2	0	**1.8**
4. A governance and administrative support structure supports the system.	**1**	**2**	**3**	**4**	**5**	**2.2**
a. Governing entities oversee and coordinate programs in the system.	**4**	**4**	2	**4**	0	**2.4**
b. A consistent set of standards exist across the system.	**9**	1	3	0	1	**1.8**
c. Education and training ensures a competent workforce.	1	4	**7**	2	1	**2.9**
d. Technical assistance supports systems development.	2	**7**	2	3	0	**2.4**
e. Roles and mechanisms for accountability are well defined.	4	3	**5**	2	0	**2.4**
f. Funding streams are less categorical.	4	**8**	2	1	0	**2.0**
g, Consumers are involved in oversight activities.	**5**	4	2	0	0	**1.7**
5. The system is comprehensive and available to all communities in need.	**1**	**2**	**3**	**4**	**5**	**2.0**
a. Programs are available for all geographies in need.	**8**	1	5	0	0	**1.8**
b. A comprehensive array of services are available.	0	**7**	6	1	0	**2.6**
c. Needs within geographies are monitored regularly with population-based data.	4	**7**	3	0	0	**1.9**
d. Funding to the system is stable and sustainable.	**9**	3	2	0	0	**1.5**
e. A broad array of people involved in the system assume responsibility for its maintenance.	3	**6**	4	1	0	**2.2**

** Extracted and modified from "Issue Brief: Early childhood systems building from a community perspective," by The Colorado Trust (April, 2009). Also informed by "A self-assessment tool for states," by Zero to Three (2010).*

Appendix 6
Data Reports
Statewide and Communities of Very High Need, 2008

Geography: Statewide

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Births (%)	10.8	--	--	--		
Low Birth Weight Rate (per 100)	8.00	--	--	--		
Infant Mortality Rate (per 1,000)	5.65	--	--	--		
Poverty (%)		--		--	11.6	
Crime Rate (per 1,000)	--	--	--	--	27.2	
Domestic Violence (%)	--	--		--	0.08	
School Drop-out Rates (%)		--	--	--	1.90	
Substance Abuse (per 1,000)	--	--			5.65	
Unemployment (%)	--	--		--	5.70	
Child Maltreatment (per 1,000)	--			--	1.30	
Young Children Living in Poverty (%)					15.6	
Excess Low Birth Weight	0					
Excess Non-private Insurance at Birth	0					
Excess Child Maltreatment					0	
Number of Low CMT Scores					0	

Geography: Ansonia

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	8.80	--	--	--		
Low Birth Weight Rate (per 100)	9.70	--	--	--		
Infant Mortality Rate (per 1,000)	6.98	--	--	--		number of occurences < 20
Poverty (%)		--		--	17.7	
Crime Rate (per 1,000)	--	--	--	--	19.7	
Domestic Violence (%)	--	--		--	0.89	number of occurences < 20
School Drop-out Rates (%)		--	--	--	3.20	
Substance Abuse (per 1,000)	--	--			na	na = data not available
Unemployment (%)	--	--		--	7.10	
Child Maltreatment (per 1,000)	--			--	19.3	
Young Children Living in Poverty (%)					20.7	
Excess Low Birth Weight	0					
Excess Non-private Insurance at Birth	21					
Excess Child Maltreatment					28	
Number of Low CMT Scores					2	

Geography: Bloomfield

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	16.8	--	--	--		
Low Birth Weight Rate (per 100)	14.6	--	--	--		
Infant Mortality Rate (per 1,000)	16.8	--	--	--		
Poverty (%)		--		--	12.1	
Crime Rate (per 1,000)	--	--	--	--	29.3	
Domestic Violence (%)	--	--		--	0.46	number of occurences < 20
School Drop-out Rates (%)		--	--	--	1.72	
Substance Abuse (per 1,000)	--	--			na	na = data not available
Unemployment (%)	--	--		--	10.7	
Child Maltreatment (per 1,000)	--			--	9.40	
Young Children Living in Poverty (%)					17.7	
Excess Low Birth Weight	7					
Excess Non-private Insurance at Birth	4					
Excess Child Maltreatment					-14	
Number of Low CMT Scores					1	

