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ABSTRACT

This KIDS COUNT data book examines statewide trends in the well-being of Connecticut's children. After listing the regional population, racial/ethnic background, poverty status, and family setting of Connecticut's children, the statistical report examines 13 indicators of well-being: (1) percentage of children receiving welfare benefits; (2) low birth weight per 1,000 births; (3) infant mortality rate; (4) percentage of births with late or no prenatal care; (5) percentage of all births to teen mothers; (6) child death rate; (7) percentage of students meeting Connecticut Mastery Test goals; (8) percentage of tenth graders well below the Connecticut Academic Performance Test standard; (9) percentage of all students grades 9-12 who are high school dropouts; (10) juvenile violent crime arrest rate; (11) child abuse/neglect rates; (12) teen death rate; and (13) child poverty. Section 1 of the report summarizes recent brain development research and the ways development is hindered or helped by the environment. Sections 2 and 3 present child well-being indicators, organized by indicator and region, respectively. The document concludes with an explanation of terms and methodology. Findings indicate that about 19 percent of children live in poverty. In the last 10 years, there has been a slight worsening of the low birth weight rate, improvements in infant mortality, an increase in the percentage of mothers receiving prenatal care, and a decrease in the percentage of all births to teenage mothers. In 1995-96, 30 percent of sixth graders met state goals on the Connecticut Mastery Test. The dropout rate improved slightly during the past 5 years. The juvenile violent crime arrest rate per 100,000 increased from 1991-92 to 1995-96. (Contains 22 references.) (KB)

# Connecticut's Children: A Cause for Hope


## 1997 Data Book

# CAHS

The Connecticut Association for Human Services (CAHS) is an independent nonprofit, research, public education and policy development organization committed to promoting the health and well-being of our state's residents—young and old alike. CAHS serves as a catalyst, working with diverse constituencies throughout the state to ensure the provision of human services that are of the highest quality, responsive to people's needs and cost-effective.

Founded in 1910 as the Conference on Charities and Corrections, the Association was reorganized in 1974 as CAHS. Our membership includes concerned citizens, religious leaders, corporations, labor leaders, human services professionals and organizations, educators, and policy makers. We welcome your membership and support.



# Connecticut Association for Human Services

# Connecticut's Children: A Cause for Hope

# 1997 Data Book

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**CAHS**

Published by

THE CONNECTICUT ASSOCIATION FOR HUMAN SERVICES

Paul Gionfriddo, Executive Director

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# Overview of Contents

This book is divided into five sections:

The **Introduction** by CAHS's Executive Director, Paul Gionfriddo.

**The Development of the Human Brain: New Knowledge and New Implications** is a summary of the latest research on the development of children, and how the physical development of their brains is helped or hindered by their environments.

The **Child Well-Being Indicators** section is made up of 15 important indicators of the well-being of children and two demographic measures. Each indicator is a separate table, comparing different cities and regions of the state. Regions with rates worse than the statewide rate are highlighted. Indexes to the towns and regions, and a map of these regions, are included at the beginning of this section.

In the **Regional Indicators** section the same child well-being information is presented, but it is organized by region instead of by indicator. Where possible, the rate for the region is shown as a percentage better or worse than the statewide rate. This section allows readers to see, at a glance, how well children are faring in their region of the state.

An explanation of the **Terms and Methodology** used in the indicators sections appears at the back of the book.



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# Introduction

For all of us who care about children and the world in which they grow, this is proving to be an extraordinary time —in unfortunately negative ways. The state and federal welfare reforms of 1995 and 1996 have become harsh reminders to children that their safety nets are in tatters. Because of the neglect of parents or government or both, some children will need to fend for themselves as they grow up.

In recent years, the expansions of Medicaid eligibility for children and the promise of new health insurance programs have been wonderful news to Connecticut's 80,000 uninsured children. These programs carry the promise of more access to health care and more money to pay for it. With some exceptions, however, government's willingness to answer the needs of children has been curiously absent at a time when the most sustained economic recovery in recent memory has yielded state and federal balanced budgets and plenty of opportunity to "grow the economy."

This edition of *Connecticut's Children* calls attention to the irony of our neglect of children. As policies take on harder edges, a new field of brain research has blossomed which entwines tightly together the growth and development of children with investments in children at the state and federal levels.

In a way, this book is about that research, but it is decidedly not just a book for researchers. It is a book for children's policy makers, policy thinkers, and policy advocates, because it summarizes that research and ties it to real programs and practices *that make a difference* in children's lives.

This book invites the reader to ask questions about this new and exciting research. What does it mean for policy makers? What can government do to address risk factors in our children's lives? What can policy leaders do to prevent children from suffering from a lack of stimulation and nurturing care and to ameliorate the damage done when parent *or* society neglects the child?

Lately, some policy leaders have claimed that government can do very little—that the responsibility is squarely and securely on the shoulders of families and friends. Now, however, we can all actually see the *physical* proof in brain research of the cost to children of poverty and neglect. As concern over the emotional and cognitive abilities of our children grows, and as evidence mounts that interventions with families and children can have lasting effects, it is impossible to argue that the government should not be more active.

It is impossible to say that government should not dedicate itself anew to creating an environment in which our next generation can thrive from birth to death.

This book may not be comfortable to read this year. The data charts on children still show too many risk factors and too few improvements over time. The research newly cited in the text shows that our continuing neglect is exacting a great toll. These things are bound to make a compassionate reader distressed, and perhaps a little frustrated.

However, there are wonderful hints in both the data and the text that the actions of a civil society can and will make a difference. For that reason, we subtitled this edition *A Cause For Hope*. If we seize the opportunities to learn about, to promote, and to carry out best practices in nurturing our children, we will reap the fruits of our labors. But (and this is a *big* but) we must act together—condemning neither parent nor government for their prior neglect—for our efforts to succeed.

Paul Gionfriddo
Executive Director
September 1997


Tonka

# The Development of the Human Brain: New Knowledge and New Implications

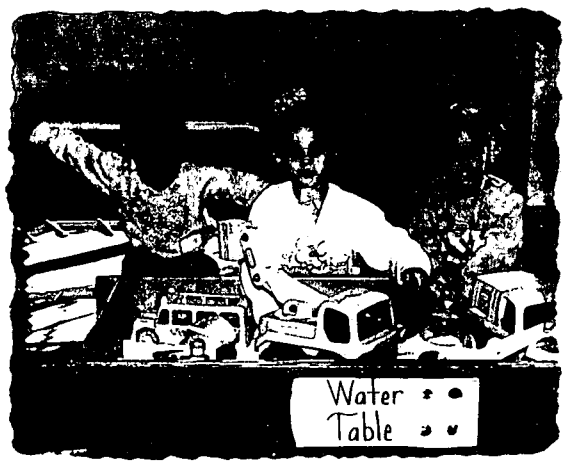
By now, millions of Americans have peered at the mysterious images called PET scans that compare the brain of a child who has been neglected with that of a child who is developing normally. We have come to understand that the differences they see in these blurry pictures—the visual evidence of lower electrical activity in some sectors of the brain—are indicators of serious emotional and cognitive problems resulting from deprivation. These PET scans are, in effect, physical evidence for the arguments child development and child care policy experts have been making for years—that children who fail to receive adequate stimulation and positive interactions with their adult care givers, whether at home or in a child care setting, risk losing the opportunity to acquire the cognitive and emotional skills needed to be successful in life.

Represented in these eerie pictures are a whole host of policy implications which should be important to anyone concerned with children's well-being and with the future of our state and our nation. They point to the importance of early interventions, parent education and support, economic support, adequate family leave policies, higher standards and adequate funding for quality child care programs, efforts to address the stresses associated with poverty that can chemically affect the brains of children and place them at a disadvantage later in life. The list goes on and on.

This new research into how brains develop in the early years has changed the tenor of the debate over nurture and nature. The Families and Work Institute recently published a report, *Rethinking the Brain: New Insights Into Early Development*, which summarized the discussions at its national conference on this new research and provided additional information on the subject. This report is the primary source of information for our summary of the new brain research here.[1] Rima Shore, author of the report, described this complex relationship between genetics and the environment:

> Today, most experts on early development, whether neurobiologists or psychologists, tend to view brain development as a dynamic process, described by Dr. Stanley Greenspan (Clinical Professor of Psychiatry at George Washington University Medical Center) as "an elaborate dance between biology and the environment." But which partner leads and when? Is it the genetic endowment that most severely limits an individual's capacities? Or is it the environment?[2]

While we still don't know which plays a greater role at what stage in a child's development, we do know that *both* heredity *and* experience affect the actual physical structure of the brain and play a critical role in the capacity of children to develop their cognitive and emotional abilities. What scientists now recognize is that the kind of care parents and other care givers provide to a child has an even more important impact on that child's development than was previously understood.




## Influences on the Physical Structure of the Brain

The brain of a newborn baby is made up of billions of brain cells or neurons. Each simple interaction with a care giver, whether a parent, relative or teacher in a child care program, sets off electrical impulses creating synapses (connections between brain cells) in a child's brain which, when repeated over time, form neural "pathways" (synapses linked together). These are the passageways through which we learn and process information throughout life.

These electrical connections are created at the highest rate during the early years. By age three, a child's brain has many more of these connections than does an adult brain. By about age eleven, however, the brain begins to focus more heavily on the process of organization by shedding connections that have not been used. Neural connections tend to survive this winnowing process and become permanent only if they are repeated often enough during childhood through the varied experiences provided to a child. Other connections, not activated often enough by experience, may not survive. Early experiences, therefore, whether positive or negative, heavily influence this process and either enhance or undermine the ability of children to gain a healthy foundation for lifelong thinking, learning and social interaction.

The attachment between a child and parent is especially pivotal to a child's capacity to control emotions—a critical skill for success in life. In 1991, developmental

psychologist Urie Brofenbrenner summed up the importance of this relationship when he wrote, "[For a child to develop normally,] somebody has to be irrationally crazy about that kid."[3] New research on the brain gives Brofenbrenner's observations about the emotional development of children even greater meaning. Healthy and secure relationships with adults have been found to help children handle stress more effectively. Stress produces a hormone called cortisol which directly affects the brain's chemistry. If excessive amounts of this hormone are released, alterations in the brain can lead to fewer of those important electrical connections being forged. Brain cells can even be destroyed. Children who have very high levels of cortisol are more likely to have developmental delays. Children who receive primarily warm, nurturing care and are secure in their attachments to their primary care givers, have been found to be better able to handle daily stresses and to learn from these experiences. They are also better able to recover from major trauma. In short, loving care seems to nurture resiliency in children.[4]

Conditions that interfere with parents' ability to develop these strong attachments may have a profound impact on the brain development of children. Certainly a prime example of these conditions is clinical depression. Researchers are finding that the emotional tone of the exchanges between mother and child—whether mothers are predominantly engaged or distant, calm or irritable, patient or impatient with their babies—affects how their babies' brains develop. When the babies' brain waves were monitored, those whose mothers were depressed had less activity in the frontal lobe of their brains—the center for expressing and regulating feelings such as joy and anger. These babies had higher levels of cortisol and were more likely to show later cognitive and behavioral problems.[5]

Continuing research on the development of the brain also has led to a greater understanding of the physiological effects of risk factors during pregnancy. These include undernutrition of the mother and exposure in utero to toxic substances such as drugs, alcohol and nicotine.

## What Does a Child Learn from His Experiences with Adults?

The technical language used to describe this research and the seriousness of its implications might paralyze some parents. They may be unsure what this new knowledge means for their everyday life with their children. They might ask, "Am I doing the right thing in meeting my child's needs?" And, with even greater fear, "*Have* I done the right thing?" Yet what sparks the

electricity in a child's brain are really the most ordinary acts of parenting—exchanging funny faces with a tiny infant, imitating a baby's sounds while changing her diapers, being a willing participant in a drama about castles and monsters, or giving encouragement while a child clambers up a jungle gym. However, relying on some innate ability of parents to provide regular stimulation to their children may not be enough. Some parents may know how to nurture their children and how to provide for their basic physical needs but may not know how to talk to them, or play with them, or how important those activities are.

Zero to Three: The National Center for Infants and Toddlers, a Washington, D.C. organization that promotes the importance of the first three years of life, commissioned a national survey of parents to gauge the level of their knowledge about child development.[6] The survey found that most parents do not fully understand how their daily interactions with their children influence their development. When it came to learning, the vast majority of parents surveyed (87%) did not know that too much stimulation could be harmful to children. They believed that more stimulation was always better for babies. They were not aware that the amount and kind of stimulation a baby gets should vary by his/her level of development. A majority of parents also said they were the least informed about the emotional development of their children.

Parents not only need more knowledge about how to provide for the needs of their children—they also need stress-free time to do so. The same survey found that half of the parents surveyed felt that they were not able to spend enough time with their children. It's the need to *enable* parents and child care providers, through education and support, to offer those experiences day in and day out, that raises the important policy questions discussed in the sections below.

Through vignettes, Zero to Three tries to bridge the gap between science and the daily life of parents and child care providers by educating them, in everyday terms, about the ways in which the quality of their interactions with the children in their care can affect both how and what those children learn. The contrast between the examples they give, especially of the approaches to caring for the tiniest of infants, are illuminating and chilling at the same time:

> At home, a young mother hears a cry from her 5 week old baby in the nearby crib. It is 3 a.m. The mother's initial dismay quickly turns to anticipation of the feeding that will now begin. The baby senses the light turned on, feels the touches and cradling of her body and, though hungry, begins immediately to calm from the

cues that tell her that her discomfort is about to end. For half-an-hour the baby nurses, pausing between bursts of sucking and gazing up into her mother's eyes, woozily but with what the mother feels is pleasure and recognition. During the pauses the mother speaks softly to her new daughter. The baby smiles, watching her mother's shifting expressions. "Hi, Emily—sweet Emily—you are very pretty. Were you hungry? Do you want more? Do you need a burp? I am glad to see you even if it is 3 a.m." The baby slowly begins to drift off. Her mother puts her in the crib, kisses her, covers her, and says, "Sweet dreams."

[By contrast, another mother,] hearing the cries from her baby, tenses. She has just fallen asleep after a fight with the baby's father. The baby's cries rapidly intensify. "Oh be quiet," says the mother exhaustedly. "I can't take one more thing." The baby cries more and more loudly.... She rolls out of bed and approaches the crib. "I'm coming—I'm coming..." She lifts the baby up and he quiets a bit. "Already think you can just cry and get what you want, don't you? That won't last long, I can tell you. Come on—let's get it over with." As the baby begins to nurse, the mother stares fixedly ahead, going over the recent angry fight. The mother grows more agitated as she recalls the details. The baby responds to his mother's tension by squirming restlessly. Finally, the baby stiffens, arches, draws back from his mother's nipple and yelps. "You don't want to eat? Fine, don't eat," says the mother, and abruptly puts the still hungry baby back into the crib. The baby cries and the mother feels a surge of anger. "Shut up—just shut up." The mother leaves the bedroom, shuts the door and in the kitchen turns up the radio loudly enough so that she cannot hear the baby cry. He cries until he falls into an exhausted sleep.[7]

In the first scenario, the authors describe what the baby is learning:

> What is happening is utterly ordinary; a mother is feeding her baby. But what is happening to the baby is extraordinary. Because while being fed, she is learning about gentleness, about cries being answered, about her ability to make giants come running. She is beginning to feel effective and secure. She is beginning to sense the subtle rhythm of exchange with her mother.

> It is the beginning of learning that she is worth responding to, that she is important, and that something or someone can be counted upon.[8]

What is being learned in the second exchange, as the authors describe, is very different:

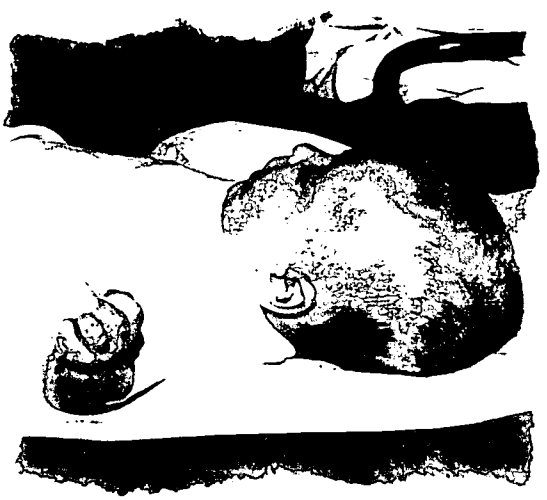
> This baby is also learning. He is learning that to be handled and held can be uncomfortable and distressing; that desperate crying may lead only to a sharp and angry voice; that his needs and wants are not important and that there is no one to count on.[9]

Parents reading these examples might panic remembering a time when they might have been short-tempered with their child or were too preoccupied to be fully responsive to their child's needs. That happens to all parents now and then. What matters is whether the relationship is *predominantly* positive, whether the interaction between parent and child is *typically* warm, responsive and engaging.

The same contrasts can occur in a child care setting. Children can be profoundly affected by these experiences when they spend a substantial amount of time in out-of-home care. In providing advice to child care programs about care giving, Zero to Three provides similar examples of positive and negative interactions between children and their care givers in a child care setting. The lessons learned by the baby are the same.

**Appropriate Practice:** In a child care center a young infant, being fed his bottle, pats his hand on the bottle and looks at the care giver's face. His care giver smiles, stroking his hand and leg gently. She lets him push the bottle away when he wants a break but she holds the bottle within his reach. When he is ready, he reaches for the bottle and pulls it to his mouth. They resume their peaceful rocking, touching and looking into each other's eyes.

**Inappropriate Practice:** A care giver holds the baby without looking at him. He has to turn his head to take a breath. She doesn't respond to his patting. The baby looks up at her, but she is watching other children.[10]



## Is the Damage Reversible?

For those children damaged by a predominantly negative experience with adults, what is not fully known is the degree to which the frightening effects of this deprivation can be reversed when parents and children get help. The researchers who studied the children of depressed mothers found that the brain waves of the children returned to normal, provided the mothers received treatment by the time their children were six months old. A brief period of postpartum depression that lasted only a few months appeared not to adversely affect babies. However, if the depression continued into what researchers found to be the most vulnerable period for children—six to eighteen months of age—the babies tended to show later cognitive and behavioral problems.[11]

Experts acknowledge that the process of development in the human brain is complex—that different parts of the brain develop at different times and that certain stimuli are therefore required according to a set schedule. As Rima Shore writes,

> The brain's circuitry is not formed at a steady pace; rather, brain development proceeds in waves, with different parts of the brain becoming active "construction sites" at different times and with different degrees of intensity.[12]

Some researchers believe that these critical periods are so rigidly predetermined that past a certain age, a kind of "locking in" occurs if certain stimuli needed at those times are not provided.[13] Others caution that these critical periods may last longer and that there simply is not enough information yet to provide a definitive answer to this difficult question. Some children do survive early neglect and abuse and go on to become successful. Some are helped to do so through intensive programs of nurturing care and behavior management. In her report, *Rethinking the Brain,* Rima Shore writes,

> Risk is not destiny. The medical, psychological, and educational literatures contain a sufficient number of examples of people who develop or recover significant capacities after critical periods have passed to sustain hope for every individual.[14]

What is important for policy makers to understand is that, in either case, interventions need to occur as early and as intensively as possible if children are to be given the best chance possible to grow up healthy. The conclusion from these PET scan images must be to make a greater investment in helping at-risk families before a birth occurs and when their children are very young. It is foolish to wait until the kindergarten or early elementary school years to provide enrichment to at-risk children. Yet Connecticut's investment during the

early years is disproportionately low compared to state spending on education. In the early 1990s Connecticut spent $78 for children under age five, and in the same years, $7,800 on children age five and above. In other words, for every dollar that we invested in children under age five, we invested $100 in children age five and above. Recent increases in state spending for child care do not come close to closing this gap.[15]

At the same time we increase investment in the early years, however, we need to be careful that this is not done at the expense of older children who need help. This new research should not be interpreted as determining their destiny. We know that older children, too, can and should be helped to turn around, even if the task may prove to be more difficult.

## The Link Between Poverty and Risk

As this ground-breaking research continues across the country, each new twist helps to complete the picture of how certain adverse conditions place children at risk. While we have long known that these factors were correlated with developmental problems in children, we now are learning about this "right down to the cellular level," as Rima Shore puts it. At this more tangible level, we are beginning to be able to see and understand the physiological effects when children are placed at risk. What are these risk factors? Parental depression, lack of knowledge about child development, exposure to toxins during pregnancy, undernutrition, abuse and trauma, lack of stimulation, poor quality child care—these have all been identified as leading directly to physical alterations in the development of the brain that can stunt the emotional and cognitive growth of children.

All of these factors have also been found to be closely linked to poverty. While emotional neglect and excessive stress can occur in families at every income level and in child care settings across the economic spectrum, children living in poverty are especially vulnerable. Poor children live in environments in which survival is a constant struggle; where violence at home and in the community is more frequent; where environmental hazards are more common; where some parents are too overwhelmed to provide their children with the care, stimulation and sense of security they need; and where child care quality is often lacking. It is little wonder that poor children are more likely to suffer from learning difficulties and emotional and behavioral problems. The cumulative impact of these various risk factors on children's well-being can be devastating. According to a report by the Children's Defense Fund, "Poverty's effects accumulate so forcefully that some

researchers believe that the number of problems shapes a child's future at least as much as what those problems are."[16]

## Intervention Can Make A Difference

While seeing physical evidence of the harmful effects of deprivation may make them seem more frightening, what researchers are finding about the plasticity of the brain, and the impact of early intervention, should also be a cause for greater hope. These are not intractable problems. Despite the risks associated with poverty, some children do thrive, and more and more is being learned about why they do. And evidence is mounting about the benefits of comprehensive programs to educate and support parents before childbirth and during the first years of their child's life. Early interventions are even proving effective, at least in some cases, in mitigating the effects of neurological conditions such as autism and mental retardation once regarded as hopeless.[17]

As we approach the next century, and as the dizzying pace of research in the field of neuroscience provides us with more guidance on how to meet the needs of children, there may come a greater understanding of the fact that families, particularly those who live in poverty, cannot raise their children without support from all of us—the government, the private sector and the community at large. Urie Bronfenbrenner wrote of this interdependence, "A child requires public policies and practices that provide opportunity, status, example, encouragement, stability and, above all, time for parenthood . . . And unless you have those external supports, the internal systems [in a family] can't work. They fail."[18]

There is ample evidence that government-supported programs can make a significant difference in helping children at risk. In the following pages, we will provide a few examples of the impact of government programs in addressing the particular risks facing children—risk factors that have been identified and studied in recent efforts to better understand the workings of the human brain.