Geography: Bridgeport

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	11.3	--	--	--		
Low Birth Weight Rate (per 100)	10.1	--	--	--		
Infant Mortality Rate (per 1,000)	8.79	--	--	--		
Poverty (%)		--		--	24.0	
Crime Rate (per 1,000)	--	--	--	--	54.5	
Domestic Violence (%)	--	--		--	5.24	
School Drop-out Rates (%)		--	--	--	6.50	
Substance Abuse (per 1,000)	--	--			16.7	
Unemployment (%)	--	--		--	8.80	
Child Maltreatment (per 1,000)	--			--	19.4	
Young Children Living in Poverty (%)					29.9	
Excess Low Birth Weight	53					
Excess Non-private Insurance at Birth	806					
Excess Child Maltreatment					260	
Number of Low CMT Scores					3	

Geography: Bristol

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	10.5	--	--	--		
Low Birth Weight Rate (per 100)	9.00	--	--	--		
Infant Mortality Rate (per 1,000)	5.84	--	--	--		
Poverty (%)		--		--	14.2	
Crime Rate (per 1,000)	--	--	--	--	27.5	
Domestic Violence (%)	--	--		--	2.73	
School Drop-out Rates (%)		--	--	--	1.50	
Substance Abuse (per 1,000)	--	--			10.4	
Unemployment (%)	--	--		--	6.20	
Child Maltreatment (per 1,000)	--			--	22.6	
Young Children Living in Poverty (%)					18.7	
Excess Low Birth Weight	6					
Excess Non-private Insurance at Birth	26					
Excess Child Maltreatment					129	
Number of Low CMT Scores					0	

Geography: Derby

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	15.1	--	--	--		
Low Birth Weight Rate (per 100)	7.20	--	--	--		
Infant Mortality Rate (per 1,000)	s	--	--	--		s = data suppresed
Poverty (%)		--		--	13.4	
Crime Rate (per 1,000)	--	--	--	--	29.3	
Domestic Violence (%)	--	--		--	0.53	number of occurences < 20
School Drop-out Rates (%)		--	--	--	1.34	
Substance Abuse (per 1,000)	--	--			na	na = data not available
Unemployment (%)	--	--		--	10.2	
Child Maltreatment (per 1,000)	--			--	11.7	
Young Children Living in Poverty (%)					13.4	
Excess Low Birth Weight	2					
Excess Non-private Insurance at Birth	6					
Excess Child Maltreatment					-4	
Number of Low CMT Scores					3	

Geography: East Hartford

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	13.8	--	--	--		
Low Birth Weight Rate (per 100)	11.0	--	--	--		
Infant Mortality Rate (per 1,000)	7.39	--	--	--		
Poverty (%)		--		--	19.7	
Crime Rate (per 1,000)	--	--	--	--	36.4	
Domestic Violence (%)	--	--		--	1.56	
School Drop-out Rates (%)		--	--	--	2.40	
Substance Abuse (per 1,000)	--	--			9.82	
Unemployment (%)	--	--		--	7.20	
Child Maltreatment (per 1,000)	--			--	78.9	
Young Children Living in Poverty (%)					8.00	
Excess Low Birth Weight	25					
Excess Non-private Insurance at Birth	110					
Excess Child Maltreatment					196	
Number of Low CMT Scores					3	

Geography: Hartford

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	13.6	--	--	--		
Low Birth Weight Rate (per 100)	11.6	--	--	--		
Infant Mortality Rate (per 1,000)	9.98	--	--	--		
Poverty (%)		--		--	31.9	
Crime Rate (per 1,000)	--	--	--	--	63.0	
Domestic Violence (%)	--	--		--	5.32	
School Drop-out Rates (%)		--	--	--	4.60	
Substance Abuse (per 1,000)	--	--			22.1	
Unemployment (%)	--	--		--	10.9	
Child Maltreatment (per 1,000)	--			--	25.0	
Young Children Living in Poverty (%)					36.9	
Excess Low Birth Weight	83					
Excess Non-private Insurance at Birth	821					
Excess Child Maltreatment					434	
Number of Low CMT Scores					3	

Geography: Meriden

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	10.6	--	--	--		
Low Birth Weight Rate (per 100)	8.30	--	--	--		
Infant Mortality Rate (per 1,000)	6.39	--	--	--		
Poverty (%)		--		--	18.5	
Crime Rate (per 1,000)	--	--	--	--	37.0	
Domestic Violence (%)	--	--		--	2.34	
School Drop-out Rates (%)		--	--	--	2.30	
Substance Abuse (per 1,000)	--	--			13.4	
Unemployment (%)	--	--		--	7.00	
Child Maltreatment (per 1,000)	--			--	31.3	
Young Children Living in Poverty (%)					21.4	
Excess Low Birth Weight	6					
Excess Non-private Insurance at Birth	36					
Excess Child Maltreatment					270	
Number of Low CMT Scores					3	

Geography: New Britain

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	13.4	--	--	--		
Low Birth Weight Rate (per 100)	11.1	--	--	--		
Infant Mortality Rate (per 1,000)	8.39	--	--	--		
Poverty (%)		--		--	26.5	
Crime Rate (per 1,000)	--	--	--	--	51.6	
Domestic Violence (%)	--	--		--	3.10	
School Drop-out Rates (%)		--	--	--	6.0	
Substance Abuse (per 1,000)	--	--			16.0	
Unemployment (%)	--	--		--	8.50	
Child Maltreatment (per 1,000)	--			--	27.9	
Young Children Living in Poverty (%)					31.6	
Excess Low Birth Weight	32					
Excess Non-private Insurance at Birth	323					
Excess Child Maltreatment					259	
Number of Low CMT Scores					3	

Geography: New Haven

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	14.2	--	--	--		
Low Birth Weight Rate (per 100)	11.0	--	--	--		
Infant Mortality Rate (per 1,000)	11.7	--	--	--		
Poverty (%)		--		--	26.6	
Crime Rate (per 1,000)	--	--	--	--	81.6	
Domestic Violence (%)	--	--		--	4.10	
School Drop-out Rates (%)		--	--	--	5.30	
Substance Abuse (per 1,000)	--	--			20.5	
Unemployment (%)	--	--		--	8.50	
Child Maltreatment (per 1,000)	--			--	29.8	
Young Children Living in Poverty (%)					28.9	
Excess Low Birth Weight	54					
Excess Non-private Insurance at Birth	557					
Excess Child Maltreatment					544	
Number of Low CMT Scores					3	

Geography: New London

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	9.90	--	--	--		
Low Birth Weight Rate (per 100)	9.10	--	--	--		
Infant Mortality Rate (per 1,000)	8.33	--	--	--		number of occurences < 20
Poverty (%)		--		--	21.9	
Crime Rate (per 1,000)	--	--	--	--	43.8	
Domestic Violence (%)	--	--		--	1.31	number of occurences < 20
School Drop-out Rates (%)		--	--	--	8.90	
Substance Abuse (per 1,000)	--	--			21.6	
Unemployment (%)	--	--		--	7.10	
Child Maltreatment (per 1,000)	--			--	25.3	
Young Children Living in Poverty (%)					7.40	
Excess Low Birth Weight	6					
Excess Non-private Insurance at Birth	119					
Excess Child Maltreatment					70	
Number of Low CMT Scores					3	

Geography: Putnam

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	10.0	--	--	--		number of occurences < 20
Low Birth Weight Rate (per 100)	4.60	--	--	--		number of occurences < 20
Infant Mortality Rate (per 1,000)	s	--	--	--		s = data suppressed
Poverty (%)		--		--	20.5	
Crime Rate (per 1,000)	--	--	--	--	29.7	
Domestic Violence (%)	--	--		--	s	s = data suppressed
School Drop-out Rates (%)		--	--	--	3.82	
Substance Abuse (per 1,000)	--	--			na	na = data not available
Unemployment (%)	--	--		--	10.9	
Child Maltreatment (per 1,000)	--			--	s	s = data suppressed
Young Children Living in Poverty (%)					26.7	
Excess Low Birth Weight	-2					
Excess Non-private Insurance at Birth	-2					
Excess Child Maltreatment					29	
Number of Low CMT Scores					3	