## Inadequate Nutrition

Chronic hunger is directly related to poverty and can directly affect the development of the brain. In a survey of low-income families at sites across the country, children suffering from hunger were reported by their parents to be between 2 and 11 times more likely to experience dizziness, irritability, frequent headaches and ear infections, fatigue, concentration problems, unwanted weight loss and frequent colds.[19]

Iron deficiency is a serious effect of inadequate nutrition. Low iron, with or without anemia, can impair problem solving, motor coordination, attention, concentration and long-term IQ scores. Low-income preschoolers are three to four times more likely to suffer from iron deficiency.[20] From 1989 to 1990, over one-quarter of children, most from poor families, seen at a Boston, Massachusetts hospital clinic were deficient in iron.[21] Poor nutrition during pregnancy can lead to a greater likelihood of infant mortality and low birthweight, and an insufficient intake of certain nutrients can cause serious birth defects such as spina bifida and anencephaly (being born with part of the brain missing).[22] New research on the brain, focusing particularly on the first few days after conception when the cerebral cortex of the brain of a fetus begins to develop, has revealed that inadequate nutrition during this stage of pregnancy may result in serious neurological disorders such as infantile epilepsy, autism, or schizophrenia.[23]

Poor families have been found to purchase more value for their food dollar than do upper-income families. Nevertheless, with so many families living below the poverty level, and with the poverty level not even representing an adequate income with which to purchase basic necessities, many families simply lack the necessary means to feed their children adequately. Research has shown that parents in low-income families limit their own meals before cutting back on food for their children.[24] Insufficient funds with which to buy food

is certainly the major reason why poor children go hungry. But other effects of poverty such as chronic health problems, stress, crowded living conditions (with all the distraction and lack of order and calm which that entails) and, in a small number of cases, neglect, can contribute to the problem of undernutrition by making it more difficult for poor children to eat.[25]

In the late 1960s, Senator Robert Kennedy toured the South and Appalachia and witnessed the bloated stomachs of children who were suffering from malnutrition. News coverage of this tour prompted Congress to enact a series of measures to combat childhood hunger which either created or expanded such federal programs as School Breakfast, the Food Stamp Program, the Special Supplemental Food Program for Women, Infants and Children (WIC) and the Child Care Food Program. These efforts virtually eliminated gross malnutrition among children. Specific studies of these programs support their effectiveness in addressing the problem of hunger. For example, in a five state study of WIC which involved 105,000 Medicaid births, researchers found that every dollar spent on the prenatal component of WIC saved $1.77 to $3.13 in Medicaid costs during the first 60 days after birth. Other studies have associated WIC with decreases in low birthweight rates, reduced prevalence of anemia and improved cognitive skills for children.[26]

Some thirty years after Senator Kennedy toured the South, national surveys of children in the U.S. have found that a large proportion suffer from chronic hunger due to welfare benefits and wages losing ground to inflation, and an inadequate level of food assistance.[27] While government efforts to provide nutrition support have been highly successful in staving off gross malnutrition, new research on the development of the brain has underscored the importance of the more subtle but nevertheless devastating impacts of *under*nutrition on the physical structure of the brain and its capacity to develop cognitive and emotional skills. This research should be an impetus for government to address the shortfalls in these programs, as well as other benefit programs for the poor, in order to insure that the development of our children is not jeopardized.

## Lack of Early Stimulation, Child Abuse and Neglect

While child abuse and neglect occurs in families at every income level, poverty does place children at higher risk. New research on the development of the brain underscores the profound impact maltreatment can have on the ability of a child to develop the skills necessary to learn in school and form healthy human relationships. The stress and depression so often related to poverty (and the substance abuse problems that

sometimes result) can make it difficult for some parents to provide the nurturing care their children need. According to a report by the Children's Defense Fund, "While maltreatment is not 'entirely, or even primarily, a poverty phenomenon,' a recent literature review concludes, 'poverty is perhaps the single most predictable risk factor for child abuse and neglect.' "[28]

While most children living in poverty are not neglected or abused, many still do not receive the stimulation day-in and day-out that is needed to fully develop their cognitive and emotional skills. A lack of stimulation means that critical neural pathways needed to process information effectively later in life are not made. A lack of adequate stimulation can be attributed to many factors associated with poverty: parental preoccupation of the parents with survival issues, greater family stress, lower educational levels and a lack of basic knowledge about child development.

Some of the most important and successful models of community-based intervention have been programs providing support to at-risk families to enable them to better care for their children. Some of these programs begin to serve families even before a child is born. Some have been monitored long enough to provide us with follow-up data on their impact on the lives of children as they grow into adolescence and adulthood.

Two of these examples are among the models described in the Families and Work Institute report, *Rethinking the Brain.*[29]

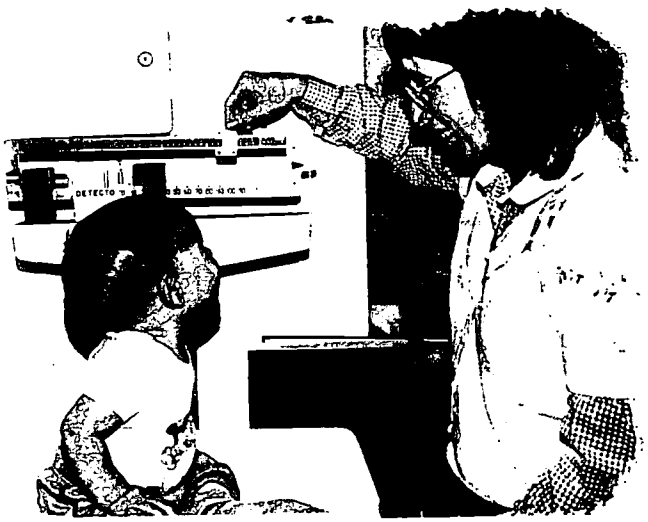
**The Carolina Abecedarian Project:** Beginning at six weeks and ending at age five, low-income children participating in this project attended a full-time early education program of high quality. Their parents were also in a parent involvement program when their children were ages five to eight.

At age 12, children in the program group had IQ scores that measured 5.3 points higher than the comparison groups. At age 15, children receiving services as preschoolers earned significantly higher scores in reading and math; 31.2% of participants were retained in grades, as opposed to 54.5% in the comparison group, and 24% required special education services compared with 48% of those in the control group.

**Parents as Teachers Program:** Begun by the Missouri Department of Education, and still operating, this program provides information about child development to parents of children from birth to age five through home visits, parent groups and referrals for needed services. Children also receive regular health screenings.

Participating children at age three scored significantly higher than national norms on measures of intellectual and language abilities. Most children from minority families did better than average on achievement and language measures. In first grade, 55% of the participating children were rated above average by their teachers. Teachers also reported higher levels of parent involvement—74% of parents who participated, according to the teachers, always assisted the children with their homework. The curriculum for this program has been provided to other states, and the program has trained some 8,000 parent educators who go out on home visits once a month.

**Healthy Start/Healthy Families America:** Another model that is also attracting a great deal of attention is Hawaii's Healthy Start Program. Designed to prevent incidences of child abuse and neglect, the program involves a screening process to identify families at risk when a child is born. Visits are then made to these mothers after they return home. The visits involve providing emotional support, modeling good parenting skills and making referrals for other services where needed. Preventive health care is also emphasized. The frequency of home visits is individualized based on need and the degree of risk. The effectiveness of the screening process used is demonstrated by the fact that among the families that went through the process and were determined *not* to be at risk, follow-up data showed that almost all (99.5%) had no abuse. The effectiveness of the comprehensive services provided is borne out by data showing that, among the families that were identified as high-risk and who received these services, child abuse and neglect was prevented in 99.8% of the cases. In studies of comparable at-risk groups, up to 20% have reports of child abuse and neglect.[30]



This program has been so successful that the National Committee for the Prevention of Child Abuse and Neglect is promoting an initiative called Healthy Families America to encourage its replication around the country. It has now spread to 265 sites in 37 states, plus the District of Columbia.[31] In Connecticut, the program is currently operating at four sites serving over 131 families. Two more sites are being added this year.[32]

# Head Start and Other Early Education Programs

High quality child care and early education can do much to stimulate children and help them acquire all-important cognitive and emotional skills. And, for low-income children, it can actually offset some of the disadvantages that result from living in poverty. A review of studies on the effectiveness of comprehensive early stimulation and early education programs, including Head Start, conducted by a committee of the U.S. House of Representatives, found that they increase the chances of success in school. For those children who attended, benefits included better grades, fewer failing marks, lower retention-in-grade rates and fewer absences. Attendance was associated with less need for special education, improved literacy, and a greater likelihood of completing high school and continuing education past the high school level. It was also linked to increased employability, decreased dependence on public assistance, and decreased criminal activity.[33]

These benefits do not emerge, however, unless the care is of high quality. Unfortunately, child care in the U.S. is a patchwork, under-funded system which does not, for the most part, provide the kind of care children need to thrive. Studies have found that between 12% and 21% of children in child care are in settings that are unsafe and compromise their development. Only 12% to 14% of kids are in settings that nurture their growth and learning. The findings are even worse for children during their most vulnerable years as infants and toddlers. Among this age group of children in care, over one-third (35 - 40%) are in settings considered unsafe and harmful to their health and development.[34]

Research has demonstrated that government can be effective in improving this dismal picture. Children who live in states with tougher regulatory standards for child care receive better quality care than children in states with weaker standards. A study by the Families and Work Institute found that when states adopt stricter standards for staff/child ratios and for the education and training requirements of staff, children are more securely attached, have better cognitive, social and language skills and fewer behavior problems.[35]

Yet the cost of good quality child care is high. The amount parents can afford to pay is not enough to cover the cost. Compared to other countries, our government does very little to subsidize our system of child care. Research shows that when child care salaries remain so low—when we ask teachers in effect to subsidize the system with their low compensation—high rates of staff turnover result. Children in centers with high staff turnover have been found to have fewer social skills and to be less competent in language.[36]

Equally frightening, according to the Zero to Three survey, is the fact that half of parents think these constant changes in staff are good for children. They believe that many changes in care givers will make children better able to cope with change. The truth is that early, stable relationships with a small number of caregivers can cushion children so that they are actually *better* able to cope with change later in life.[37]

We know that government support and regulation do make a difference in improving quality. We also know that most child care programs in this nation are not of high quality. Given the tangible evidence we now have that the physical structure of the brain can be altered and brain functions significantly impaired when children do not receive adequate care, it is foolish to continue shortchanging our child care system. In view of this new research on the brain, the large numbers of poor children about to enter the child care system because of new time limits under welfare reform represent enormous risk and enormous opportunity. If this research, coming as it does on the heels of major changes in our welfare system, can compel policy makers to invest in enriched care for our most at-risk children, we are likely to see the benefits for years to come. If, on the other hand, welfare reform is cause for even more children to be warehoused in inferior care, we will see, and pay for, the damage for years to come.

## Lack of Prenatal Care and Exposure to Toxins In Utero

New research on the brain has focused on how certain risks during pregnancy—exposure to toxins such as drugs, alcohol or nicotine, and inadequate nutrition—increase the chances that babies will be born at low birthweight, will have neurological problems or other disabilities, and will exhibit behavioral problems at preschool and later ages.[38]

Here again, government-supported programs to increase the chances of a healthy birth outcome have been effective. Medicaid coverage and its recent expansions, and other government sources of funding

for maternal and child health services, have increased the proportion of poor women receiving regular prenatal care.

Early and adequate prenatal care has been associated with reductions in infant mortality, low-weight and premature births, and the prevention of diseases and disorders in children. The Institute of Medicine calculated that for every $1 spent on prenatal care, an estimated $3.38 is saved in the medical costs of caring for a low birthweight infant.[39]

When a pregnant woman receives prenatal care, she is able to receive help in addressing the risk factors to a healthy birth outcome. For example, women who smoke can receive counseling to help them stop their addiction through structured smoking cessation programs. These have been found to result in significant quit rates among pregnant women. Reductions in smoking during pregnancy have been associated with reduced risk of fetal and infant deaths, lower rates of low-weight births, and fewer neurological problems in babies.[40] Women in prenatal care can also be referred to the WIC Program discussed earlier. WIC nutritional benefits can help to stave off the devastating effects of undernutrition during pregnancy.

## Environmental Hazards

Low-income children are at greater risk of harm from environmental hazards than other children. For example, inadequate heat, excessive dampness, and cockroach infestation—conditions often found when low-income families are forced to live in substandard housing—can cause asthma and other upper respiratory conditions. Unprotected windows in high-rise apartment buildings, a lack of safety equipment such as stair gates, and living in high-traffic areas with a lack of outdoor play space can make children more vulnerable to physical injury.[41]

Lead poisoning is another environmental risk faced by poor children. Both during pregnancy and after birth, exposure to lead places a child at greater risk of developing serious neurological problems. While lead

poisoning remains a grave problem, government has made remarkable progress in addressing this health risk. According to the Centers for Disease Control, government actions twenty years ago in banning lead in gasoline, as well as in food and drink cans, plumbing systems and household paint, have decreased blood lead levels dramatically in all segments of the population. For example, among children ages 1-5, average blood lead levels decreased from 15.0 to 2.7 micrograms per deciliter according to surveys conducted between 1976-1980 and 1991-1994.[42]

However, the remaining risks from peeling lead paint in older homes and contaminated dust and soil from past emissions of leaded gasoline are still causing a disproportionate number of low-income children to have elevated blood lead levels. Efforts to screen, identify and treat these children, and address the lead hazards in their homes and communities, need to continue if the severe neurological damage resulting from lead exposure is to be prevented.[43]

## Poor Health Status

Poor children are at greater risk for a whole host of serious health conditions, including asthma, upper respiratory infection, pneumonia, frequent diarrhea and colitis, and anemia.[44] If left untreated, these ailments can be life threatening. They also can sap children of their strength, affect their dietary intake and harm their overall development. Providing health care coverage can make a difference. Medicaid coverage and the screening and treatment services offered under its Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) have been associated with fewer abnormalities at periodic exams and significantly lower medical costs than for children who do not receive these benefits.[45]

Parents living in poverty also are at greater risk for serious health problems. Low-income women, for example, generally are at greater risk for hypertension, diabetes, anxiety and depression.[46] As the new research on the brain suggests, conditions such as depression can interfere with the ability of mothers to form warm, secure attachments to their children, and can rob them of the energy they need day to day to provide their children with adequate care and stimulation. As discussed earlier, research on the effect of maternal depression on babies also demonstrates that if the mother is treated early enough, the damage to her children can be reversed.

Even with significant expansions in Medicaid coverage, a shocking number of families with

children still go without health coverage. In Connecticut, an estimated 80,000 children are uninsured.[47] We remain the only Western industrialized country that does not have universal health care coverage. To date, efforts to guarantee coverage, at least for pregnant women and children, have failed in Congress. Depriving children of basic health care means missing critical times, including the prenatal period, during which researchers have found that intervention can make the most dramatic difference. Risks to healthy birth outcomes are not addressed, developmental problems in children are not identified, and opportunities for treatment during "prime times" of brain development are missed. Depriving *parents* of adequate health care coverage means that serious health conditions are left untreated, hampering their ability to provide their children with adequate care.

## Disabilities That Impair Cognitive and Emotional Functioning

In addition to children who live in poverty, children with neurological disabilities also face greater risks and need support. Research on the human brain points to similar conclusions about the importance of early intervention for these children. When diagnoses of these biologically-based neurological problems are done very early in a child's life, and comprehensive programs of stimulation, individualized therapy and family education and support are begun immediately, researchers are finding that remarkable results can be achieved in many children. Discoveries about the plasticity and flexibility of a child's brain, especially in the first years of life, are influencing experts to direct their efforts to affecting the environment of these children at the very earliest stages of life.

Complementing this research are new discoveries about how to identify problems earlier than was ever thought possible. For example, researchers are now able to identify auditory processing problems in children as young as six to nine months. This is a critical step toward developing programs for children to aid their

development of language so that they will be less likely to need special education later for language-based learning disabilities.[48] All of these developments give parents new hope that their children may be able to live happier, more independent and productive lives.

The federally-funded Birth to Three Program under Part H of the Individuals with Disabilities Education Act provides children with early identification of developmental problems and treatment of these conditions. The design of this program is based on the experiences gained from earlier intervention programs for infants identified as high risk. For example, the Infant Health and Development Program addressed the needs of babies born at low birthweight—a factor that greatly increases their risk of disability. The program provided low birthweight, pre-term babies and their families with a combination of developmentally-based child care and education, family support and pediatric follow-up care. Results found that participating children had higher IQ scores and exhibited fewer behavioral problems than children from a comparable group that only received the pediatric care.[49] Government support for the Birth to Three programs around the country has made it possible for many more children to receive treatment earlier than ever before. In Connecticut, 3,335 children are currently receiving Birth to Three services.[50] The new research on the brain should underscore the importance of this public investment in reaching children with developmental problems as early in life as possible.

## Poverty and its Stresses

Researchers have found that poverty has a significant, negative impact on children's development and that its impact intensifies as children grow older.[51] In addition to its other harmful effects, poverty can damage the quality of the relationship between children and their parents. Economic deprivation and financial hardship cause enormous stress in parents of young children. Low-income parents are more likely to suffer from depression and stress-related illnesses. Concerns over economic problems are compounded by the psychological toll on parents when they feel that, despite their love for their children, they are not able to keep them safe or adequately fed and housed. Parents experiencing this kind of stress are less able to have positive interactions with their children and this, as the new brain research demonstrates, harms their children's cognitive and emotional growth. Parental stress is associated with lower IQ scores and poorer emotional adjustments in children.[52]

It is important to recognize that, for all of its flaws, our safety net of government benefit programs has reduced

the incidence of poverty among children. In 1995, according to a study by the Center for Budget and Policy Priorities, government benefits reduced child poverty by one third, meaning that one-third of the children who were poor before receipt of government benefits were lifted out of poverty by those benefits.[53] Benefits used in the Center's calculations included means-tested assistance, tax policies such as the Earned Income Tax Credit, and social insurance such as unemployment compensation. Most of the children who were lifted out of poverty were in working families. The study also concluded that these programs were effective in reducing the severity of poverty among children and cushioning some of the effects of recession on families with children.

Other studies point to the importance of a single source of assistance, such as housing subsidies, as making the difference for some families in meeting basic necessities. At Boston Medical Center, Dr. Alan Meyers studied the health status of children coming to the hospital for care. An earlier study conducted by Dr. Meyers had shown significant differences in the incidence of iron deficiency among children whose families received housing subsidies and those whose families did not. In his most recent study comparing these groups, he found that only 3.3% of those children in families with subsidized housing were underweight for their age compared with a 22.6% among those whose families were on the waiting list for housing assistance. While the sample sizes were not large and the study was based in only one hospital, these results certainly suggest that housing subsidies may help to protect children from undernutrition, especially in high-rent areas.[54]

While our safety net has helped save many families from truly desperate poverty, low levels of assistance, restrictive eligibility guidelines, and insufficient supports for parents who work have meant that an unconscionable proportion of our children are still living in poverty. Nationally, one in four children under six lives in poverty.[55]

The authors of the study by the Center on Budget and Policy Priorities warn that even more children could become poor as a result of new welfare reforms which will reduce federal funding for the safety net by $54 billion over the next six years. Greater flexibility for the states could lead to a reduction in state support for these programs of $40 billion. The study's authors bolster their claim about the impact of a weakened safety net on child poverty by contrasting what happened during the recession of the early 1980s and that of the early 1990s. In the early 1980s, cuts in many benefit programs had weakened the safety net. By the early 1990s, however,

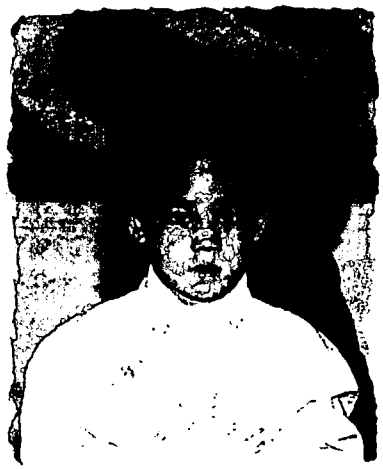
measures had been adopted to make it stronger. Before counting receipt of government benefits, the authors found that the number of people who became poor during each of these recessions was about the same—10 million. However, when benefits were taken into account, the effects of a strengthened safety net were evident. Twice as many people were thrown into poverty in the early eighties compared with the recession of a decade later. In short, a stronger safety net cushioned the effects of the recession for families with children.

In 1991, the National Commission on Children recommended that our system of support for families be bolstered to address the disturbing proportion of our children who still live in poverty. Specifically, they called for a combination of temporary assistance when parents are unable to work and measures similar to those adopted in western European countries: a strengthening of our child support system and child support assurance, child allowances in the form of refundable tax credits and support services to enable parents to work and still adequately care for their children.

Since the Commission issued its report, revolutionary changes have been adopted in our welfare system. These reforms raise difficult questions. Their aim is to promote work and compel more welfare mothers to enter the workforce. But how that is done will have a major impact on children's development. The National Commission believed that their recommendations, if adopted, would be sufficient to change the tenor of the welfare system to a temporary source of assistance to families by making work more financially beneficial. Yet the welfare reform measures that have been enacted are much more extreme and have not been accompanied by strong measures to help working families make ends meet. How will time limits which limit families to only a maximum of five years of assistance in a lifetime affect children when parents are

unable to find employment? Will the allowance for hardship exceptions under the new law be adequate to protect children, especially if the economy suffers another downturn?

For those mothers who do find jobs and may be joining the ranks of the working poor, will there be sufficient income and supports to enable them to adequately care for their children? Without bolder measures to support working poor families, will parents have to work two or three jobs in order to make ends meet? Will children in



working poor families continue to be robbed of the parenting time, free of stress, that the new research on the brain has found so critical to children's healthy development?

The new research on the brain identifies risk factors that directly influence the physical structure of the brain in ways that stunt the potential of children. All of these factors have been associated with poverty. The underlying issue is economics. We know from the experience of other countries that government can make families more secure so that they can devote their energy and attention to enriching the lives of their children instead of worrying over issues of basic survival. Providing that support, in combination with other intervention measures, can have a dramatic impact on the healthy development of the next generation.