Geography: Torrington

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	11.4	--	--	--		
Low Birth Weight Rate (per 100)	5.80	--	--	--		
Infant Mortality Rate (per 1,000)	s	--	--	--		s = data suppressed
Poverty (%)		--		--	11.7	
Crime Rate (per 1,000)	--	--	--	--	22.1	
Domestic Violence (%)	--	--		--	1.57	
School Drop-out Rates (%)		--	--	--	4.80	
Substance Abuse (per 1,000)	--	--			17.8	
Unemployment (%)	--	--		--	6.40	
Child Maltreatment (per 1,000)	--			--	23.7	
Young Children Living in Poverty (%)					19.3	
Excess Low Birth Weight	-5					
Excess Non-private Insurance at Birth	58					
Excess Child Maltreatment					80	
Number of Low CMT Scores					3	

Geography: Waterbury

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	12.1	--	--	--		
Low Birth Weight Rate (per 100)	9.50	--	--	--		
Infant Mortality Rate (per 1,000)	7.83	--	--	--		
Poverty (%)		--		--	28.5	
Crime Rate (per 1,000)	--	--	--	--	54.8	
Domestic Violence (%)	--	--		--	5.05	
School Drop-out Rates (%)		--	--	--	3.50	
Substance Abuse (per 1,000)	--	--			19.5	
Unemployment (%)	--	--		--	9.30	
Young Children Living in Poverty (%)					34.5	
Child Maltreatment (per 1,000)	--			--	18.4	
Excess Low Birth Weight	44					
Excess Non-private Insurance at Birth	560					
Excess Child Maltreatment					153	
Number of Low CMT Scores					3	

Geography: Winchester

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	17.8	--	--	--		
Low Birth Weight Rate (per 100)	10.8	--	--	--		number of occurences < 20
Infant Mortality Rate (per 1,000)	s	--	--	--		s = data suppressed
Poverty (%)		--		--	11.5	
Crime Rate (per 1,000)	--	--	--	--	24.3	
Domestic Violence (%)	--	--		--	0.66	number of occurences < 20
School Drop-out Rates (%)		--	--	--	7.80	
Substance Abuse (per 1,000)	--	--			na	na = data not available
Unemployment (%)	--	--		--	6.50	
Child Maltreatment (per 1,000)	--			--	29.7	
Young Children Living in Poverty (%)					18.4	
Excess Low Birth Weight	2					
Excess Non-private Insurance at Birth	5					
Excess Child Maltreatment					38	
Number of Low CMT Scores					1	

Geography: Windham

Indicator [1]	Title V	CAPTA	Head Start	SAMHSA	Other	Comments
Premature Birth (%)	8.90	--	--	--		
Low Birth Weight Rate (per 100)	9.50	--	--	--		
Infant Mortality Rate (per 1,000)	5.86	--	--	--		number of occurences < 20
Poverty (%)		--		--	30.7	
Crime Rate (per 1,000)	--	--	--	--	29.8	
Domestic Violence (%)	--	--		--	1.00	number of occurences < 20
School Drop-out Rates (%)		--	--	--	4.30	
Substance Abuse (per 1,000)	--	--			5.65	
Unemployment (%)	--	--		--	7.60	
Child Maltreatment (per 1,000)	--			--	42.0	
Young Children Living in Poverty (%)					38.6	
Excess Low Birth Weight	3					
Excess Non-private Insurance at Birth	87					
Excess Child Maltreatment					150	
Number of Low CMT Scores					3	

[1] - Definitions:

Premature Birth - births to Connecticut residents at less than 37 weeks gestation, relative of all births, calendar year 2008. Obtained from vital records, DPH.

Low Birth Weight Rate - babies born to Connecticut residents with a birth weight less than 2,500 grams, relative to all births, calendar year 2008. Data obtained from vital records, DPH.

Infant Mortality Rate - deaths to babies less than 265 days old, per 1,000 births, calendar years 2003-2007 combined. Data obtained from vital records, DPH.

Poverty - all children less than 18 years of age living in poverty, relative to all children less than 18 years of age, 2008. Data obtained at the county level from U.S. Census Bureau (*http://www.census.gov/cgi-bin/saipe/saipe.cgi*), and calculated to the town level.

Crime Rate - number of offenses for murder, rape, robbery, aggravated assault, burglary, larceny, motor vehicle theft, and arson, per 1000 residents, 2008. Data obtained from Connecticut Department of Public Safety (*http://www.dir.ct.gov/dps/ucr/ucr.aspx*).

Domestic Violence - number of emergency room visits related to IDC9-CM codes 995.50-995.55, 995.59, 995.80-995.85, relative to all emergency room visits, 2000-2006. Data obtained from Connecticut Hospital Association, DPH.