## Conclusion

What we have provided here are only a few examples of the many ways in which government, often in partnership with business and community groups, has helped families nurture their children. There are many others. Unfortunately, however, the multiple needs of families at risk and the tendency of policy makers to address these problems in fits and starts have spawned an often confusing, largely patchwork system of health and social services. Programs are created to target this population or that problem, compelling service providers to undertake the frustrating task of patching together these funding streams in order to serve families in any kind of comprehensive way. Eligibility rules differ from program to program because little of what we fund

to support families is universal. Many programs are discretionary instead of entitlement programs so that even if families meet the eligibility guidelines, they can be turned away when funding runs out. Despite the proven efficacy of many of these programs, such as Head Start and WIC, they are not able to serve everyone who qualifies. Lastly, even for those families who are served, benefit levels are often too low to enable many programs to fulfill their intended purpose.

The difficulty we encountered in organizing a discussion of early interventions came to reflect for us both the disjointed nature of our support system for children and the importance of comprehensive, integrated services for families at risk. Early interventions that set out to fulfill one purpose ended up serving others as well. A program designed primarily to curb child abuse and neglect also had a positive impact on immunization rates and school performance. A program to help low-income teen parents acquire good parenting skills also helped these mothers to improve their economic futures. What seems clear from these experiences and from the new research on the brain is that because so many risk factors are involved, supporting families must be done in a comprehensive way if children are to be adequately nurtured and stimulated.

This long-term, comprehensive view of how and where to make investments in our children has been lacking. What was written almost ten years ago is, sadly, still valid today:

> There is no more important contradiction in social policy than this: From child development research we now know that the first few years of life play a crucial role in shaping a person's lifelong mental, emotional, and physical abilities. And yet it is for this stage of life that we seem to make our social investments most grudgingly and tolerate the greatest deprivation. . . Although scientific knowledge about early childhood years has mushroomed, it is during these years that Americans are most likely to live in poverty. Simply put, our knowledge is not being applied.[56]

Children need time with their parents. Parents need the balance between work and family necessary to provide that time to their children. And they need to do so armed with a basic knowledge of child development and free of the stresses of poverty and the struggle to survive. They need to know that when they can't work, there will be an adequate safety net to catch them when they fall. And when they do work, they need to know that their sons and daughters are being nurtured and stimulated by caring, knowledgeable care givers.

Despite the complexity of the new discoveries in neuroscience, knowing what to do to help children is not rocket science. As a nation, we needn't wait for further developments in the scientific arena to act. What this new research shows is simply the physical manifestation of the observations made by experts for years about the harm of childhood deprivation. This research can help us fine tune our efforts to prevent that harm, but we have long known enough to justify bolder action than we have taken.

France has a system of comprehensive supports for families, including universal early education, health care, paid parental leave and child allowances. A group of Americans who toured France to examine this system asked a policy maker there how support was garnered for establishing these measures. Bewildered by the question, he answered, "We just took your research and applied it!"[57] For the sake of our children and our future, it is time we did the same.

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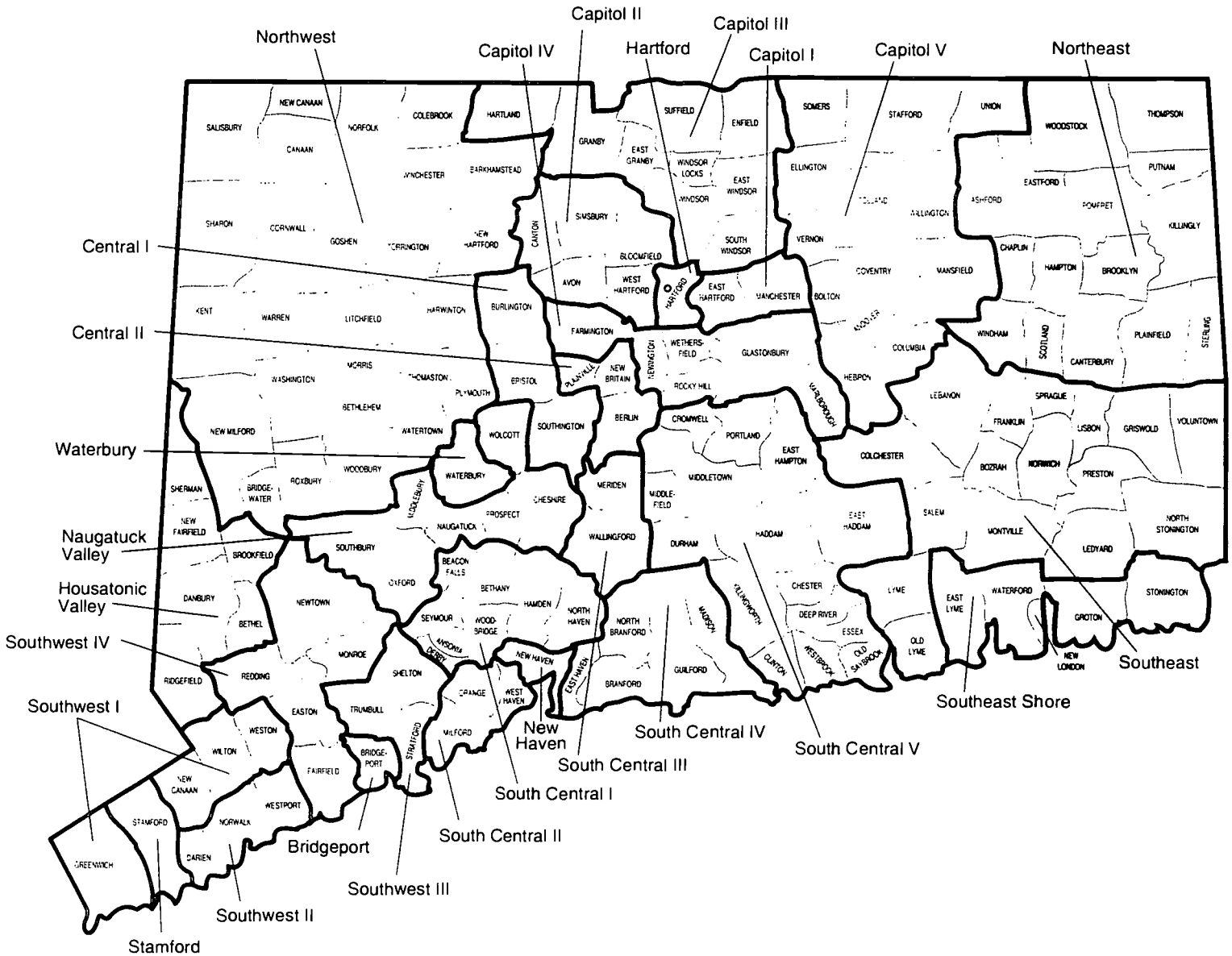
# Child Well-Being Indicators

# Town Index



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Waterbury

# School District Exceptions

| Region | Students from Other Towns |
|---|---|
| **Capitol V** | includes Ashford students who attend Region 19 |
| **Capitol V** | includes Marlborough students who attend Region 8 |
| **Central I** | includes Harwinton students who attend Region 10 |
| **Housatonic Valley** | includes Sherman students who attend Brookfield |
| **Northeast** | includes Columbia and Willington students who attend Windham |
| **Naugatuck Valley** | includes students from Beacon Falls who attend Naugatuck |
| **Northwest** | includes Hartland students who attend Gilbert |
| **Northwest** | includes Sherman students who attend New Milford |
| **Northwest** | includes Oxford students who attend Region 14 |
| **South Central I** | includes Oxford and Prospect students who attend Seymour and Orange students who attend Region 5 |
| **Southeast** | includes Canterbury students who attend Norwich or Griswold |
| **Southeast Shore** | includes Salem students who attend East Lyme |

| Region | Regional School Districts |
|---|---|
| **Capitol V** | Region 8 |
| | Region 19 |
| **Central I** | Region 10 |
| **Naugatuck Valley** | Region 15 |
| **Northeast** | Region 11 |
| **Northwest** | Region 1 |
| | Region 6 |
| | Region 7 |
| | Region 12 |
| | Region 14 |
| **South Central I** | Region 5 |
| **South Central V** | Region 4 |
| | Region 13 |
| | Region 17 |
| **Southeast** | Region 18 |
| **Southwest IV** | Region 9 |

| Region | Private/Public Schools |
|---|---|
| **Northwest** | Gilbert School |
| **Northeast** | Woodstock Academy |
| **Southeast** | Norwich Free Academy |

| Region | Vocational-Technical Schools |
|---|---|
| **Bridgeport** | Bullard-Havens |
| **Capitol I** | Howell Cheney |
| **Central II** | E.C. Goodwin |
| **Hartford** | A.I. Prince |
| **Housatonic Valley** | Henry Abbott |
| **Northeast** | H.H. Ellis |
| **Northwest** | Oliver Wolcott |
| **South Central I** | Eli Whitney |
| | Emmett O'Brien |
| **South Central II** | Platt |
| **South Central III** | H.C. Wilcox |
| **South Central V** | Vinal |
| **Southeast** | Norwich |
| **Southeast Shore** | E.T. Grasso |
| **Stamford** | J.M. Wright |
| **Waterbury** | W.F. Kaynor |

Note: These exceptions only affect the data for high school dropouts. They do not affect the data for the Connecticut Mastery Test Results or the Connecticut Academic Performance Tests.

## Number of Children and Percent of Total Population — 1970, 1980, 1990

| REGION NAME | 1970 Number | 1970 Percent | 1980 Number | 1980 Percent | 1990 Number | 1990 Percent | 1970 - 1990 % Change In Rate |
|---|---|---|---|---|---|---|---|
| Northwest | 49,000 | 34.0 | 42,643 | 27.2 | 40,719 | 23.4 | -31 |
| Housatonic Valley | 36,278 | 37.0 | 36,569 | 29.7 | 31,826 | 23.8 | -36 |
| **Stamford** | 35,903 | 33.0 | 25,053 | 24.5 | 21,773 | 20.1 | -39 |
| Southwest I | 33,619 | 34.2 | 26,469 | 26.2 | 22,217 | 22.0 | -36 |
| Southwest II | 44,202 | 34.8 | 31,855 | 26.1 | 25,128 | 20.8 | -40 |
| **Bridgeport** | 47,276 | 30.2 | 39,803 | 27.9 | 36,992 | 26.1 | -14 |
| Southwest III | 37,107 | 34.3 | 30,038 | 26.2 | 25,325 | 21.7 | -37 |
| Southwest IV | 33,441 | 34.9 | 27,687 | 27.4 | 23,864 | 22.7 | -35 |
| **Waterbury** | 34,354 | 31.8 | 26,678 | 25.8 | 25,561 | 23.5 | -26 |
| Naugatuck Valley | 28,288 | 35.8 | 26,693 | 28.1 | 26,146 | 24.1 | -33 |
| South Central I | 43,417 | 32.6 | 32,162 | 24.0 | 28,721 | 20.9 | -36 |
| **New Haven** | 39,246 | 28.5 | 31,863 | 25.3 | 30,936 | 23.7 | -17 |
| South Central II | 39,641 | 33.8 | 29,247 | 24.9 | 25,131 | 21.5 | -36 |
| South Central III | 31,878 | 34.8 | 25,140 | 26.6 | 23,517 | 23.4 | -33 |
| South Central IV | 28,573 | 36.6 | 25,171 | 27.6 | 22,606 | 22.1 | -39 |
| South Central V | 38,746 | 33.7 | 33,748 | 26.2 | 31,401 | 21.9 | -35 |
| Central I | 33,346 | 36.8 | 28,188 | 28.2 | 24,524 | 23.1 | -37 |
| Central II | 34,790 | 30.4 | 23,689 | 22.5 | 23,375 | 21.3 | -30 |
| **Hartford** | 48,353 | 30.6 | 39,530 | 29.0 | 38,390 | 27.5 | -10 |
| Capitol I | 34,245 | 32.4 | 24,779 | 24.2 | 20,992 | 20.6 | -37 |
| Capitol II | 38,867 | 32.7 | 29,181 | 24.3 | 25,984 | 21.0 | -36 |
| Capitol III | 51,183 | 40.2 | 36,453 | 28.3 | 33,495 | 23.1 | -42 |
| Capitol IV | 34,267 | 33.6 | 27,992 | 24.4 | 25,583 | 20.4 | -39 |
| Capitol V | 35,791 | 34.6 | 30,171 | 26.4 | 29,006 | 22.5 | -35 |
| Northeast | 29,070 | 34.4 | 26,750 | 29.0 | 26,363 | 25.7 | -25 |
| Southeast | 41,589 | 36.0 | 35,051 | 29.1 | 32,940 | 25.1 | -30 |
| Southeast Shore | 38,532 | 33.6 | 30,316 | 25.7 | 27,066 | 21.8 | -35 |
| CONNECTICUT | 1,021,002 | 33.7 | 822,919 | 26.5 | 749,581 | 22.8 | -32 |

Sources: U.S. Bureau of the Census, Census of Population and Housing, 1970, 1980 and 1990.

## Racial/Ethnic Background of Connecticut's Children — 1990

| REGION NAME | WHITE Number | WHITE Rate | BLACK Number | BLACK Rate | ALL OTHER RACES Number | ALL OTHER RACES Rate | HISPANIC-ORIGIN Number | HISPANIC-ORIGIN Rate |
|---|---|---|---|---|---|---|---|---|
| Northwest | 39,488 | 97.0 | 472 | 1.2 | 759 | 1.9 | 607 | 1.5 |
| Housatonic Valley | 28,674 | 90.1 | 1,289 | 4.1 | 1,863 | 5.9 | 1,759 | 5.5 |
| **Stamford** | 14,139 | 64.9 | 5,908 | 27.1 | 1,726 | 7.9 | 2,780 | 12.8 |
| Southwest I | 20,695 | 93.1 | 413 | 1.9 | 1,109 | 5.0 | 792 | 3.6 |
| Southwest II | 20,142 | 80.2 | 3,483 | 13.9 | 1,503 | 6.0 | 2,465 | 9.8 |
| **Bridgeport** | 16,643 | 45.0 | 12,617 | 34.1 | 7,732 | 20.9 | 14,134 | 38.2 |
| Southwest III | 23,043 | 91.0 | 1,468 | 5.8 | 814 | 3.2 | 1,016 | 4.0 |
| Southwest IV | 23,044 | 96.6 | 242 | 1.0 | 578 | 2.4 | 576 | 2.4 |
| **Waterbury** | 17,722 | 69.3 | 4,618 | 18.1 | 3,221 | 12.6 | 5,781 | 22.6 |
| Naugatuck Valley | 25,103 | 96.0 | 432 | 1.7 | 611 | 2.3 | 615 | 2.4 |
| South Central I | 25,771 | 89.7 | 2,017 | 7.0 | 933 | 3.2 | 846 | 2.9 |
| **New Haven** | 10,530 | 34.0 | 15,969 | 51.6 | 4,437 | 14.3 | 6,692 | 21.6 |
| South Central II | 22,046 | 87.7 | 2,236 | 8.9 | 849 | 3.4 | 973 | 3.9 |
| South Central III | 20,845 | 88.6 | 1,009 | 4.3 | 1,663 | 7.1 | 3,503 | 14.9 |
| South Central IV | 21,978 | 97.2 | 226 | 1.0 | 402 | 1.8 | 430 | 1.9 |
| South Central Shore | 28,520 | 90.8 | 1,998 | 6.4 | 883 | 2.8 | 1,078 | 3.4 |
| Central I | 23,431 | 95.5 | 538 | 2.2 | 555 | 2.3 | 795 | 3.2 |
| Central II | 17,914 | 76.6 | 1,946 | 8.3 | 3,515 | 15.0 | 5,217 | 22.3 |
| **Hartford** | 9,487 | 24.7 | 16,978 | 44.2 | 11,925 | 31.1 | 17,930 | 46.7 |
| Capitol I | 17,716 | 84.4 | 2,087 | 9.9 | 1,189 | 5.7 | 1,409 | 6.7 |
| Capitol II | 22,147 | 85.2 | 2,701 | 10.4 | 1,136 | 4.4 | 947 | 3.6 |
| Capitol III | 30,470 | 91.0 | 1,911 | 5.7 | 1,114 | 3.3 | 855 | 2.6 |
| Capitol IV | 24,236 | 94.7 | 457 | 1.8 | 890 | 3.5 | 697 | 2.7 |
| Capitol V | 27,684 | 95.4 | 479 | 1.7 | 843 | 2.9 | 612 | 2.1 |
| Northeast | 24,709 | 93.7 | 333 | 1.3 | 1,321 | 5.0 | 1,796 | 6.8 |
| Southeast | 30,820 | 93.6 | 1,115 | 3.4 | 1,005 | 3.1 | 931 | 2.8 |
| Southeast Shore | 22,607 | 83.5 | 2,581 | 9.5 | 1,878 | 6.9 | 2,105 | 7.8 |
| **CONNECTICUT** | 609,604 | 81.3 | 85,523 | 11.4 | 54,454 | 7.3 | 77,341 | 10.3 |

Note: People of Hispanic origin may be of any race.

Sources: U.S. Bureau of the Census. Census of Population and Housing, 1990.

## Children Living Below the Federal Poverty Level —1979, 1989

| REGION NAME | 1979 Number | 1979 Percent | 1989 Number | 1989 Percent | 1979 - 1989 % Change in Rate |
|---|---|---|---|---|---|
| Northwest | 2,386 | 5.7 | 1,657 | 4.2 | -27 |
| Housatonic Valley | 2,078 | 5.7 | 1,393 | 4.4 | -22 |
| **Stamford** | 3,122 | 12.6 | 2,141 | 9.9 | -21 |
| Southwest I | 603 | 2.3 | 560 | 2.5 | 10 |
| Southwest II | 2,399 | 7.6 | 1,495 | 6.1 | -20 |
| **Bridgeport** | 13,370 | 34.0 | 10,436 | 29.0 | -15 |
| Southwest III | 1,519 | 5.1 | 824 | 3.3 | -36 |
| Southwest IV | 984 | 3.6 | 562 | 2.4 | -34 |
| **Waterbury** | 5,960 | 22.6 | 5,177 | 20.6 | -9 |
| Naugatuck Valley | 1,683 | 6.4 | 725 | 2.8 | -56 |
| South Central I | 1,947 | 6.1 | 1,584 | 5.6 | -8 |
| **New Haven** | 11,001 | 35.3 | 9,927 | 33.8 | -4 |
| South Central II | 2,243 | 7.8 | 1,442 | 5.8 | -25 |
| South Central III | 2,091 | 8.4 | 2,029 | 8.6 | 3 |
| South Central IV | 1,402 | 5.6 | 638 | 2.9 | -49 |
| South Central V | 2,565 | 7.8 | 1,716 | 5.6 | -28 |
| Central I | 1,695 | 6.1 | 1,040 | 4.3 | -29 |
| Central II | 3,361 | 14.4 | 4,189 | 18.3 | 27 |
| **Hartford** | 15,104 | 39.3 | 16,054 | 43.6 | 11 |
| Capitol I | 1,784 | 7.3 | 1,333 | 6.5 | -11 |
| Capitol II | 904 | 3.1 | 667 | 2.6 | -17 |
| Capitol III | 1,660 | 4.6 | 758 | 2.3 | -50 |
| Capitol IV | 1,079 | 3.9 | 588 | 2.3 | -40 |
| Capitol V | 1,644 | 5.5 | 1,228 | 4.3 | -22 |
| Northeast | 2,964 | 11.4 | 2,953 | 11.4 | 1 |
| Southeast | 3,563 | 10.4 | 3,012 | 9.4 | -10 |
| Southeast Shore | 3,495 | 11.8 | 2,444 | 9.2 | -22 |
| **CONNECTICUT** | 92,606 | 11.4 | 76,572 | 10.4 | -9 |

■ = Worse than statewide rate.

Note: The census collects income information from the previous year.

Sources: U.S. Bureau of the Census, Census of Population and Housing, 1980 and 1990.

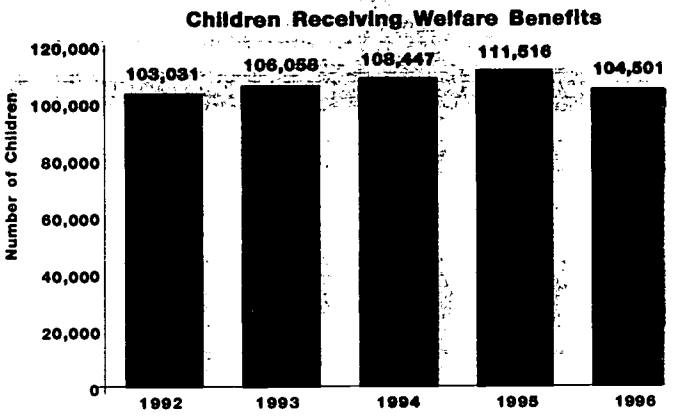
## Family Setting of Connecticut's Children — 1990

| REGION NAME | TWO-PARENT FAMILIES Number | Percent | SINGLE-PARENT FAMILIES Number | Percent | CHILDREN LIVING IN OTHER SITUATIONS Number | Percent |
|---|---|---|---|---|---|---|
| Northwest | 32,939 | 80.9 | 5,256 | 12.9 | 2,524 | 6.2 |
| Housatonic Valley | 26,103 | 82.0 | 3,915 | 12.3 | 1,808 | 5.7 |
| **Stamford** | 14,789 | 67.9 | 4,719 | 21.7 | 2,265 | 10.4 |
| Southwest I | 19,241 | 86.6 | 2,054 | 9.2 | 922 | 4.1 |
| Southwest II | 19,088 | 76.0 | 3,953 | 15.7 | 2,087 | 8.3 |
| **Bridgeport** | 17,381 | 47.0 | 14,569 | 39.4 | 5,042 | 13.6 |
| Southwest III | 20,705 | 81.8 | 2,867 | 11.3 | 1,753 | 6.9 |
| Southwest IV | 20,740 | 86.9 | 2,026 | 8.5 | 1,098 | 4.6 |
| **Waterbury** | 15,208 | 59.5 | 8,022 | 31.4 | 2,331 | 9.1 |
| Naugatuck Valley | 22,106 | 84.5 | 2,610 | 10.0 | 1,430 | 5.5 |
| South Central I | 22,814 | 79.4 | 4,042 | 14.1 | 1,865 | 6.5 |
| **New Haven** | 11,951 | 38.6 | 14,359 | 46.4 | 4,626 | 15.0 |
| South Central II | 18,957 | 75.4 | 4,259 | 16.9 | 1,915 | 7.6 |
| South Central III | 17,325 | 73.7 | 4,800 | 20.4 | 1,392 | 5.9 |
| South Central IV | 18,586 | 82.2 | 2,610 | 11.5 | 1,410 | 6.2 |
| South Central Shore | 24,233 | 77.2 | 4,704 | 15.0 | 2,464 | 7.8 |
| Central I | 19,676 | 80.2 | 3,581 | 14.6 | 1,267 | 5.2 |
| Central II | 15,167 | 64.9 | 6,350 | 27.2 | 1,858 | 7.9 |
| **Hartford** | 11,638 | 30.3 | 21,463 | 55.9 | 5,289 | 13.8 |
| Capitol I | 14,858 | 70.8 | 4,650 | 22.2 | 1,484 | 7.1 |
| Capitol II | 21,656 | 83.3 | 3,007 | 11.6 | 1,321 | 5.1 |
| Capitol III | 27,429 | 81.9 | 3,881 | 11.6 | 2,185 | 6.5 |
| Capitol IV | 21,550 | 84.2 | 2,911 | 11.4 | 1,122 | 4.4 |
| Capitol V | 23,784 | 82.0 | 3,731 | 12.9 | 1,491 | 5.1 |
| Northeast | 19,348 | 73.4 | 5,233 | 19.8 | 1,782 | 6.8 |
| Southeast | 25,569 | 77.6 | 5,263 | 16.0 | 2,108 | 6.4 |
| Southeast Shore | 20,353 | 75.2 | 4,867 | 18.0 | 1,846 | 6.8 |
| **CONNECTICUT** | 543,194 | 72.5 | 149,702 | 20.0 | 56,685 | 7.6 |

■ = Lower percentage of children living in two-parent families than statewide rate.