School Drop-out Rate - number of high school students enrolled in grades 9-12 who drop out of school, relative to all students enrolled in the school, for calendar years 2002-2005 combined. Data obtained from the Connecticut Department of Education.

Substance Abuse - prevalence of individuals in active substance abuse treatment, per 1,000 residents. Data obtained from the Connecticut State Department of Mental Health and Addictions Services.

Unemployment - percent of unemployed, relative to resident population, 2008. Data obtained from the Connecticu Economic Resource Center.

Child Maltreatment - average number of annual substantiated cases of maltreatment, per 1,000 children, aged 0-17, for years 2006-2008 combined. Data obtained from the Connecticut Department of Children and Families.

Young Children Living in Poverty - number of children aged 0-4, inclusive, who are living in poverty, relative to all children in this age group, 2008. Data obtained at the county level from the U.S. Census Bureau, and calculated to the town level.

Excess Low Birth Weight - number of observed low birth weight babies, above the expected number of low birth weight occurences, given the statewide average rate of 5.8 per 100 live births, calendar year 2008. Data obtained from vital records, DPH.

Excess Non-Private Insurance at Birth - number of observed births paid by non-private sources, beyond the number of births expected, given the size of the birth cohort, calendar year 2008. Data obtained from vital records, DPH.

Excess Child Maltreatment - number of substantiated cases, annually, above the number expected, given the statewide annual average rate of 1.3 per 1,000 children, calendar years 2008-1010. Data obtained from the Connecticut Department of Children and Families.

Number of Low CMT Scores -of the three Connecticut Mastery Tests (Mathematics, Reading, and Writing), the number that fell below the state average of 80.7%, 68.4%, and 82.9%, respectively, of students who met proficiency standards, 2008

Appendix 7
Letters of Support

1) Rosa M. Biaggi, Director, Connecticut Title V, Connecticut Department of Public Health

2) Michael P. Starkowski, Commissioner, Connecticut Department of Social Services, Title II (CAPTA) Agency

3) Patricia A. Rehmer, Commissioner, Connecticut Department of Mental Health and Addiction Services, State Agency for Substance Abuse Services

4) Grace-Ann Whitney, Director, Connecticut Head Start State Collaboration Office

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

September 14, 2010

J. Robert Galvin, M.D., M.P.H., M.B.A., Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue, MS#13COM
P.O. Box 340308
Hartford, Connecticut 06134-0308

RE: Statewide Needs Assessment for HRSA Grant Number X02MC19427, Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program

Dear Commissioner Galvin:

As Director of the Title V Maternal and Child Health Block Grant, I am pleased to concur with the statewide needs assessment document prepared in fulfillment of requirements for the U.S. Health Resources and Services Administration, Grant Number X02MC19427. I actively participated in the needs assessment group to guide development of the document, prepared narrative where needed, and shared other readily available materials for the document.

The Title V Maternal and Child Health Block Grant recognizes that home visiting is a critical service delivery strategy and research-based approach for building trusting relationships within families and providing the knowledge, skills and tools to create healthy and safe homes where children can develop optimally and succeed in school. Our work with existing home visiting programs funded by the Block Grant demonstrates the value of this important strategy for families at high risk for poor outcomes.

As Director of the Title V Maternal and Child Health Block Grant, I am committed to continued collaboration with state and local partners in support of this needs assessment and later work during the planning phase. Please feel free to contact me at (860) 509-7773 if you have any questions or require additional information.

Sincerely,

Rosa M. Biaggi, MPH, MPA
Director, Title V Maternal and Child Health Block Grant
Director, Family Health Section

Phone:
Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS # _____
P.O. Box 340308 Hartford, CT 06134
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STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

MICHAEL P. STARKOWSKI
Commissioner

TELEPHONE
(860) 424-5053

TDD/TTY
1-800-842-4524

FAX
(860) 424-5057

EMAIL
commis.dss@ct.gov

September 13, 2010

J. Robert Galvin, M.D., M.P.H., M.B.A., Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue, MS#13COM
P.O. Box 340308
Hartford, Connecticut 06134-0308

RE: Statewide Needs Assessment for HRSA Grant Number X02MC19427, Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program

Dear Commissioner Galvin:

The State of Connecticut Department of Social Services (DSS) is pleased to concur with the statewide needs assessment document prepared in fulfillment of requirements for the U.S. Health Resources and Services Administration, Grant Number X02MC19427. The Director of the State's Community-Based Grants for the Prevention of Child Abuse and Neglect Program (CBCAP) actively participated in the needs assessment group to guide development of the document, prepared narrative where needed, and shared other readily available materials for the document.