Sources: U.S. Bureau of the Census, Census of Population and Housing, 1990.

# Children Receiving Welfare Benefits




From the 1990 census we know that in Connecticut, children are almost twice as likely to be poor as adults. We know that our youngest children are more likely to live in poverty than older children. We know that children living with only their mother are sixteen times more likely to be poor than those living with two parents. Over the past 25 years, Connecticut has seen its children get poorer, while the income of its elderly has grown. The Center on Budget and Policy Priorities analysis of census data of 1992-94 indicated that 18.7% of Connecticut's children live in poverty.

Beyond the harmful physical effects of poverty described earlier (see page 12), poverty in childhood places children at risk for many other problems, including poor mental health, school failure, teenage childbearing, child abuse and neglect, crime, and delinquency. The data throughout this book are testament to the link between growing up in poverty and experiencing the other problems examined here, such as infant mortality, child deaths, teen violence and teen pregnancy.

There are few local measures of child poverty other than the national census conducted every ten years. The number of children who receive welfare benefits—previously Aid to Families with Dependent Children (AFDC) and now Temporary Assistance to Needy Families (TANF)—is the best measure available in Connecticut to supplement the poverty data from the 1990 census. On average, one in seven children in Connecticut relied on TANF in 1996, down more than 7,000 children from a year earlier. This decrease in program participation is i part due to a decrease in Connecticut's unemployment rate during this time—the public assistance caseload has historically paralleled th unemployment rate—as well as to changes in the welfare system such as time limits and the earned income disregard, which makes work pa

Yet, these statistics underestimate the number of poor children in our state. The number of children receiving welfare benefits is less tha the total number of children who are poor. This is partially because the high cost of living in Connecticut is not taken into account by federal and state welfare programs. For example, the federal poverty level of $13,330 per year for a family of three is not even enough to pay for an average two-bedroom apartment in our state.

Poor children are disproportionately concentrated in Connecticut's four largest cities—more than half of the AFDC caseload (53%) live in Hartford, New Haven, Bridgeport or Waterbury. Poverty is not exclusively an urban problem, however; there are children in every town in Connecticut living below a subsistence level.

Note: The numbers shown here are the total number of children receiving benefits on June 30th of that year. It is a snapshot in time and does not represent the total numbe of children who received benefits at any time during that year. The annual average number is calculated by adding the number of children receiving benefits on June 30th of each year, and dividing by two. The annual average rate is calculated by dividing the annual average number by the total number of children in that region. The number of children used to calculate the rates is based on applying the percentage of population under 18 for each region from the 1990 Census to the Connecticut Department of Hea estimate of population by town for the years 1992 and 1994. The estimate of the costs of child poverty is based upon a direct estimate of the total impact of childhood poven nnual earnings including effects on work hours and unemployment and effects related to quality of schooling, poor health and other factors.

## Children Receiving AFDC Benefits — 1992-1993, 1995-1996
## (Aid to Families with Dependent Children)

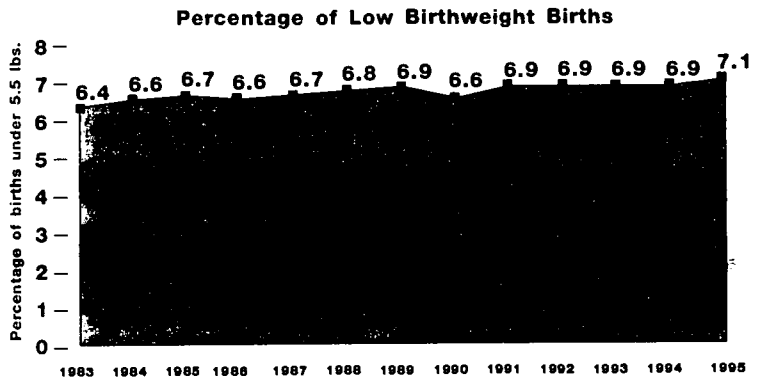
| REGION NAME | 1992-93 ANNUAL AVERAGE Number | Percent | 1995-96 ANNUAL AVERAGE Number | Percent | % Change in Rate | Better or Worse |
|---|---|---|---|---|---|---|
| Northwest | 1,835 | 4.5 | 1,974 | 4.7 | 4 | - |
| Housatonic Valley | 2,093 | 6.5 | 2,143 | 6.5 | 0 | 0 |
| **Stamford** | 2,980 | 13.8 | 3,035 | 13.6 | -1 | + |
| Southwest I | 260 | 1.2 | 301 | 1.3 | 8 | - |
| Southwest II | 2,301 | 9.1 | 2,347 | 9.2 | 1 | - |
| **Bridgeport** | 13,559 | 37.3 | 13,684 | 38.3 | 3 | |
| Southwest III | 1,077 | 4.3 | 1,167 | 4.7 | 9 | - |
| Southwest IV | 341 | 1.4 | 346 | 1.4 | 0 | 0 |
| **Waterbury** | 7,913 | 31.5 | 8,327 | 33.0 | 5 | |
| Naugatuck Valley | 893 | 3.4 | 958 | 3.6 | 6 | - |
| South Central I | 2,015 | 7.0 | 2,347 | 8.3 | 19 | - |
| **New Haven** | 13,807 | 45.5 | 13,711 | 46.8 | 3 | |
| South Central II | 2,499 | 10.0 | 2,882 | 11.8 | 18 | - |
| **South Central III** | 3,534 | 15.0 | 4,012 | 17.1 | 14 | |
| South Central IV | 853 | 3.7 | 950 | 4.1 | 11 | - |
| South Central V | 1,935 | 6.1 | 2,040 | 6.3 | 3 | - |
| Central I | 1,771 | 7.2 | 2,025 | 8.3 | 15 | - |
| Central II | 5,440 | 23.7 | 6,086 | 27.0 | 14 | |
| **Hartford** | 23,193 | 60.3 | 21,549 | 57.8 | -4 | |
| Capitol I | 2,792 | 13.4 | 3,763 | 18.4 | 37 | |
| Capitol II | 1,028 | 4.0 | 1,357 | 5.4 | 35 | - |
| Capitol III | 1,342 | 4.0 | 1,605 | 4.8 | 20 | - |
| Capitol IV | 613 | 2.4 | 729 | 2.9 | 21 | - |
| Capitol V | 1,377 | 4.7 | 1,500 | 5.1 | 9 | - |
| Northeast | 3,424 | 12.9 | 3,494 | 13.0 | 1 | - |
| Southeast | 2,665 | 8.1 | 2,657 | 8.1 | 0 | 0 |
| Southeast Shore | 3,008 | 11.2 | 3,027 | 11.5 | 3 | - |
| **CONNECTICUT** | 104,545 | 14.0 | 108,009 | 14.5 | 4 | - |

= Worse than statewide rate.

urces: Table data from unpublished data from the Connecticut Department of Social Services and *Estimated Populations in Connecticut* from the Connecticut Department Health. Text also includes information from the Children's Defense Fund. *Wasting America's Future*. 1994: U.S. Bureau of the Census. *Census of Population 1970* and *90*; National Commission on Children. *Beyond Rhetoric*. 1991; and Legal Assistance Resource Center. *The New Welfare Law: Issues and Options for Connecticut*. 1997.

# Low Birthweight Rate

In 1995, 7.1% of all babies born in Connecticut had a low birthweight (under 2,500 grams, about 5 1/2 pounds). This translates to 3,129 of the more than 44,000 babies born that year. During the last decade there has been a slight worsening of this rate as seen on the graph below.




Low birthweight is a measure of the immediate risk to a newborn; low birthweight babies account for about 60% of all infant deaths. It is also a measure of future risks to the child; low birthweight babies who survive are about three times more likely to experience serious health and developmental problems, such as sight and hearing deficiencies, chronic respiratory problems and learning difficulties. These children may require special medical and educational services throughout their lives.

Although researchers do not know all the factors that cause low birthweight, the health of the mother and the care she receives whe pregnant are the two most important factors for a healthy baby. Smoking, inadequate nutrition, alcohol or other drug use, and stre during pregnancy all increase the likelihood that a mother will have a low birthweight baby. Similarly, mothers who receive late or infrequent prenatal care are also much more likely to have a low birthweight baby.

Note: The rates are calculated by dividing the number of low birthweight births by the total number of births in that region, then multiplying that by 1,000 to obtain a low ...t rate per 1,000 births.

## Low Birthweight Rate — 1985, 1990, 1995
## (per 1,000 births)

| REGION NAME | 1985 Number | 1985 Rate | 1990 Number | 1990 Rate | 1995 Number | 1995 Rate | % Change in Rate 1990-95 | Better or Worse |
|---|---|---|---|---|---|---|---|---|
| Northwest | 108 | 52.3 | 127 | 52.4 | 119 | 60.0 | 15 | - |
| Housatonic Valley | 96 | 54.7 | 91 | 42.7 | 111 | 54.8 | 28 | - |
| **Stamford** | 83 | 54.2 | 146 | 76.3 | 132 | 75.3 | -1 | + |
| Southwest I | 31 | 36.4 | 51 | 45.0 | 70 | 55.6 | 24 | - |
| Southwest II | 101 | 63.3 | 118 | 62.4 | 128 | 65.7 | 5 | - |
| **Bridgeport** | 259 | 94.7 | 286 | 93.5 | 202 | 89.5 | -4 | + |
| Southwest III | 76 | 57.9 | 73 | 51.6 | 75 | 57.6 | 12 | - |
| Southwest IV | 50 | 43.7 | 59 | 47.5 | 66 | 46.0 | -3 | + |
| **Waterbury** | 125 | 72.4 | 171 | 83.0 | 190 | 108.3 | 30 | - |
| Naugatuck Valley | 81 | 65.5 | 59 | 43.2 | 68 | 55.0 | 27 | - |
| South Central I | 107 | 63.1 | 103 | 55.6 | 101 | 62.2 | 12 | - |
| **New Haven** | 265 | 117.8 | 237 | 96.3 | 201 | 108.6 | 13 | - |
| South Central II | 81 | 52.1 | 96 | 57.8 | 86 | 61.5 | 6 | - |
| South Central III | 66 | 46.5 | 98 | 60.7 | 78 | 54.9 | -10 | + |
| South Central IV | 57 | 49.2 | 74 | 53.5 | 63 | 48.2 | -10 | + |
| South Central V | 103 | 59.1 | 120 | 56.4 | 112 | 59.2 | 5 | - |
| Central I | 93 | 69.2 | 84 | 56.7 | 79 | 60.3 | 6 | - |
| Central II | 111 | 76.5 | 129 | 75.6 | 124 | 89.9 | 19 | - |
| **Hartford** | 326 | 115.6 | 421 | 129.7 | 309 | 133.9 | 3 | - |
| Capitol I | 85 | 67.7 | 80 | 53.4 | 125 | 89.6 | 68 | - |
| Capitol II | 63 | 50.6 | 75 | 56.1 | 106 | 73.2 | 30 | - |
| Capitol III | 101 | 57.7 | 102 | 49.4 | 105 | 57.1 | 16 | - |
| Capitol IV | 57 | 45.9 | 74 | 49.4 | 71 | 48.5 | -2 | + |
| Capitol V | 85 | 50.7 | 83 | 49.0 | 97 | 63.7 | 30 | - |
| Northeast | 95 | 68.7 | 98 | 65.5 | 101 | 70.2 | 7 | - |
| Southeast | 104 | 54.7 | 125 | 62.0 | 120 | 67.6 | 9 | - |
| Southeast Shore | 106 | 55.4 | 114 | 56.6 | 90 | 52.1 | -8 | + |
| **CONNECTICUT** | 2,915 | 66.6 | 3,294 | 66.2 | 3,129 | 71.0 | 7 | - |

= Worse than statewide rate.

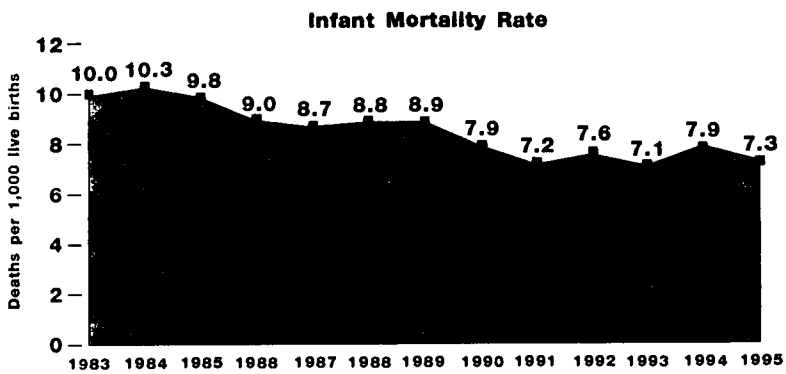
ırces: Table data from the Connecticut Department of Public Health and Addiction Services, unpublished data, and *Registration Reports*. 1983 through 1995. Text also ɔdes information from the Institute of Medicine. *Preventing Low Birthweight*. 1985: Schorr. L.B., *Within Our Reach: Breaking the Cycle of Disadvantage*. 1988: National nmission on Children, *Beyond Rhetoric*. 1993.

# Infant Mortality

The infant mortality rate compares the number of children who die before their first birthday with the number of live births. In 1995, the infant mortality rate was 7.3 per 1,000 live births (or 0.73%).

This continues a steady but slow decline as seen on the graph below. State officials attribute this decline in infant mortality to improvements in expensive medical technologies used to keep premature and low birthweight babies alive, as well as to improvements in access to preventive health care for infants and prenatal care for women of childbearing age.

However, this progress has not been even across the state. When compared to ten years ago, 23 of the 27 regions showed an improvement in infant mortality rates, but four regions became worse. The South Central IV region had the largest improvement during the past five years, with a 55% decrease in rates.




Note: The annual average infant deaths shown here is the total number of babies who die before their first birthday over a three year period, divided by three. The annual average rate is the total number of infant deaths over three years, divided by the total number of live births over the same three years, then multiplied by 1,000 to obtain an infant mortality rate per 1,000 live births.

## Infant Mortality Rate — 1986-88, 1991-93, 1993-1995
## (per 1,000 live births)

| REGION NAME | 1986-1988 ANNUAL AVERAGE Deaths | Rate | 1991-1993 ANNUAL AVERAGE Deaths | Rate | 1993-1995 ANNUAL AVERAGE Deaths | Rate | % Change in Rate | Better or Worse |
|---|---|---|---|---|---|---|---|---|
| Northwest | 15 | 7.6 | 12 | 4.9 | 11 | 5.1 | 4 | - |
| Housatonic Valley | 9 | 5.6 | 11 | 5.5 | 12 | 5.8 | 5 | - |
| **Stamford** | 15 | 10.1 | 17 | 9.1 | 10 | 5.2 | -43 | + |
| Southwest I | 5 | 5.5 | 6 | 5.0 | 4 | 3.2 | -36 | + |
| Southwest II | 14 | 9.0 | 13 | 7.1 | 11 | 5.7 | -20 | + |
| **Bridgeport** | 39 | 14.5 | 40 | 13.2 | 28 | 11.8 | -11 | + |
| Southwest III | 12 | 9.4 | 7 | 4.7 | 8 | 6.1 | 30 | - |
| Southwest IV | 9 | 8.3 | 6 | 4.9 | 6 | 4.1 | -16 | + |
| **Waterbury** | 17 | 10.6 | 20 | 10.0 | 15 | 8.2 | -18 | + |
| Naugatuck Valley | 8 | 7.0 | 10 | 7.4 | 7 | 5.7 | -23 | + |
| South Central I | 14 | 8.6 | 11 | 5.9 | 9 | 5.4 | -8 | + |
| **New Haven** | 39 | 18.0 | 38 | 15.3 | 23 | 11.8 | -23 | + |
| **South Central II** | 14 | 8.9 | 12 | 7.5 | 12 | 8.4 | 12 | - |
| South Central III | 10 | 7.3 | 14 | 8.5 | 10 | 6.7 | -21 | + |
| South Central IV | 5 | 4.6 | 7 | 5.5 | 3 | 2.5 | -55 | + |
| South Central V | 16 | 9.3 | 14 | 6.8 | 15 | 7.4 | 9 | - |
| Central I | 10 | 7.6 | 12 | 8.1 | 5 | 4.0 | -51 | + |
| Central II | 15 | 10.7 | 14 | 9.5 | 10 | 6.9 | -10 | + |
| **Hartford** | 52 | 18.6 | 50 | 15.8 | 42 | 16.3 | 3 | - |
| Capitol I | 9 | 7.6 | 13 | 8.7 | 11 | 7.9 | -9 | + |
| **Capitol II** | 10 | 8.6 | 9 | 6.7 | 15 | 10.3 | 54 | - |
| Capitol III | 17 | 9.8 | 16 | 7.6 | 15 | 8.4 | 11 | - |
| Capitol IV | 7 | 6.2 | 13 | 8.8 | 6 | 4.2 | -52 | + |
| Capitol V | 13 | 7.9 | 10 | 5.7 | 13 | 8.4 | 47 | - |
| Northeast | 16 | 12.0 | 11 | 7.5 | 11 | 8.1 | 8 | - |
| Southeast | 18 | 9.5 | 14 | 7.1 | 12 | 6.8 | -4 | + |
| Southeast Shore | 18 | 9.7 | 22 | 10.9 | 12 | 6.9 | -37 | + |
| **CONNECTICUT** | 427 | 10.1 | 421 | 8.6 | 339 | 7.4 | -14 | + |

= Worse than statewide rate.

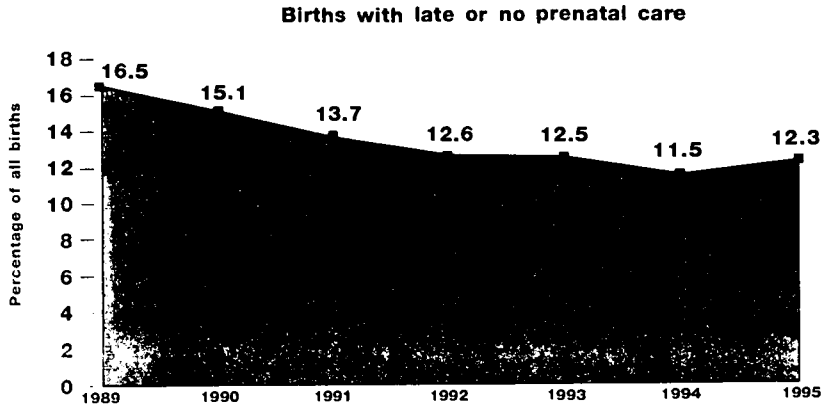
Sources: Table data from the Connecticut Department of Public Health, unpublished data, and *Registration Reports*, 1984 through 1995.

# Late or No Prenatal Care

One of every eight babies born in our state (12.3%) in 1995 was born to mothers who received late or no prenatal care (care beginning after the first three months, or trimester, of pregnancy). Yet early prenatal care is a cost-effective means to reduce problems later in life which are associated with early birth and health problems. The Institute of Medicine estimates that for every $1 invested in prenatal care, $3.38 will be saved in expenditures for the care of low birthweight babies in their first year of life.

The good news is that the percentage of babies receiving prenatal care is increasing. In 1989, one in six babies got late or no prenatal care, but in 1993, the rate had improved to one of every eight. The bad news is that the 1995 rate is worse than it was in 1994.

The babies of women who receive early prenatal care have lower risks of low birthweight, infant illness, and infant mortality. Women who do not receive routine care are approximately three times as likely to deliver low birthweight infants as those who do. The positive effects of early care are greatest for those women who are at the highest risk of poor birth outcomes: black women, women of Hispanic origin, poor women, very young women, and poorly educated women. Unfortunately, these women are also the least likely to receive that care. Barriers to seeking prenatal care include a lack of knowledge about the importance of care and a lack of health care insurance and access.




Note: The annual average number shown here is the total number of births with late or no prenatal care over a two-year period, divided by two. The annual rage rate is the total number of births with late or no prenatal care over two years, divided by the total number of births where the status of prenatal care has n determined.

## Births with Late or No Prenatal Care — 1989-90, 1994-95

| REGION NAME | 1989-90 ANNUAL AVERAGE Number | Percent | 1994-95 ANNUAL AVERAGE Number | Percent | % Change in Rate | Better or Worse |
|---|---|---|---|---|---|---|
| Northwest | 323 | 14.5 | 178 | 8.9 | -38 | + |
| Housatonic Valley | 194 | 10.0 | 115 | 5.7 | -43 | + |
| **Stamford** | 396 | 22.3 | 320 | 18.6 | -17 | + |
| Southwest I | 85 | 8.3 | 54 | 5.1 | -39 | + |
| Southwest II | 322 | 18.5 | 238 | 13.8 | -25 | + |
| **Bridgeport** | 699 | 29.7 | 354 | 17.4 | -41 | + |
| Southwest III | 104 | 8.7 | 70 | 5.5 | -37 | + |
| Southwest IV | 80 | 7.3 | 44 | 3.5 | -52 | + |
| **Waterbury** | 700 | 40.4 | 531 | 31.3 | -23 | + |
| Naugatuck Valley | 199 | 15.9 | 134 | 11.0 | -31 | + |
| South Central I | 198 | 12.5 | 138 | 8.8 | -30 | + |
| **New Haven** | 540 | 32.5 | 367 | 22.3 | -31 | + |
| South Central II | 168 | 12.4 | 117 | 8.5 | -31 | + |
| South Central III | 220 | 15.1 | 221 | 15.2 | 1 | - |
| South Central IV | 88 | 8.0 | 69 | 5.5 | -31 | + |
| South Central V | 174 | 9.1 | 195 | 10.2 | 13 | - |
| Central I | 144 | 10.7 | 91 | 8.1 | -24 | + |
| Central II | 187 | 11.6 | 195 | 14.8 | 26 | - |
| **Hartford** | 645 | 24.4 | 362 | 17.5 | -29 | + |
| Capitol I | 143 | 10.6 | 135 | 10.4 | -3 | + |
| Capitol II | 70 | 5.5 | 60 | 4.5 | -20 | + |
| Capitol III | 127 | 6.5 | 104 | 6.0 | -9 | + |
| Capitol IV | 62 | 4.5 | 68 | 4.9 | 7 | - |
| Capitol V | 140 | 8.5 | 159 | 10.1 | 19 | - |
| Northeast | 217 | 15.2 | 137 | 9.9 | -35 | + |
| Southeast | 279 | 15.8 | 247 | 13.7 | -13 | + |
| Southeast Shore | 402 | 20.8 | 300 | 17.1 | -18 | + |
| **CONNECTICUT** | 6,899 | 15.8 | 4,998 | 11.9 | -25 | + |

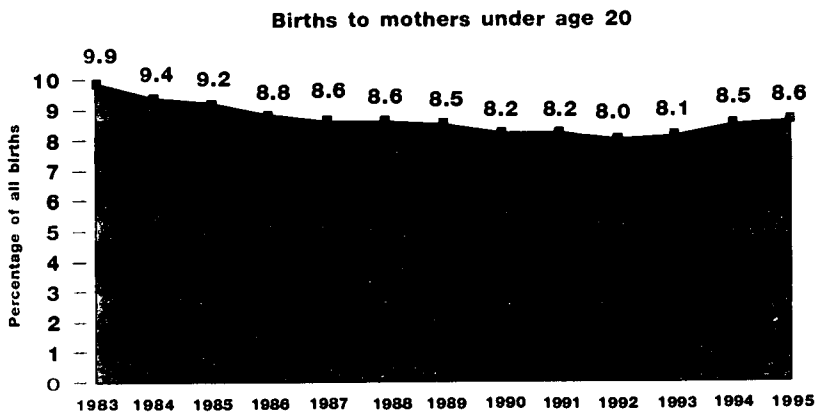
= Worse than statewide rate.

urces: Table data from the Connecticut Department of Public Health, unpublished data, and *Registration Reports*, 1989-1995. Text also includes information from the titute of Medicine, *Preventing Low Birthweight*, 1985; and National Commission on Children, *Beyond Rhetoric*, 1993

# Births to Teenage Mothers

There are three important ways to look at teen pregnancy. One is to look at the absolute number of teen births. Another is to compare thi number to the total number of births to mothers of all ages in that year—this would tell us something about the risks to that generation of babies. The third way to look at teen pregnancy is to compare the number of teen births to the number of teenage girls, the "teen birth rate"—this would tell us something about the sexual activity and risk of teen pregnancy among teenage girls.

The table on the right displays the first two of these measures, which focuses on the risk to our youngest generation. Research indicates that children of teen mothers are more likely to grow up poor, relying on public assistance. They are also at greater risk o lower intellectual and academic achievement, behavior problems, and early childbearing than are children of older mothers. Both th rate and the number of all births to teenage mothers have decreased over the past ten years, which shows some improvement for th generation of children being born today.




The teen birth rate, that is the number of teen births compared to the number of teenage girls, is no longer increasing in Connecticut or th United States. Nevertheless, with 40 births for every 1,000 girls and a large increase in the number of teenagers over the next ten years, w can expect an increase in the total number of births to teen mothers in Connecticut in the near future.

The teen birth rate is a function of teens' capacity and motivation to prevent pregnancy. If girls believe they have alternative life options such as college or a career, they are much more likely to delay parenthood. Thus, being poor and without these hopes increases the likelihood of teen pregnancy. Teens who exhibit problem behavior in school are more likely to end up teen mothers; girls whose friends and siblings are already mothers are also more likely to become teenage mothers.

Note: The number of teen births shown here is the total number of babies born to mothers age 19 or younger. The rate is the total number of teen births divided by the total number of births, then multiplied by 100 to get a percentage. The percentage shown here measures the risks to the generation of babies being born today. The teen birth ra which compares the number of teen births to the number of teenage girls, is not available at a local level. This is because of a lack of reliable data for the number of teenage as a denominator and the inability to make estimates because of the narrow age range. The teen birth rate of 40 births per 1000 girls is based on the number of 15-19.

## Percent of All Births That Are to Teenage Mothers — 1985, 1990, 1995

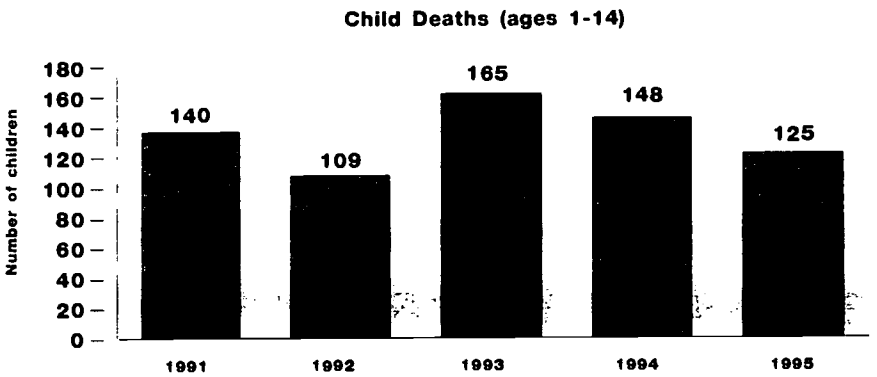
| REGION NAME | 1985 Number | 1985 Percent | 1990 Number | 1990 Percent | 1995 Number | 1995 Percent | % Change in Rate 1990-95 | Better or Worse |
|---|---|---|---|---|---|---|---|---|
| Northwest | 143 | 6.9 | 119 | 4.9 | 114 | 5.7 | 16 | - |
| Housatonic Valley | 82 | 4.6 | 87 | 4.0 | 118 | 5.8 | 45 | - |
| Stamford | 127 | 8.1 | 119 | 6.1 | 112 | 6.2 | 2 | - |
| Southwest I | 11 | 1.2 | 14 | 1.1 | 5 | 0.4 | -64 | + |
| Southwest II | 124 | 7.6 | 103 | 5.3 | 93 | 4.6 | -13 | + |
| Bridgeport | 539 | 19.7 | 544 | 17.8 | 428 | 18.9 | 6 | - |
| Southwest III | 64 | 4.9 | 53 | 3.7 | 52 | 4.0 | 8 | - |
| Southwest IV | 17 | 1.5 | 12 | 1.0 | 15 | 1.0 | 0 | 0 |
| Waterbury | 274 | 15.9 | 314 | 15.2 | 283 | 16.1 | 6 | - |
| Naugatuck Valley | 46 | 3.7 | 55 | 4.0 | 45 | 3.6 | -10 | + |
| South Central I | 64 | 3.8 | 80 | 4.3 | 85 | 5.2 | 21 | - |
| New Haven | 432 | 19.2 | 392 | 15.9 | 320 | 17.3 | 9 | - |
| South Central II | 112 | 7.2 | 93 | 5.6 | 89 | 6.3 | 13 | - |
| South Central III | 127 | 8.9 | 146 | 9.0 | 150 | 10.6 | 18 | - |
| South Central IV | 39 | 3.4 | 44 | 3.2 | 49 | 3.7 | 16 | - |
| South Central V | 126 | 7.2 | 88 | 4.1 | 82 | 4.3 | 5 | - |
| Central I | 77 | 5.7 | 101 | 6.8 | 102 | 7.8 | 15 | - |
| Central II | 157 | 10.8 | 207 | 12.1 | 186 | 13.5 | 12 | - |
| Hartford | 637 | 22.5 | 747 | 23.0 | 598 | 25.9 | 13 | - |
| Capitol I | 81 | 6.4 | 108 | 7.2 | 127 | 9.1 | 26 | - |
| Capitol II | 40 | 3.2 | 45 | 3.4 | 66 | 4.6 | 35 | - |
| Capitol III | 75 | 4.3 | 88 | 4.3 | 97 | 5.3 | 23 | - |
| Capitol IV | 33 | 2.7 | 19 | 1.3 | 38 | 2.6 | 100 | - |
| Capitol V | 86 | 5.1 | 85 | 5.0 | 49 | 3.2 | -36 | + |
| Northeast | 158 | 11.4 | 141 | 9.4 | 175 | 12.2 | 30 | - |
| Southeast | 197 | 10.4 | 149 | 7.4 | 153 | 8.6 | 16 | - |
| Southeast Shore | 185 | 9.7 | 168 | 8.3 | 175 | 10.1 | 22 | - |
| CONNECTICUT | 4,053 | 9.2 | 4,121 | 8.2 | 3,806 | 8.6 | 5 | - |

= Worse than statewide rate.

urces: Table data from the Connecticut Department of Public Health, unpublished data, and *Registration Reports*, 1983 through 1995. Text also includes information n National Center for Health Statistics, "Recent Declines in Teenage Birth Rates in the United States: Variations by State, 1990-94 " 1996; Child Trends, *Facts at a Glance* )3; National Research Council, *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*, 1987; and National Commission on Children, *Beyond Rhetoric*, 1993

# Child Deaths

There are approximately 146 deaths each year to children ages 1-14. For every death, there are 41 hospitalizations. The majority of deaths to children between the ages of one and fourteen are due to injuries, most of them unintentional.




The primary causes are different for injury deaths and hospitalizations and vary by the age of the child. For children ages 1-4, pedestrian injuries (21%), burns (20%), and drowning (18%) account for most of the injury deaths, while falls (30%), poisoning (27%), and burns (10%) account for most of the hospitalizations.

The three leading causes of injury deaths for children ages 5-9 are pedestrian injuries (27%), drowning (17%), and motor vehicle occupant injuries (10%), while falls (37%), bicycle injuries (14%), and pedestrian injuries (11%) account for the majority of hospitalizations.

For children ages 10-14, pedestrian injuries (16%), homicide (12%), and motor vehicle occupant injuries (11%) account for most of the injury deaths. Falls (26%), bicycle-related injuries (14%), and being struck by an object (12%) account for most of the hospitalizations for this preteen age group.

Note: The annual average number of child deaths shown here is the total number of deaths to children ages 1 to 14 over a three-year period, divided by three. The annual average rate is the total number of child deaths over three years, divided by the total number of children ages 1-14 in 1994, then multiplied by 100,000 to get a rate per 100,0 children in that age group. The number of children used to calculate the rates is based on applying the percentage of population ages 1-14 for each region from the 1990 the Connecticut Department of Public Health estimate of population by town for 1994.

## Child Death Rate — 1993-95
## (per 100,000 children ages 1-14)

| REGION NAME | 1991 Deaths | 1992 Deaths | 1993 Deaths | 1994 Deaths | 1995 Deaths | 1993-95 ANNUAL AVERAGE Deaths | 1993-95 ANNUAL AVERAGE Rate |
|---|---|---|---|---|---|---|---|
| Northwest | 4 | 6 | 6 | 13 | 6 | 8 | 25.1 |
| Housatonic Valley | 7 | 3 | 5 | 5 | 5 | 5 | 19.8 |
| Stamford | 4 | 1 | 5 | 5 | 1 | 4 | 21.1 |
| Southwest I | 3 | 3 | 4 | 5 | 3 | 4 | 23.2 |
| Southwest II | 4 | 3 | 4 | 1 | 4 | 3 | 15.1 |
| **Bridgeport** | 10 | 13 | 21 | 10 | 6 | 12 | 43.2 |
| Southwest III | 4 | 3 | 4 | 4 | 1 | 3 | 15.3 |
| Southwest IV | 5 | 2 | 3 | 3 | 3 | 3 | 15.9 |
| **Waterbury** | 3 | 2 | 11 | 10 | 6 | 9 | 44.9 |
| Naugatuck Valley | 7 | 5 | 4 | 5 | 3 | 4 | 19.1 |
| South Central I | 7 | 3 | 7 | 4 | 4 | 5 | 22.4 |
| **New Haven** | 12 | 9 | 12 | 13 | 6 | 10 | 43.3 |
| South Central II | 7 | 4 | 3 | 3 | 5 | 4 | 18.9 |
| South Central III | 2 | 6 | 6 | 5 | 6 | 6 | 30.4 |
| South Central IV | 3 | 4 | 1 | 4 | 5 | 3 | 18.4 |
| South Central V | 4 | 3 | 4 | 7 | 3 | 5 | 18.5 |
| Central I | 5 | 6 | 4 | 7 | 1 | 4 | 20.6 |
| Central II | 10 | 3 | 6 | 5 | 6 | 6 | 31.4 |
| **Hartford** | 11 | 6 | 16 | 16 | 15 | 16 | 52.7 |
| Capitol I | 2 | 2 | 2 | 1 | 5 | 3 | 16.7 |
| Capitol II | 5 | 3 | 3 | 2 | 3 | 3 | 13.0 |
| Capitol III | 4 | 4 | 11 | 0 | 4 | 5 | 18.8 |
| Capitol IV | 2 | 2 | 6 | 2 | 1 | 3 | 15.2 |
| Capitol V | 3 | 3 | 2 | 6 | 3 | 4 | 15.7 |
| Northeast | 3 | 4 | 5 | 5 | 8 | 6 | 28.1 |
| Southeast | 4 | 3 | 6 | 2 | 7 | 5 | 19.4 |
| Southeast Shore | 5 | 3 | 4 | 5 | 5 | 5 | 22.2 |
| **CONNECTICUT** | 140 | 109 | 165 | 148 | 125 | 146 | 24.8 |

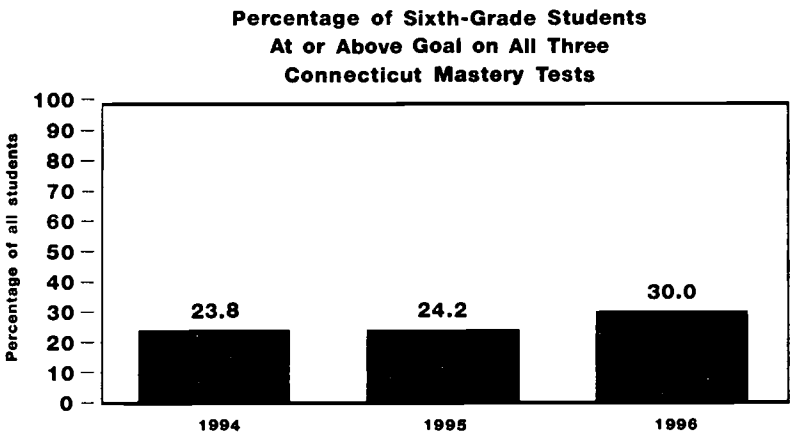
= Worse than statewide rate.

urces: Table data from the Connecticut Department of Public Health, unpublished data, and *Registration Reports*, 1991-1994. Text also includes information from the nnecticut Department of Public Health, "Childhood Injuries in Connecticut, Selected Statistics," and unpublished data; hospitalization information from an analysis of hospital charge data, 1986-1990, and causes of death analysis of 1988-1992 Vital Statistics data, both by the Connecticut Childhood Injury Prevention Center.

# Connecticut Mastery Test Results — Above Goal

Connecticut tests students on their reading, writing, and mathematical skills in the 4th, 6th and 8th grades using the Connecticut Mastery Tests. One standard set by the State Department of Education to evaluate students' performance on these tests is the state goal; this is the level that ideally every student at that grade level is expected to achieve.

In the 1995-96 school year, 30% of Connecticut's sixth graders met the state goal on all three subject tests. This signifies that less than a third of our sixth graders are learning everything expected of them.




Performance on these tests varies tremendously by region, and differences between poor and wealthy areas of our state continue. In Connecticut's four poorest cities, fewer than one in twenty students (5% or lower) met the state goal on all three tests. The good news is that 26 of 27 regions showed an improvement on these scores in the past year.

Note: The State Department of Education no longer reports using a remedial level on the Connecticut Mastery Test so the second chart has been dropped from the databook. For this reason, the Mastery Test results are not included in the Regional Indicators section. We have added two new educational indicators, the Connecticut Academic Performance Test Results on page 54, which are included in the Regional Indicators.

## At or Above State Goal on All Three Connecticut Mastery Tests
## Sixth Grade Students — 1994-95, 1995-96 and 1996-97 School Years

| REGION NAME | 1994 Number | 1994 Percent | 1995 Number | 1995 Percent | 1996 Number | 1996 Percent | % Change In Rate | Better or Worse |
|---|---|---|---|---|---|---|---|---|
| Northwest | 523 | 25.0 | 589 | 27.7 | 811 | 35.7 | 29 | + |
| Housatonic Valley | 460 | 29.1 | 423 | 28.1 | 500 | 31.3 | 11 | + |
| **Stamford** | 129 | 15.1 | 89 | 11.1 | 146 | 16.5 | 49 | + |
| Southwest I | 409 | 42.2 | 436 | 42.4 | 499 | 46.5 | 10 | + |
| Southwest II | 326 | 29.1 | 288 | 25.1 | 375 | 30.9 | 23 | + |
| **Bridgeport** | 48 | 3.6 | 49 | 3.3 | 67 | 4.7 | 42 | + |
| Southwest III | 327 | 26.2 | 362 | 28.4 | 464 | 36.1 | 27 | + |
| Southwest IV | 453 | 36.5 | 407 | 32.7 | 538 | 41.2 | 26 | + |
| **Waterbury** | 43 | 5.0 | 44 | 5.0 | 31 | 3.3 | -34 | - |
| Naugatuck Valley | 432 | 29.7 | 507 | 34.5 | 546 | 35.0 | 1 | + |
| South Central I | 369 | 26.1 | 294 | 20.7 | 518 | 34.4 | 66 | + |
| **New Haven** | 36 | 3.1 | 31 | 2.7 | 59 | 5.2 | 93 | + |
| South Central II | 264 | 22.6 | 318 | 26.3 | 425 | 32.9 | 25 | + |
| **South Central III** | 152 | 15.4 | 213 | 19.6 | 277 | 24.8 | 27 | + |
| South Central IV | 393 | 32.1 | 378 | 30.7 | 457 | 36.2 | 18 | + |
| South Central V | 467 | 28.6 | 570 | 33.9 | 680 | 40.7 | 20 | + |
| Central I | 349 | 28.8 | 266 | 21.6 | 400 | 31.7 | 47 | + |
| Central II | 118 | 13.0 | 179 | 17.4 | 209 | 19.8 | 14 | + |
| **Hartford** | 36 | 2.2 | 52 | 3.2 | 53 | 3.5 | 9 | + |
| Capitol I | 174 | 18.9 | 240 | 23.7 | 239 | 24.1 | 2 | + |
| Capitol II | 611 | 43.6 | 600 | 41.1 | 671 | 47.4 | 15 | + |
| Capitol III | 452 | 25.0 | 424 | 23.4 | 609 | 33.9 | 45 | + |
| Capitol IV | 468 | 34.6 | 593 | 39.8 | 675 | 45.2 | 14 | + |
| Capitol V | 402 | 27.1 | 453 | 30.3 | 573 | 35.7 | 18 | + |
| Northeast | 246 | 18.4 | 280 | 20.0 | 300 | 21.6 | 8 | + |
| Southeast | 431 | 24.9 | 470 | 26.7 | 561 | 32.1 | 20 | + |
| Southeast Shore | 276 | 22.8 | 236 | 19.8 | 418 | 33.5 | 69 | + |
| **CONNECTICUT** | 8,394 | 23.8 | 8,791 | 24.2 | 11,101 | 30.0 | 24 | + |

**Bold** = Worse than statewide rate.

Sources: Table data from the Connecticut State Department of Education. *Connecticut Mastery Test Results. 1994. 1995.* and *1996.*

# Connecticut Academic Performance Test

The State Department of Education tests tenth grade students using the Connecticut Academic Performance Test. Each test consists of four major subtests: language arts, mathematics, science and an interdisciplinary task, and involves writing an explanation or response in addition to multiple choice questions. The Department has set a goal standard for each subtest to certify students' mastery of an area.

In May 1997, only one in eight Connecticut tenth graders (12.3%) was above the mastery level on all four subtests.

The Connecticut State Department of Education also determines two distinct levels below mastery: below standard and well below standard. About one in three students (37.9%) was well below standard on one or more subtests. This indicates that two-thirds of students are failing to learn even the basics which are expected for their age group.

The differences between poor and wealthy areas of our state is particularly striking when looking at education scores. In Connecticut's four poorest cities, more than two-thirds of tenth graders (70.5% or higher) scored well below standard on at least one subtest, more than three times the rate of the wealthiest regions. Even more alarming is that less than 2% of the students in these four cities were above mastery in all four areas.