As Commissioner of the state agency responsible for CBCAP, I recognize that home visiting is a critical service delivery strategy and research-based approach for building trusting relationships within families and providing the knowledge, skills and tools to create healthy and safe homes where children can develop optimally and succeed in school.

CBCAP is committed to continued collaboration with DPH in support of this needs assessment and later work during the planning phase. Please feel free to contact me at (860) 424-5053 if you have any questions or require additional information.

Sincerely,

Michael P. Starkowski
Commissioner

Cc: Claudette Beaulieu, Deputy Commissioner
Karen Foley-Schain, Executive Director, Children's Trust Fund

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH
AND ADDICTION SERVICES
A HEALTHCARE SERVICE AGENCY

M. JODI RELL
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

September 8, 2010

J. Robert Galvin, M.D., M.P.H., M.B.A., Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue, MS#13COM
P.X. Box 340308
Hartford, Connecticut 06134-0308

RE: Statewide Needs Assessment for HRSA Grant Number X02MC19427, Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program

Dear Commissioner Galvin:

The Connecticut Department of Mental Health and Addiction Services (DMHAS) is pleased to concur with the statewide needs assessment document prepared in fulfillment of requirements for the U.S. Health Resources and Services Administration, Grant Number X02MC19427. Staff from DMHAS' Statewide Services actively participated in the needs assessment group to guide development of the document, prepared narrative where needed, and shared other readily available materials for the document.

As Connecticut's single state agency for substance abuse prevention and treatment services, DMHAS recognizes home visiting as a critical service delivery strategy and research-based approach for building trusting relationships with parents and other caregivers with the knowledge, skills and tools to assist their children in being healthy, safe and ready to succeed in school. DMHAS is committed to continued collaboration with DPH in support of this needs assessment and later work during the planning phase.

Best wishes on a successful application.

Sincerely,

Patricia A. Rehmer, MSN
Commissioner

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Department of Public Health
Office of the Commissioner

(AC 860) 418-7000
410 CAPITOL AVENUE, P.O. BOX 341431 • HARTFORD, CT 06134
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CONNECTICUT HEAD START STATE COLLABORATION OFFICE

September 8, 2010

J. Robert Galvin, M.D., M.P.H., M.B.A., Commissioner
State of Connecticut Department of Public Health
410 Capitol Avenue, MS#13COM
P.X. Box 340308
Hartford, Connecticut 06134-0308

RE: Statewide Needs Assessment for HRSA Grant Number X02MC19427, Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program

Dear Commissioner Galvin:

As State Director of Head Start Collaboration I am pleased to concur with the statewide needs assessment document prepared in fulfillment of requirements for the U.S. Health Resources and Services Administration, Grant Number X02MC19427. I participated in the group conducting the need assessment from the start and was able to contribute input from the Head Start and Early Head Start communities. After many reviews and discussions we developed an informative document. Our process was inclusive and collaborative resulted in a good snapshot of the needs and challenges in our state today.

Our need for additional home visiting resources in our state is enormous. Home visiting is a critical service delivery strategy and research-based approach for building trusting relationships within families and providing the knowledge, skills and tools to create healthy and safe homes where children can develop optimally and succeed in school. We would greatly benefit from additional resources to complement Head Start and especially Early Head Start and will integrate our resources and services in whatever ways we can to make the new program successful for our state.

The CT Head Start State Collaboration Office is committed to continued collaboration with DPH in support of this needs assessment and later work during the planning phase. Please feel free to contact me at (860) 424-5066 if you have any questions or require additional information.

Please keep me apprised of your progress. I look forward to working with you on this very valuable project.

Sincerely,

Grace Whitney, PhD. MPA.

Grace Whitney, PhD, MPA
Director

Commissioner's Office, Department of Social Services, 25 Sigourney Street, Hartford, CT 06106
Phone: 860-424-5066 Blackberry: 860-478-0586 Email: grace.whitney@ct.gov