## Connecticut Academic Performance Test Results
## Tenth Grade Students — 1996-97 School Year

| REGION NAME | 1997 Above on all 4 tests Number | Percent | 1997 Below on any one test Number | Percent |
|---|---|---|---|---|
| Northwest | 263 | 14.7 | 560 | 31.3 |
| Housatonic Valley | 267 | 19.1 | 396 | 28.3 |
| **Stamford** | 49 | 7.0 | 376 | 53.8 |
| Southwest I | 244 | 25.4 | 180 | 18.8 |
| Southwest II | 156 | 15.3 | 363 | 35.6 |
| **Bridgeport** | 15 | 1.4 | 803 | 75.8 |
| Southwest III | 140 | 12.0 | 407 | 34.9 |
| Southwest IV | 190 | 18.3 | 211 | 20.3 |
| **Waterbury** | 10 | 1.5 | 459 | 70.5 |
| Naugatuck Valley | 138 | 11.3 | 371 | 30.4 |
| South Central I | 104 | 9.5 | 436 | 39.7 |
| **New Haven** | 13 | 1.6 | 663 | 79.1 |
| South Central II | 89 | 9.3 | 397 | 41.5 |
| South Central III | 54 | 6.4 | 351 | 41.3 |
| South Central IV | 147 | 13.8 | 317 | 29.7 |
| South Central V | 172 | 14.5 | 361 | 30.3 |
| Central I | 124 | 11.9 | 336 | 32.2 |
| Central II | 69 | 8.3 | 389 | 46.6 |
| **Hartford** | 7 | 0.7 | 830 | 82.6 |
| Capitol I | 86 | 11.1 | 300 | 38.9 |
| Capitol II | 331 | 27.0 | 289 | 23.6 |
| Capitol III | 198 | 13.6 | 428 | 29.4 |
| Capitol IV | 212 | 17.3 | 263 | 21.4 |
| Capitol V | 224 | 16.2 | 366 | 26.5 |
| Northeast | 103 | 7.8 | 546 | 41.4 |
| Southeast | 136 | 9.3 | 484 | 33.0 |
| Southeast Shore | 124 | 11.8 | 395 | 37.7 |
| CONNECTICUT | 3,665 | 12.3 | 11,277 | 37.9 |

= Worse than statewide rate.

Sources: Table data from the Connecticut State Department of Education, *Connecticut Mastery Test Results. 1994* and *1995.*

# High School Dropouts

Each year, one in every 22 students (4.6%) in Connecticut drops out of high school. Three cities have dropout rates that are more than double the state average—Waterbury (13.1%), New Haven (10.3%), and Hartford (21.0%).

The dropout rate improved only slightly during the past five years, although the total number has increased (mostly due to the fact that there are more kids enrolled in high school). Thirteen of the twenty-seven regions showed no improvement during this time.

Applying the state dropout rate to a hypothetical class of 100 students entering ninth grade, only 82 would graduate from high school in a typical Connecticut town. In Hartford, only 51 would graduate.

The consequences of dropping out of high school can be severe. For example, in any given year, the likelihood of slipping into poverty is about three times higher for high school dropouts than for those who have finished high school. Changes in the economy have made the financial outlook of dropouts even worse—the average hourly wage of high school dropouts (adjusted for inflation) fell by 23% between 1973 and 1995.

Note: Dropout rates used here are only for high school students. They do not include the number of children who drop out of school before ninth grade. The calculation of dropouts of a typical class in Hartford paints an optimistic picture of the dropout problem in Hartford because it does not take into account the high dropout rate for students in grades 7 and 8. The dropout figures calculated by the State Department of Education include students who officially withdraw from school, those who enter a non-educational program (e.g. truck driving school or GED classes), and those whose status is unknown. Students transferring to another school are not counted as dropouts. These figures do not include the one percent of students who are enrolled in ungraded classes.

## High School Dropout Rate — 1991-92 and 1995-96 School Years

| REGION NAME | 1991-92 Number | 1991-92 Percent | 1995-96 Number | 1995-96 Percent | % Change in Rate 1991-95 | Better or Worse |
|---|---|---|---|---|---|---|
| Northwest | 291 | 4.2 | 287 | 3.8 | -10 | + |
| Housatonic Valley | 171 | 2.8 | 177 | 2.9 | 4 | - |
| **Stamford** | 58 | 1.6 | 81 | 2.1 | 31 | - |
| Southwest I | 80 | 2.0 | 69 | 1.7 | -15 | + |
| Southwest II | 208 | 5.1 | 160 | 3.6 | -29 | + |
| **Bridgeport** | 430 | 9.3 | 303 | 6.1 | -34 | + |
| Southwest III | 84 | 2.0 | 79 | 1.7 | -15 | + |
| Southwest IV | 70 | 1.7 | 46 | 1.0 | -41 | + |
| **Waterbury** | 365 | 9.7 | 449 | 13.1 | 35 | - |
| Naugatuck Valley | 78 | 2.0 | 80 | 1.8 | -10 | + |
| South Central I | 205 | 3.4 | 171 | 2.7 | -21 | + |
| **New Haven** | 454 | 12.5 | 421 | 10.3 | -18 | + |
| South Central II | 228 | 5.8 | 203 | 4.9 | -16 | + |
| South Central III | 241 | 5.7 | 180 | 4.3 | -25 | + |
| South Central IV | 80 | 2.0 | 106 | 2.4 | 20 | - |
| South Central V | 171 | 3.5 | 177 | 3.3 | -6 | + |
| Central I | 197 | 4.4 | 210 | 4.6 | 5 | - |
| Central II | 282 | 7.9 | 230 | 5.6 | -29 | + |
| **Hartford** | 954 | 16.2 | 1,157 | 21.0 | 30 | - |
| Capitol I | 162 | 4.1 | 355 | 8.7 | 112 | - |
| Capitol II | 93 | 1.9 | 114 | 2.2 | 16 | - |
| Capitol III | 195 | 3.4 | 227 | 3.7 | 9 | - |
| Capitol IV | 66 | 1.4 | 72 | 1.4 | 0 | 0 |
| Capitol V | 149 | 3.0 | 164 | 3.0 | 0 | 0 |
| Northeast | 211 | 4.2 | 244 | 4.6 | 10 | - |
| Southeast | 202 | 3.6 | 224 | 3.6 | 0 | 0 |
| Southeast Shore | 206 | 4.7 | 166 | 3.7 | -21 | + |
| **CONNECTICUT** | 5,931 | 4.7 | 6,152 | 4.6 | -2 | + |

= Worse than statewide rate

:e: Table data from the Connecticut State Department of Education, *Dropout Data Analysis on Public School Districts in Connecticut.* Text also includes inforrnation J.S. Bureau of the Census, *Statistical Abstract of the United States 1993*, Table 264; and Annie E. Casey Foundation, *KIDS COUNT Data Book*, 1997.

# Juvenile Violent Crime

Children under 18 make up one in five arrests for violent crimes in Connecticut. The vast majority of those youths arrested are boys. However, only a relatively small percentage of youths are violent. Less than one-half of one percent of juveniles in the U.S. are arrested for a violent offense in any given year.

Juvenile crime is somewhat different than adult crime. Violent crimes committed by juveniles peak at the close of the school day and decline throughout the evening hours. In contrast, violent crimes committed by adults increase steadily from early morning through midnight. Similarly, juveniles are more likely to commit crimes in groups than are adults.

Most homicides committed by youth are committed with a firearm, occur during an argument, and occur among people who know each other. Although teenage boys have always had fights, the consequences of the violence have become more extreme. Guns turn what might have been a fist fight thirty years ago into a homicide today. In 1995, 690 arrests of people under the age of 18 were made in Connecticut on weapons charges, mostly guns. This represents a decrease of 277 arrests compared with two years before.

Overall, children are disproportionately the victims of violent crime. In 1994, about a third of all victims of violent crimes were ages 12-19. Other youth are the most likely victims of crimes committed by young people; juvenile offenders account for nearly three-quarters of violent crimes against youth. The National Victimization Study shows that teenagers are more than twice as likely to be victims of all forms of crime than people age 20 or older, and more than three times as likely to be victims of violent crime than adults. Yet the vast majority of juvenile victimization is hidden from public view because only 30% of the crimes are reported to police.

Even children who are not direct victims of crime are still profoundly affected by it. Exposure to violence affects children's emotional stability, their ability to function in school, and their sense of hope about the future. A 1992 survey of sixth, eighth, and tenth grade students in New Haven found that over 40% had witnessed violence in the past year.

Note: Violent crimes include murder, rape, robbery and aggravated assault. Because of the large difference in the number of arrests each year, all five years' data are shown separately. The annual average number of arrests is a total for the two-year period divided by two. The annual average rate is the annual average number divided by the number of children age 10-17, multiplied by 100,000 to get a rate per 100,000 children of this age group. The number of children used to calculate the rates is based on applying the percentage of population age 10-17 for each region from the 1990 Census to the Connecticut Department of Health estimate of population by town for the years 1992 and 1995. The number of arrests of children for violent crimes includes arrests made by local and state police. Unfortunately, the data are not reported identically for these agencies. Approximately 85% of all juvenile arrests for violent crimes are made by local police, and these data are reported by the town in which the arrest was made. The 15% of arrests made by the state police are reported by the town in which the child lives. State police arrests are important to include because many rural regions do not have municipal police departments, and the majority of the arrests in these regions are made by the state police. Therefore, one should exercise caution when using this data because the total number of juvenile arrests for each region includes data from these two sources. Despite these limitations, given the limited mobility of children ages 10-17, police experts believe that these data are still valid.

## Juvenile Violent Crime Arrest Rate — 1991-95
## (per 100,000 children ages 10-17)

| REGION NAME | 1991 Number | 1992 Number | 1993 Number | 1994 Number | 1995 Number | 1991-1992 Annual Average Number | 1991-1992 Annual Average Rate | 1994-1995 Annual Average Number | 1994-1995 Annual Average Rate |
|---|---|---|---|---|---|---|---|---|---|
| Northwest | 15 | 17 | 51 | 21 | 26 | 16 | 93.6 | 24 | 137.1 |
| Housatonic Valley | 56 | 65 | 47 | 49 | 43 | 61 | 442.9 | 46 | 327.0 |
| **Stamford** | 77 | 61 | 56 | 65 | 58 | 69 | 805.0 | 62 | 701.4 |
| Southwest I | 7 | 6 | 14 | 6 | 11 | 7 | 67.7 | 9 | 86.7 |
| Southwest II | 18 | 124 | 127 | 26 | 45 | 71 | 674.5 | 36 | 339.8 |
| **Bridgeport** | 127 | 121 | 125 | 162 | 105 | 124 | 852.2 | 134 | 936.7 |
| Southwest III | 24 | 31 | 26 | 30 | 25 | 28 | 254.5 | 28 | 257.9 |
| Southwest IV | 29 | 26 | 16 | 7 | 3 | 28 | 267.2 | 5 | 47.3 |
| **Waterbury** | 56 | 40 | 47 | 39 | 51 | 48 | 480.8 | 45 | 448.9 |
| Naugatuck Valley | 11 | 20 | 36 | 23 | 24 | 16 | 141.0 | 24 | 208.8 |
| South Central I | 45 | 21 | 42 | 53 | 50 | 33 | 277.9 | 52 | 444.8 |
| **New Haven** | 262 | 205 | 187 | 233 | 235 | 234 | 1,986.2 | 234 | 2,055.9 |
| South Central II | 21 | 15 | 25 | 39 | 28 | 18 | 173.3 | 34 | 334.3 |
| South Central III | 4 | 17 | 9 | 13 | 32 | 11 | 114.7 | 23 | 240.5 |
| South Central IV | 11 | 7 | 11 | 8 | 10 | 9 | 91.3 | 9 | 90.6 |
| South Central V | 29 | 32 | 67 | 82 | 102 | 31 | 235.9 | 92 | 678.7 |
| Central I | 11 | 16 | 29 | 28 | 53 | 14 | 134.4 | 41 | 396.3 |
| Central II | 62 | 60 | 62 | 85 | 77 | 61 | 671.6 | 81 | 908.7 |
| **Hartford** | 201 | 158 | 151 | 188 | 194 | 180 | 1,146.2 | 191 | 1,254.7 |
| Capitol I | 33 | 28 | 46 | 63 | 58 | 31 | 364.1 | 61 | 729.1 |
| Capitol II | 40 | 31 | 50 | 70 | 46 | 36 | 309.8 | 58 | 509.7 |
| Capitol III | 32 | 35 | 34 | 40 | 62 | 34 | 243.2 | 51 | 368.6 |
| Capitol IV | 43 | 22 | 11 | 24 | 30 | 33 | 298.4 | 27 | 245.8 |
| Capitol V | 16 | 31 | 48 | 45 | 48 | 24 | 200.2 | 47 | 383.3 |
| Northeast | 30 | 55 | 52 | 37 | 47 | 43 | 385.3 | 42 | 372.0 |
| Southeast | 62 | 59 | 77 | 99 | 69 | 61 | 442.0 | 84 | 613.9 |
| Southeast Shore | 43 | 55 | 52 | 30 | 52 | 49 | 485.5 | 41 | 414.1 |
| **CONNECTICUT** | 1,365 | 1,358 | 1,498 | 1,565 | 1,584 | 1,362 | 437.0 | 1,575 | 506.4 |

▒ = Worse than statewide rate.

urces: Table data from the Connecticut Department of Public Safety, *Crime in Connecticut, 1991 - 1995 Annual Reports*, and unpublished data. Text also includes ormation from the U.S. Department of Justice, *Juvenile Offenders and Victims: A National Report*, 1995, and *Criminal Victimization in the United States*, 1994; Grove, ., et. al. "Silent Victims: Children Who Witness Violence." *Journal of the American Medical Association*, January 13, 1993; New Haven Public Schools, *New Haven blic Schools Social Development Project: 1991-92 Evaluation Report, (Report on the Social and Health Assessment)*, December 1992.

# Teen Deaths

The vast majority of teen deaths are caused by injury rather than disease. For teens age 15-19, unintentional injuries caused 45% of all deaths in 1995. In most regions of the state, these injuries are unintentional; they are mostly due to car crashes, the leading cause of deat This is not true, however, in Connecticut's three largest cities, where teen homicides are more than twice as likely as deaths from uninten tional injuries.

The risk of injury-related deaths increases with age — teens ages 15-19 are more likely to die of injuries than are children ages 1-14. Also, teen injury deaths are much more likely to be to teen boys than teen girls.

Homicide and suicide are the second and third single leading causes of death for 15-to-19-year-olds in our state. In 1995, 24 teenagers were homicide victims (the lowest number in five years), accounting for one-fifth of all deaths for this age group. Eleven teens committe suicide in 1995, also the lowest in five years.

**Teen Deaths (ages 15-19)**

| | Unint'l Injury | Homicide | Suicide | Other | Total |
|---|---|---|---|---|---|
| **1991** | 64 | 29 | 21 | 22 | 136 |
| **1992** | 47 | 33 | 12 | 24 | 116 |
| **1993** | 52 | 34 | 14 | 38 | 138 |
| **1994** | 55 | 40 | 19 | 29 | 143 |
| **1995** | 57 | 24 | 11 | 33 | 125 |
| **Total** | 275 | 160 | 77 | 146 | 658 |

Young males are more likely to be victims of homicide than females. Girls are more likely to attempt suicide than boys, but boys are mor likely to be successful in their suicide attempts.

Note: Because of the small number of teen deaths in any given year, the chart shows only five-year total numbers of deaths by cause, not an annual average as in the other or the same reason, rates could not be calculated by region, and therefore this data is not shown on the regional pages.

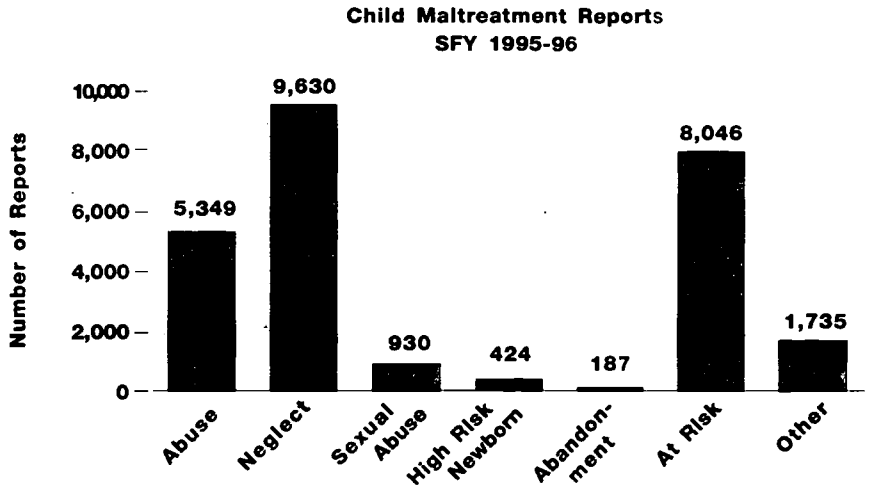
## Teen Deaths by Cause — 1991-1995
## (ages 15 - 19)

| REGION NAME | 1991-1995 Five-Year Total | | | | |
|---|---|---|---|---|---|
| | Unintentional Injury | Suicide | Homicide | All Other Causes | Total Deaths |
| Northwest | 9 | 5 | 2 | 8 | 24 |
| Housatonic Valley | 10 | 2 | 2 | 6 | 20 |
| **Stamford** | 2 | 4 | 4 | 3 | 13 |
| Southwest I | 7 | 5 | 2 | 2 | 16 |
| Southwest II | 5 | 1 | 5 | 2 | 13 |
| **Bridgeport** | 10 | 5 | 48 | 7 | 70 |
| Southwest III | 11 | 3 | 2 | 9 | 25 |
| Southwest IV | 10 | 6 | 0 | 5 | 21 |
| **Waterbury** | 10 | 1 | 11 | 6 | 28 |
| Naugatuck Valley | 10 | 2 | 0 | 4 | 16 |
| South Central I | 12 | 5 | 1 | 4 | 22 |
| **New Haven** | 12 | 5 | 36 | 4 | 57 |
| South Central II | 12 | 1 | 1 | 5 | 19 |
| South Central III | 6 | 3 | 2 | 6 | 17 |
| South Central IV | 11 | 1 | 0 | 5 | 17 |
| South Central V | 9 | 2 | 2 | 4 | 17 |
| Central I | 18 | 2 | 2 | 6 | 28 |
| Central II | 8 | 2 | 7 | 4 | 21 |
| **Hartford** | 13 | 1 | 23 | 20 | 57 |
| Capitol I | 9 | 3 | 1 | 2 | 15 |
| Capitol II | 7 | 2 | 0 | 2 | 11 |
| Capitol III | 12 | 1 | 2 | 4 | 19 |
| Capitol IV | 9 | 1 | 1 | 1 | 12 |
| Capitol V | 13 | 1 | 1 | 4 | 19 |
| Northeast | 19 | 1 | 0 | 5 | 25 |
| Southeast | 11 | 7 | 1 | 8 | 27 |
| Southeast Shore | 10 | 5 | 4 | 10 | 29 |
| **CONNECTICUT** | 275 | 77 | 160 | 146 | 658 |

ırces: Table data from the Department of Public Health, unpublished data, and *Registration Reports*, 1991. Text also includes information from the Department of Public ılth, Connecticut Health Check, school year 1993-94.

# Child Abuse

Child abuse occurs in all socioeconomic groups and in all types of families. No town in Connecticut is left untouched. The number of children who are abused is considered to be substantially higher than the numbers which are reported to the authorities. In Connecticut, 4.3% of all children are found to be abused or neglected, yet officials estimate between 8% and 10% of all children may be seriously maltreated.




People who are victims of child abuse or neglect are more likely than other adolescents or adults to get into trouble later in life. Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 53%, as an adult by 38%, and for a violent crime by 38%. Research also suggests that the long-term consequences of childhood abuse include poor educational performance, health problems, and low levels of achievement in adult life. Although most people who were abused as children do not grow up to abuse their own children, one characteristic that abusers have been found to share is a history of abuse in their own childhoods.

Note: The table to the right shows the number of children who were confirmed as abused or neglected, meaning that their case was reported to DCF, investigated, and evidence of maltreatment found, although if children were substantiated as abused twice in one year they have been counted twice. Even so, the number of children who are abused or neglected is higher than the numbers shown here — not every case of child abuse is reported, and sometimes those that are reported are not substantiated. The rate is the total number of children who were abused between July 1, 1995 and June 30, 1996, divided by the total number of children ages 1-18 in 1995, then multiplied by 100 to get a percentage. The number of children used to calculate the rates is based on applying the percentage of population under 18 for each region from the 1990 Census to the Connecticut Department of Public Health estimate of population by town for 1995.

## Children Confirmed as Abused/Neglected
## SFY 1994-95 and 1995-96

| REGION NAME | 1994-95 Number | 1994-95 Percent | 1995-96 Number | 1995-96 Percent | % Change in Rate 1995-96 | Better or Worse |
|---|---|---|---|---|---|---|
| Northwest | 1,007 | 2.4 | 990 | 2.4 | 0 | 0 |
| Housatonic Valley | 1,051 | 3.2 | 1,150 | 3.5 | 9 | - |
| **Stamford** | 421 | 1.9 | 357 | 1.6 | -16 | + |
| Southwest I | 106 | 0.5 | 67 | 0.3 | -40 | + |
| Southwest II | 368 | 1.4 | 564 | 2.2 | 57 | - |
| **Bridgeport** | 1,460 | 4.1 | 1,769 | 5.0 | 22 | - |
| Southwest III | 287 | 1.1 | 403 | 1.6 | 45 | - |
| Southwest IV | 180 | 0.7 | 229 | 0.9 | 29 | - |
| **Waterbury** | 1,218 | 4.8 | 1,547 | 6.1 | 27 | - |
| Naugatuck Valley | 352 | 1.3 | 377 | 1.4 | 8 | - |
| South Central I | 814 | 2.9 | 1,010 | 3.6 | 24 | - |
| **New Haven** | 3,164 | 10.7 | 3,408 | 11.6 | 8 | - |
| South Central II | 879 | 3.6 | 1,026 | 4.2 | 17 | - |
| **Waterbury** | 1,218 | 4.8 | 1,547 | 6.1 | 27 | - |
| South Central IV | 681 | 3.0 | 608 | 2.6 | -13 | + |
| South Central V | 1,105 | 3.4 | 1,041 | 3.2 | -6 | + |
| Central I | 954 | 3.9 | 1,341 | 5.5 | 41 | - |
| Central II | 1,328 | 5.8 | 2,132 | 9.4 | 62 | - |
| **Hartford** | 3,724 | 10.0 | 5,065 | 13.6 | 36 | - |
| Capitol I | 1,014 | 5.0 | 1,011 | 4.9 | -2 | + |
| Capitol II | 384 | 1.5 | 646 | 2.6 | 73 | - |
| Capitol III | 674 | 2.0 | 765 | 2.3 | 15 | - |
| Capitol IV | 316 | 1.2 | 493 | 1.9 | 58 | - |
| Capitol V | 793 | 2.7 | 809 | 2.7 | 0 | 0 |
| Northeast | 1,928 | 7.2 | 1,884 | 7.0 | -3 | + |
| Southeast | 1,321 | 4.1 | 1,197 | 3.7 | -10 | + |
| Southeast Shore | 1,236 | 4.7 | 1,155 | 4.4 | -6 | + |
| **CONNECTICUT** | 27,726 | 3.7 | 32,147 | 4.3 | 16 | - |

**Bold** = Worse than statewide rate.

Sources: Table data from the Department of Children and Families. Text also includes information from the Children's Division of the American Humane Association, *Child Protection Leader*, March 1994; Department of Children and Families, *Strategic Plan 1993-1998: Caring for Connecticut's Future*, 1993; National Institute of Justice, *The Cycle of Violence*, September 1992; and National Center on Child Abuse and Neglect, *National Child Abuse and Neglect Data System (NCANDS)*.

# Regional Indicators

Northwest
Housatonic Valley
Stamford
Southwest I
Southwest II
Bridgeport
Southwest III
Southwest IV
Waterbury
Naugatuck Valley
South Central I
New Haven
South Central II
South Central III
South Central IV
South Central V
Central I
Central II
Hartford
Capitol I
Capitol II
Capitol III
Capitol IV
Capitol V
Northeast
Southeast
Southeast Shore

# Northwest

Barkhamstead
Bethlehem
Bridgewater
Canaan
Colebrook
Cornwall
Goshen
Harwinton
Kent
Litchfield
Morris
New Hartford
New Milford
Norfolk
North Canaan
Plymouth
Roxbury
Salisbury
Sharon
Thomaston
Torrington
Warren
Washington
Watertown
Winchester
Woodbury

| | |
|---|---|
| Total Number of Children | 40,719 |
| Percent of Total Population | 23.1 |
| Per Capita Income | $19,971 |
| Child Poverty | 4.2% |
| Living With Two Parents | 80.9% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 97.0% |
| Black | 1.2% |
| Other Races | 1.9% |
| Hispanic (may be of any race) | 1.5% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 1,974 | 4.7 | | 14.5 | 68% |
| **Low Birthweight** per 1,000 births, 1995 | 119 | 60.0 | | 71.0 | 15% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 11 | 5.1 | | 7.4 | 31% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 178 | 8.9 | | 11.9 | 25% |
| **Births to Teen Mothers** percent of all births, 1995 | 114 | 5.7 | | 8.6 | 34% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 8 | 25.1 | 1% | 24.8 | |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 263 | 14.7 | | 12.3 | 20% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 560 | 31.3 | | 37.9 | 17% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 287 | 3.8 | | 4.6 | 17% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 24 | 137.1 | | 506.4 | 73% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 990 | 2.4 | | 4.3 | 44% |

# Housatonic Valley

| | |
|---|---|
| Total Number of Children | 31,826 |
| Percent of Total Population | 23.8 |
| Per Capita Income | $22,919 |
| Child Poverty | 4.4% |
| Living With Two Parents | 82.0% |

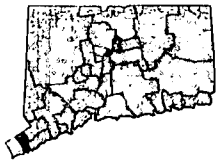
Bethel
Brookfield
Danbury
New Fairfield
Ridgefield
Sherman

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 90.1% |
| Black | 4.1% |
| Other Races | 5.9% |
| Hispanic (may be of any race) | 5.5% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 2,143 | 6.5 | | 14.5 | 55% |
| **Low Birthweight** per 1,000 births, 1995 | 111 | 54.8 | | 71.0 | 23% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 12 | 5.8 | | 7.4 | 22% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 115 | 5.7 | | 11.9 | 52% |
| **Births to Teen Mothers** percent of all births, 1995 | 118 | 5.8 | | 8.6 | 33% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 5 | 19.8 | | 24.8 | 20% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 267 | 19.1 | | 12.3 | 55% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 396 | 28.3 | | 37.9 | 25% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 177 | 2.9 | | 4.6 | 37% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 46 | 327.0 | | 506.4 | 35% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,150 | 3.5 | | 4.3 | 19% |

# Stamford



| | |
|---|---|
| Total Number of Children | 21,773 |
| Percent of Total Population | 20.1 |
| Per Capita Income | $27,092 |
| Child Poverty | 9.9% |
| Living With Two Parents | 67.9% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 64.9% |
| Black | 27.1% |
| Other Races | 7.9% |
| Hispanic (may be of any race) | 12.8% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 3,035 | 13.6 | | 14.5 | 6% |
| **Low Birthweight** per 1,000 births, 1995 | 132 | 75.3 | 6% | 71.0 | |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 10 | 5.2 | | 7.4 | 30% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 320 | 18.6 | 56% | 11.9 | |
| **Births to Teen Mothers** percent of all births, 1995 | 112 | 6.2 | | 8.6 | 28% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 4 | 21.1 | | 24.8 | 15% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 49 | 7.0 | 43% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 376 | 53.8 | 42% | 37.9 | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 81 | 2.1 | | 4.6 | 54% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 62 | 701.4 | 39% | 506.4 | |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 357 | 1.6 | | 4.3 | 63% |

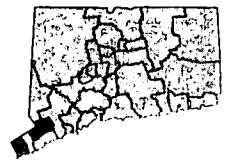
# Southwest I

| | |
|---|---|
| Total Number of Children | 22,217 |
| Percent of Total Population | 22.0 |
| Per Capita Income | $46,670 |
| Child Poverty | 2.5% |
| Living With Two Parents | 86.6% |

Children's Racial/Ethnic Background

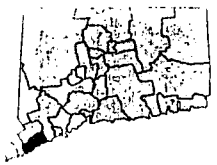
| | |
|---|---|
| White | 93.1% |
| Black | 1.9% |
| Other Races | 5.0% |
| Hispanic (may be of any race) | 3.6% |

Greenwich
New Canaan
Weston
Wilton



| Indicator | Region No. | Region Rate | Worse Than State Rate (100% 75% 50% 25% 0) | State Rate | Better Than State Rate (0 25% 50% 75% 100%) |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 301 | 1.3 | | 14.5 | 91% |
| **Low Birthweight** per 1,000 births, 1995 | 70 | 55.6 | | 71.0 | 22% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 4 | 3.2 | | 7.4 | 57% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 54 | 5.1 | | 11.9 | 57% |
| **Births to Teen Mothers** percent of all births, 1995 | 5 | 0.4 | | 8.6 | 95% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 4 | 23.2 | | 24.8 | 6% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 244 | 25.4 | | 12.3 | 107% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 180 | 18.8 | | 37.9 | 50% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 69 | 1.7 | | 4.6 | 63% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 9 | 86.7 | | 506.4 | 83% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 67 | 0.3 | | 4.3 | 93% |

# Southwest II



Darien
Norwalk
Westport

| | |
|---|---|
| Total Number of Children | 25,128 |
| Percent of Total Population | 20.8 |
| Per Capita Income | $31,966 |
| Child Poverty | 6.1% |
| Living With Two Parents | 76.0% |

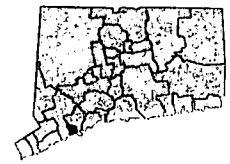
Children's Racial/Ethnic Background

| | |
|---|---|
| White | 80.2% |
| Black | 13.9% |
| Other Races | 6.0% |
| Hispanic (may be of any race) | 9.8% |

| Indicator | Region No. | Region Rate | State Rate | Worse Than State Rate / Better Than State Rate |
|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 2,347 | 9.2 | 14.5 | 37% |
| **Low Birthweight** per 1,000 births, 1995 | 128 | 65.7 | 71.0 | 7% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 11 | 5.7 | 7.4 | 23% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 238 | 13.8 | 11.9 | 16% |
| **Births to Teen Mothers** percent of all births, 1995 | 93 | 4.6 | 8.6 | 47% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 3 | 15.1 | 24.8 | 39% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 156 | 15.3 | 12.3 | 24% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 363 | 35.6 | 37.9 | 6% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 160 | 3.6 | 4.6 | 22% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 36 | 339.8 | 506.4 | 33% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 564 | 2.2 | 4.3 | 49% |

# Bridgeport

| | |
|---|---|
| Total Number of Children | 36,992 |
| Percent of Total Population | 26.1 |
| Per Capita Income | $13,156 |
| Child Poverty | 29.0% |
| Living With Two Parents | 47.0% |



Children's Racial/Ethnic Background

| | |
|---|---|
| White | 45.0% |
| Black | 34.1% |
| Other Races | 20.9% |
| Hispanic (may be of any race) | 38.2% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 13,684 | 38.3 | 164% | 14.5 | |
| **Low Birthweight** per 1,000 births, 1995 | 202 | 89.5 | 26% | 71.0 | |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 28 | 11.8 | 59% | 7.4 | |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 354 | 17.4 | 46% | 11.9 | |
| **Births to Teen Mothers** percent of all births, 1995 | 428 | 18.9 | 120% | 8.6 | |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 12 | 43.2 | 74% | 24.8 | |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 15 | 1.4 | 89% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 803 | 75.8 | 100% | 37.9 | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 303 | 6.1 | 33% | 4.6 | |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 134 | 936.7 | 85% | 506.4 | |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,769 | 5.0 | 16% | 4.3 | |

# Southwest III

Shelton
Stratford

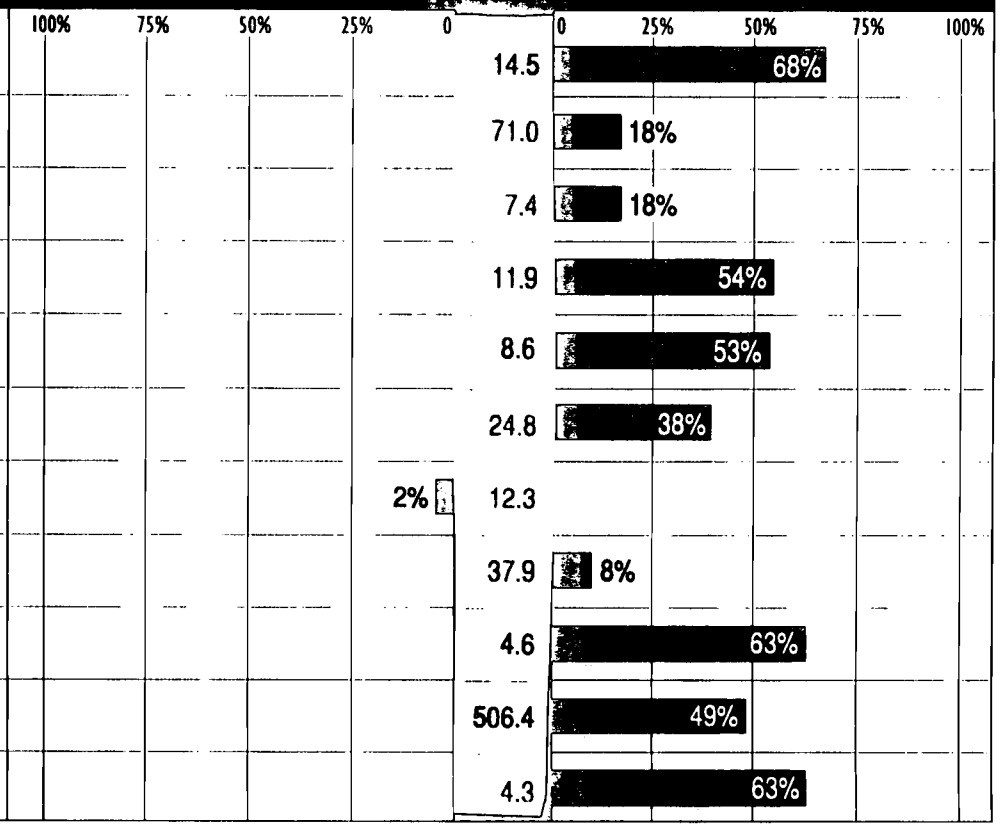
Trumbull

| | |
|---|---|
| Total Number of Children | 25,325 |
| Percent of Total Population | 21.7 |
| Per Capita Income | $20,855 |
| Child Poverty | 3.3% |
| Living With Two Parents | 81.8% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 91.0% |
| Black | 5.8% |
| Other Races | 3.2% |
| Hispanic (may be of any race) | 4.0% |

| Indicator | Region No. | Region Rate | State Rate |
|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 1,167 | 4.7 | 14.5 |
| **Low Birthweight** per 1,000 births, 1995 | 75 | 57.6 | 71.0 |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 8 | 6.1 | 7.4 |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 70 | 5.5 | 11.9 |
| **Births to Teen Mothers** percent of all births, 1995 | 52 | 4.0 | 8.6 |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 3 | 15.3 | 24.8 |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 140 | 12.0 | 12.3 |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 407 | 34.9 | 37.9 |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 79 | 1.7 | 4.6 |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 28 | 257.9 | 506.4 |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 403 | 1.6 | 4.3 |



# Southwest IV

| | |
|---|---|
| Total Number of Children | 23,864 |
| Percent of Total Population | 22.7 |
| Per Capita Income | $26,388 |
| Child Poverty | 2.4% |
| Living With Two Parents | 86.9% |

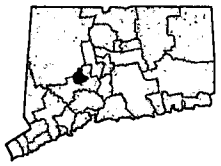
Easton
Fairfield
Monroe
Newtown
Redding

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 96.6% |
| Black | 1.0% |
| Other Races | 2.4% |
| Hispanic (may be of any race) | 2.4% |

| Indicator | Region No. | Region Rate | Worse Than State Rate (100% 75% 50% 25% 0) | State Rate | Better Than State Rate (0 25% 50% 75% 100%) |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 346 | 1.4 | | 14.5 | 90% |
| **Low Birthweight** per 1,000 births, 1995 | 66 | 46.0 | | 71.0 | 35% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 6 | 4.1 | | 7.4 | 45% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 44 | 3.5 | | 11.9 | 71% |
| **Births to Teen Mothers** percent of all births, 1995 | 15 | 1.0 | | 8.6 | 88% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 3 | 15.9 | | 24.8 | 36% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 190 | 18.3 | | 12.3 | 49% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 211 | 20.3 | | 37.9 | 46% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 46 | 1.0 | | 4.6 | 78% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 5 | 47.3 | | 506.4 | 91% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 229 | 0.9 | | 4.3 | 79% |

# Waterbury



| | |
|---|---|
| Total Number of Children | 25,561 |
| Percent of Total Population | 23.5 |
| Per Capita Income | $14,209 |
| Child Poverty | 20.6% |
| Living With Two Parents | 59.5% |

Children's Racial/Ethnic Background

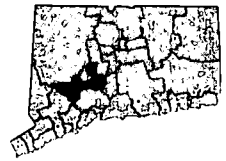
| | |
|---|---|
| White | 69.3% |
| Black | 18.1% |
| Other Races | 12.6% |
| Hispanic (may be of any race) | 22.6% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 8,327 | 33.0 | 128% | 14.5 | |
| **Low Birthweight** per 1,000 births, 1995 | 190 | 108.3 | 53% | 71.0 | |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 15 | 8.2 | 11% | 7.4 | |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 531 | 31.3 | 163% | 11.9 | |
| **Births to Teen Mothers** percent of all births, 1995 | 283 | 16.1 | 87% | 8.6 | |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 9 | 44.9 | 81% | 24.8 | |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 10 | 1.5 | 88% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 459 | 70.5 | 86% | 37.9 | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 449 | 13.1 | 185% | 4.6 | |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 45 | 448.9 | | 506.4 | 11% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,547 | 6.1 | 42% | 4.3 | |

# Naugatuck Valley

| | |
|---|---|
| Total Number of Children | 26,146 |
| Percent of Total Population | 24.1 |
| Per Capita Income | $20,010 |
| Child Poverty | 2.8% |
| Living With Two Parents | 84.5% |

Cheshire
Middlebury
Naugatuck
Oxford
Prospect
Southbury
Wolcott



Children's Racial/Ethnic Background

| | |
|---|---|
| White | 96.0% |
| Black | 1.7% |
| Other Races | 2.3% |
| Hispanic (may be of any race) | 2.4% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 958 | 3.6 | | 14.5 | 75% |
| **Low Birthweight** per 1,000 births, 1995 | 68 | 55.0 | | 71.0 | 23% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 7 | 5.7 | | 7.4 | 23% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 134 | 11.0 | | 11.9 | 8% |
| **Births to Teen Mothers** percent of all births, 1995 | 45 | 3.6 | | 8.6 | 58% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 4 | 19.1 | | 24.8 | 23% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 138 | 11.3 | 8% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 371 | 30.4 | | 37.9 | 20% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 80 | 1.8 | | 4.6 | 61% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 24 | 208.8 | | 506.4 | 59% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 377 | 1.4 | | 4.3 | 67% |

# South Central I

Ansonia
Beacon Falls
Bethany
Derby
Hamden
North Haven
Seymour
Woodbridge

| | |
|---|---|
| Total Number of Children | 28,721 |
| Percent of Total Population | 20.9 |
| Per Capita Income | $19,855 |
| Child Poverty | 5.6% |
| Living With Two Parents | 79.4% |

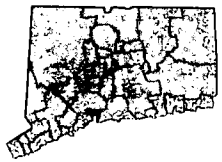
Children's Racial/Ethnic Background

| | |
|---|---|
| White | 89.7% |
| Black | 7.0% |
| Other Races | 3.2% |
| Hispanic (may be of any race) | 2.9% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 2,347 | 8.3 | | 14.5 | 43% |
| **Low Birthweight** per 1,000 births, 1995 | 101 | 62.2 | | 71.0 | 12% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 9 | 5.4 | | 7.4 | 27% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 138 | 8.8 | | 11.9 | 26% |
| **Births to Teen Mothers** percent of all births, 1995 | 85 | 5.2 | | 8.6 | 40% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 5 | 22.4 | | 24.8 | 10% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 104 | 9.5 | 23% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 436 | 39.7 | 5% | 37.9 | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 171 | 2.7 | | 4.6 | 41% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 52 | 448.8 | | 506.4 | 12% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,010 | 3.6 | | 4.3 | 16% |

# New Haven

| | |
|---|---|
| Total Number of Children | 30,936 |
| Percent of Total Population | 23.7 |
| Per Capita Income | $12,968 |
| Child Poverty | 33.8% |
| Living With Two Parents | 38.6% |



Children's Racial/Ethnic Background

| | |
|---|---|
| White | 34.0% |
| Black | 51.6% |
| Other Races | 14.3% |
| Hispanic (may be of any race) | 21.6% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 13,711 | 46.8 | 223% | 14.5 | |
| **Low Birthweight** per 1,000 births, 1995 | 201 | 108.6 | 53% | 71.0 | |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 23 | 11.8 | 59% | 7.4 | |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 367 | 22.3 | 87% | 11.9 | |
| **Births to Teen Mothers** percent of all births, 1995 | 320 | 17.3 | 101% | 8.6 | |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 10 | 43.3 | 75% | 24.8 | |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 13 | 1.6 | 87% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 663 | 79.1 | 109% | 37.9 | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 421 | 10.3 | 124% | 4.6 | |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 234 | 2,055.9 | 306% | 506.4 | |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 3,408 | 11.6 | 170% | 4.3 | |

# South Central II

Milford
Orange

West Haven

| | |
|---|---|
| Total Number of Children | 25,131 |
| Percent of Total Population | 21.5 |
| Per Capita Income | $18,430 |
| Child Poverty | 5.8% |
| Living With Two Parents | 75.4% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 87.7% |
| Black | 8.9% |
| Other Races | 3.4% |
| Hispanic (may be of any race) | 3.9% |

| Indicator | Region No. | Region Rate | State Rate | Worse Than State Rate / Better Than State Rate |
|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 2,882 | 11.8 | 14.5 | 19% |
| **Low Birthweight** per 1,000 births, 1995 | 86 | 61.5 | 71.0 | 13% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 12 | 8.4 | 7.4 | 14% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 117 | 8.5 | 11.9 | 29% |
| **Births to Teen Mothers** percent of all births, 1995 | 89 | 6.3 | 8.6 | 27% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 4 | 18.9 | 24.8 | 24% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 89 | 9.3 | 12.3 | 24% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 397 | 41.5 | 37.9 | 9% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 203 | 4.9 | 4.6 | 7% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 34 | 334.3 | 506.4 | 34% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,026 | 4.2 | 4.3 | 2% |

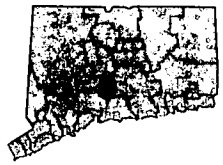
# South Central III

| | |
|---|---|
| Total Number of Children | 23,517 |
| Percent of Total Population | 23.4 |
| Per Capita Income | $16,684 |
| Child Poverty | 8.6% |
| Living With Two Parents | 73.7% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 88.6% |
| Black | 4.3% |
| Other Races | 7.1% |
| Hispanic (may be of any race) | 14.9% |

Meriden
Wallingford



| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 4,012 | 17.1 | 18% | 14.5 | |
| **Low Birthweight** per 1,000 births, 1995 | 78 | 54.9 | | 71.0 | 23% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 10 | 6.7 | | 7.4 | 9% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 221 | 15.2 | 28% | 11.9 | |
| **Births to Teen Mothers** percent of all births, 1995 | 150 | 10.6 | 23% | 8.6 | |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 6 | 30.4 | 23% | 24.8 | |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 54 | 6.4 | 48% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 351 | 41.3 | 9% | 37.9 | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 180 | 4.3 | | 4.6 | 7% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 23 | 240.5 | | 506.4 | 53% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,103 | 4.7 | 9% | 4.3 | |

# South Central IV

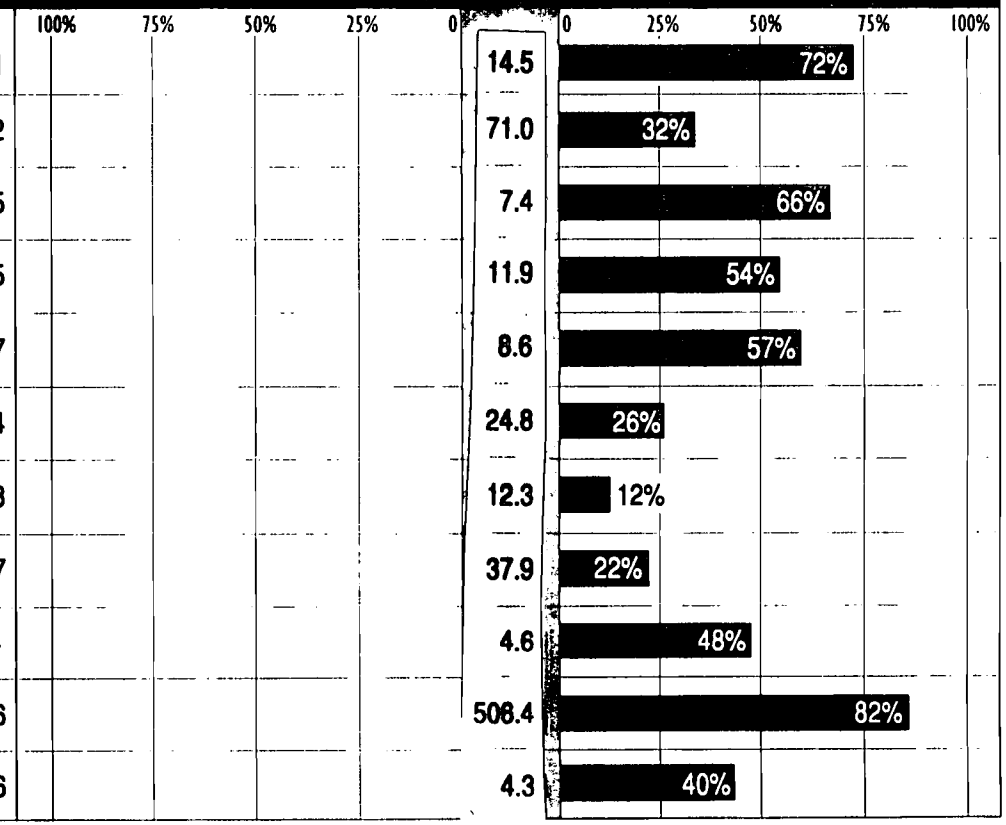
Branford
East Haven
Guilford
Madison
North Branford

| | |
|---|---|
| Total Number of Children | 22,606 |
| Percent of Total Population | 22.1 |
| Per Capita Income | $22,021 |
| Child Poverty | 2.9% |
| Living With Two Parents | 82.2% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 97.2% |
| Black | 1.0% |
| Other Races | 1.8% |
| Hispanic (may be of any race) | 1.9% |

| Indicator | Region No. | Region Rate | State Rate |
|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 950 | 4.1 | 14.5 |
| **Low Birthweight** per 1,000 births, 1995 | 63 | 48.2 | 71.0 |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 3 | 2.5 | 7.4 |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 69 | 5.5 | 11.9 |
| **Births to Teen Mothers** percent of all births, 1995 | 49 | 3.7 | 8.6 |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 3 | 18.4 | 24.8 |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 147 | 13.8 | 12.3 |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 317 | 29.7 | 37.9 |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 106 | 2.4 | 4.6 |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 9 | 90.6 | 508.4 |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 608 | 2.6 | 4.3 |

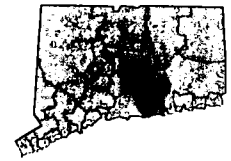


# South Central V

Total Number of Children ..... 31,401
Percent of Total Population ..... 21.9
Per Capita Income ..... $19,660
Child Poverty ..... 5.6%
Living With Two Parents ..... 77.2%

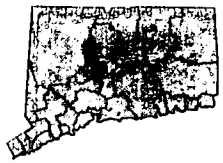
Children's Racial/Ethnic Background
White ..... 90.8%
Black ..... 6.4%
Other Races ..... 2.8%
Hispanic (may be of any race) ..... 3.4%

Chester
Clinton
Cromwell
Deep River
Durham
East Haddam
East Hampton
Essex
Haddam
Killingworth
Middlefield
Middletown
Old Saybrook
Portland



| Indicator | Region No. | Region Rate | State Rate | Worse Than State Rate / Better Than State Rate |
|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 2,040 | 6.3 | 14.5 | 57% |
| **Low Birthweight** per 1,000 births, 1995 | 112 | 59.2 | 71.0 | 17% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 15 | 7.4 | 7.4 | 0% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 195 | 10.2 | 11.9 | 14% |
| **Births to Teen Mothers** percent of all births, 1995 | 82 | 4.3 | 8.6 | 50% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 5 | 18.5 | 24.8 | 25% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 172 | 14.5 | 12.3 | 18% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 361 | 30.3 | 37.9 | 20% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 177 | 3.3 | 4.6 | 28% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 92 | 678.7 | 506.4 | 34% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,041 | 3.2 | 4.3 | 26% |

# Central I



Bristol
Burlington
Southington

| | |
|---|---|
| Total Number of Children | 24,524 |
| Percent of Total Population | 23.1 |
| Per Capita Income | $18,747 |
| Child Poverty | 4.3% |
| Living With Two Parents | 80.2% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 95.5% |
| Black | 2.2% |
| Other Races | 2.3% |
| Hispanic (may be of any race) | 3.2% |

| Indicator | Region No. | Region Rate | Worse Than State Rate (100% 75% 50% 25% 0) | State Rate | Better Than State Rate (0 25% 50% 75% 100%) |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 2,025 | 8.3 | | 14.5 | 43% |
| **Low Birthweight** per 1,000 births, 1995 | 79 | 60.3 | | 71.0 | 15% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 5 | 4.0 | | 7.4 | 46% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 91 | 8.1 | | 11.9 | 32% |
| **Births to Teen Mothers** percent of all births, 1995 | 102 | 7.8 | | 8.6 | 9% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 4 | 20.6 | | 24.8 | 17% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 124 | 11.9 | 3% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 336 | 32.2 | | 37.9 | 15% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 210 | 4.6 | | 4.6 | 0% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 41 | 396.3 | | 506.4 | 22% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,341 | 5.5 | 28% | 4.3 | |

# Central II

| | |
|---|---|
| Total Number of Children | 23,375 |
| Percent of Total Population | 21.3 |
| Per Capita Income | $15,916 |
| Child Poverty | 18.3% |
| Living With Two Parents | 64.9% |

Berlin
New Britain
Plainville

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 76.6% |
| Black | 8.3% |
| Other Races | 15.0% |
| Hispanic (may be of any race) | 22.3% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 6,086 | 27.0 | 86% | 14.5 | |
| **Low Birthweight** per 1,000 births, 1995 | 124 | 89.9 | 27% | 71.0 | |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 10 | 6.9 | | 7.4 | 7% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 195 | 14.8 | 24% | 11.9 | |
| **Births to Teen Mothers** percent of all births, 1995 | 186 | 13.5 | 57% | 8.6 | |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 6 | 31.4 | 27% | 24.8 | |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 69 | 8.3 | 33% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 389 | 46.6 | 23% | 37.9 | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 230 | 5.6 | 22% | 4.6 | |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 81 | 908.7 | 79% | 506.4 | |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 2,132 | 9.4 | 119% | 4.3 | |

# Hartford

| | |
|---|---|
| Total Number of Children | 38,390 |
| Percent of Total Population | 27.5 |
| Per Capita Income | $11,081 |
| Child Poverty | 43.6% |
| Living With Two Parents | 30.3% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 24.7% |
| Black | 44.2% |
| Other Races | 31.1% |
| Hispanic (may be of any race) | 46.7% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 21,549 | 57.8 | 299% | 14.5 | |
| **Low Birthweight** per 1,000 births, 1995 | 309 | 133.9 | 89% | 71.0 | |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 42 | 16.3 | 120% | 7.4 | |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 362 | 17.5 | 47% | 11.9 | |
| **Births to Teen Mothers** percent of all births, 1995 | 598 | 25.9 | 201% | 8.6 | |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 16 | 52.7 | 113% | 24.8 | |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 7 | 0.7 | 94% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 830 | 82.6 | 118% | 37.9 | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 1,157 | 21.0 | 357% | 4.6 | |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 191 | 1,254.7 | 148% | 506.4 | |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 5,065 | 13.6 | 216% | 4.3 | |

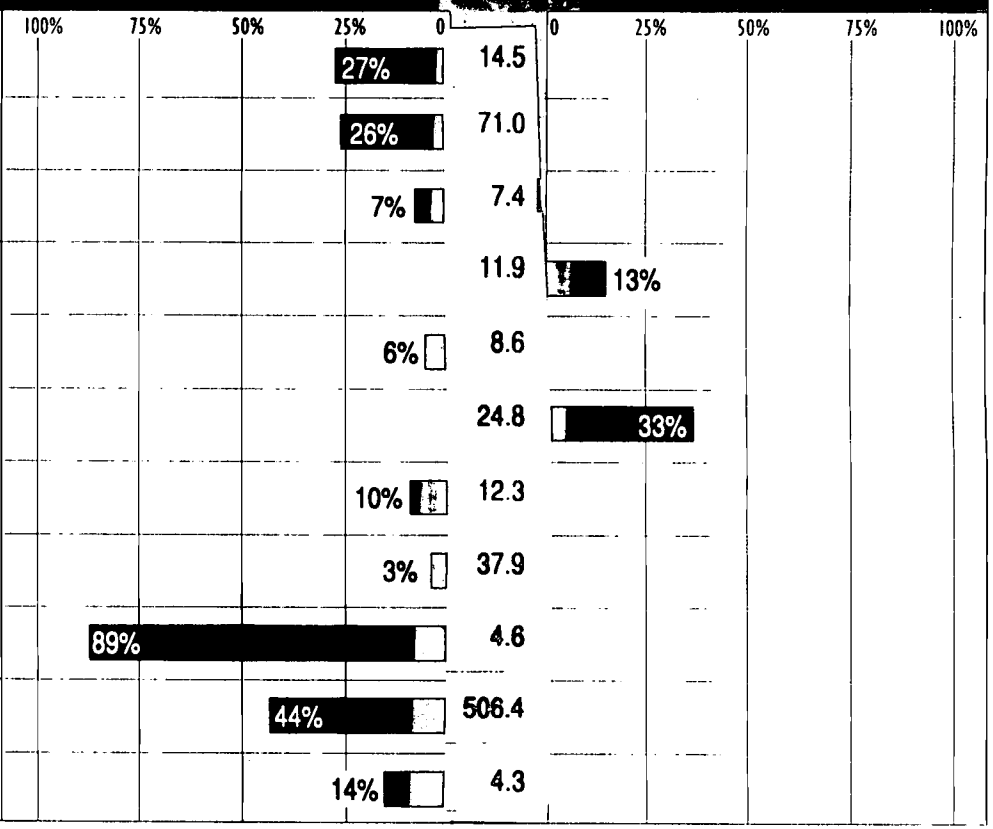
# Capitol I

Total Number of Children ..... 20,992
Percent of Total Population ..... 20.6
Per Capita Income ..... $17,627
Child Poverty ..... 6.5%
Living With Two Parents ..... 70.8%

Children's Racial/Ethnic Background
White ..... 84.4%
Black ..... 9.9%
Other Races ..... 5.7%
Hispanic (may be of any race) ..... 6.7%

East Hartford
Manchester

| Indicator | Region No. | Region Rate | State Rate |
|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 3,763 | 18.4 | 14.5 |
| **Low Birthweight** per 1,000 births, 1995 | 125 | 89.6 | 71.0 |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 11 | 7.9 | 7.4 |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 135 | 10.4 | 11.9 |
| **Births to Teen Mothers** percent of all births, 1995 | 127 | 9.1 | 8.6 |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 3 | 16.7 | 24.8 |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 86 | 11.1 | 12.3 |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 300 | 38.9 | 37.9 |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 355 | 8.7 | 4.6 |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 61 | 729.1 | 506.4 |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,011 | 4.9 | 4.3 |



# Capitol II

Avon
Bloomfield
Canton
Simsbury
West Hartford

| | |
|---|---|
| Total Number of Children | 25,984 |
| Percent of Total Population | 21.0 |
| Per Capita Income | $27,077 |
| Child Poverty | 2.6% |
| Living With Two Parents | 83.3% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 85.2% |
| Black | 10.4% |
| Other Races | 4.4% |
| Hispanic (may be of any race) | 3.6% |

| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 1,357 | 5.4 | | 14.5 | 63% |
| **Low Birthweight** per 1,000 births, 1995 | 106 | 73.2 | 3% | 71.0 | |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 15 | 10.3 | 39% | 7.4 | |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 60 | 4.5 | | 11.9 | 62% |
| **Births to Teen Mothers** percent of all births, 1995 | 66 | 4.6 | | 8.6 | 47% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 3 | 13.0 | | 24.8 | 46% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 331 | 27.0 | | 12.3 | 120% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 289 | 23.6 | | 37.9 | 38% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 114 | 2.2 | | 4.6 | 52% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 58 | 509.7 | 1% | 506.4 | |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 646 | 2.6 | | 4.3 | 40% |

# Capitol III

| | |
|---|---|
| Total Number of Children | 33,495 |
| Percent of Total Population | 23.1 |
| Per Capita Income | $19,233 |
| Child Poverty | 2.3% |
| Living With Two Parents | 81.9% |

East Granby
East Windsor
Enfield
Granby
Hartland
South Windsor
Suffield
Windsor
Windsor Locks

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 91.0% |
| Black | 5.7% |
| Other Races | 3.3% |
| Hispanic (may be of any race) | 2.6% |

| Indicator | Region No. | Region Rate | State Rate | Worse Than State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 1,605 | 4.8 | 14.5 | | 67% |
| **Low Birthweight** per 1,000 births, 1995 | 105 | 57.1 | 71.0 | | 20% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 15 | 8.4 | 7.4 | 14% | |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 104 | 6.0 | 11.9 | | 50% |
| **Births to Teen Mothers** percent of all births, 1995 | 97 | 5.3 | 8.6 | | 38% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 5 | 18.8 | 24.8 | | 24% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 198 | 13.6 | 12.3 | | 11% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 428 | 29.4 | 37.9 | | 22% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 227 | 3.7 | 4.6 | | 20% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 51 | 368.6 | 506.4 | | 27% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 765 | 2.3 | 4.3 | | 47% |

# Capitol IV

Farmington
Glastonbury
Marlborough
Newington
Rocky Hill
Wethersfield

| | |
|---|---|
| Total Number of Children | 25,583 |
| Percent of Total Population | 20.4 |
| Per Capita Income | $23,426 |
| Child Poverty | 2.3% |
| Living With Two Parents | 84.2% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 94.7% |
| Black | 1.8% |
| Other Races | 3.5% |
| Hispanic (may be of any race) | 2.7% |

| Indicator | Region No. | Region Rate | State Rate | Worse Than State Rate / Better Than State Rate |
|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 729 | 2.9 | 14.5 | 80% |
| **Low Birthweight** per 1,000 births, 1995 | 71 | 48.5 | 71.0 | 32% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 6 | 4.2 | 7.4 | 43% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 68 | 4.9 | 11.9 | 59% |
| **Births to Teen Mothers** percent of all births, 1995 | 38 | 2.6 | 8.6 | 70% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 3 | 15.2 | 24.8 | 39% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 212 | 17.3 | 12.3 | 41% |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 263 | 21.4 | 37.9 | 44% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 72 | 1.4 | 4.6 | 70% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 27 | 245.8 | 506.4 | 51% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 493 | 1.9 | 4.3 | 56% |

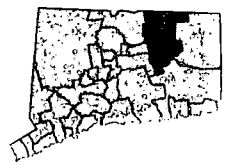
# Capitol V

| | |
|---|---|
| Total Number of Children | 29,006 |
| Percent of Total Population | 22.5 |
| Per Capita Income | $17,849 |
| Child Poverty | 4.3% |
| Living With Two Parents | 82.0% |

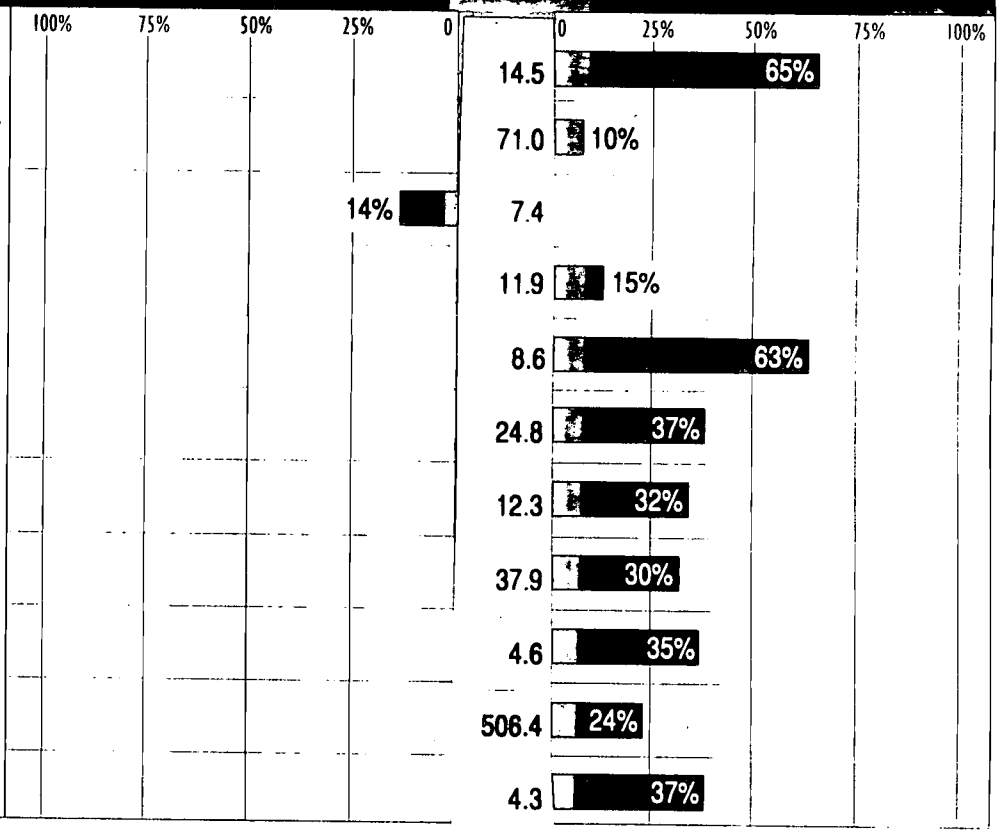
Children's Racial/Ethnic Background

| | |
|---|---|
| White | 95.4% |
| Black | 1.7% |
| Other Races | 2.9% |
| Hispanic (may be of any race) | 2.1% |

Andover
Bolton
Columbia
Coventry
Ellington
Hebron
Mansfield
Somers
Stafford
Tolland
Union
Vernon
Willington



| Indicator | Region No. | Region Rate | State Rate |
|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 1,500 | 5.1 | 14.5 |
| **Low Birthweight** per 1,000 births, 1995 | 97 | 63.7 | 71.0 |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 13 | 8.4 | 7.4 |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 159 | 10.1 | 11.9 |
| **Births to Teen Mothers** percent of all births, 1995 | 49 | 3.2 | 8.6 |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 4 | 15.7 | 24.8 |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 224 | 16.2 | 12.3 |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 366 | 26.5 | 37.9 |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 164 | 3.0 | 4.6 |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 47 | 383.3 | 506.4 |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 809 | 2.7 | 4.3 |



# Northeast

Ashford
Brooklyn
Canterbury
Chaplin
Eastford
Hampton
Killingly
Plainfield
Pomfret
Putnam
Scotland
Sterling
Thompson
Windham
Woodstock

| | |
|---|---|
| Total Number of Children | 26,363 |
| Percent of Total Population | 25.7 |
| Per Capita Income | $14,520 |
| Child Poverty | 11.4% |
| Living With Two Parents | 73.4% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 93.7% |
| Black | 1.3% |
| Other Races | 5.0% |
| Hispanic (may be of any race) | 6.8% |

| Indicator | Region No. | Region Rate | State Rate | Worse Than State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 3,494 | 13.0 | 14.5 | | 10% |
| **Low Birthweight** per 1,000 births, 1995 | 101 | 70.2 | 71.0 | | 1% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 11 | 8.1 | 7.4 | 9% | |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 137 | 9.9 | 11.9 | | 17% |
| **Births to Teen Mothers** percent of all births, 1995 | 175 | 12.2 | 8.6 | 42% | |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 6 | 28.1 | 24.8 | 13% | |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 103 | 7.8 | 12.3 | 37% | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 546 | 41.4 | 37.9 | 9% | |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 244 | 4.6 | 4.6 | | 0% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 42 | 372.0 | 506.4 | | 27% |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,884 | 7.0 | 4.3 | 63% | |

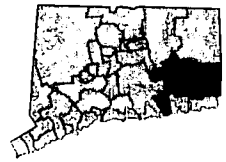
# Southeast

| | |
|---|---|
| Total Number of Children | 32,940 |
| Percent of Total Population | 25.1 |
| Per Capita Income | $16,639 |
| Child Poverty | 9.4% |
| Living With Two Parents | 77.6% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 93.6% |
| Black | 3.4% |
| Other Races | 3.1% |
| Hispanic (may be of any race) | 2.8% |

Bozrah
Colchester
Franklin
Griswold
Lebanon
Ledyard
Lisbon
Lyme
Montville
North Stonington
Norwich
Old Lyme
Preston
Salem
Sprague
Voluntown



| Indicator | Region No. | Region Rate | Worse Than State Rate | State Rate | Better Than State Rate |
|---|---|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 2,657 | 8.1 | | 14.5 | 44% |
| **Low Birthweight** per 1,000 births, 1995 | 120 | 67.6 | | 71.0 | 5% |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 12 | 6.8 | | 7.4 | 8% |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 247 | 13.7 | 15% | 11.9 | |
| **Births to Teen Mothers** percent of all births, 1995 | 153 | 8.6 | | 8.6 | 0% |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 5 | 19.4 | | 24.8 | 22% |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 136 | 9.3 | 24% | 12.3 | |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 484 | 33.0 | | 37.9 | 13% |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 224 | 3.6 | | 4.6 | 22% |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 84 | 613.9 | 21% | 506.4 | |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,197 | 3.7 | | 4.3 | 14% |

# outheast Shore

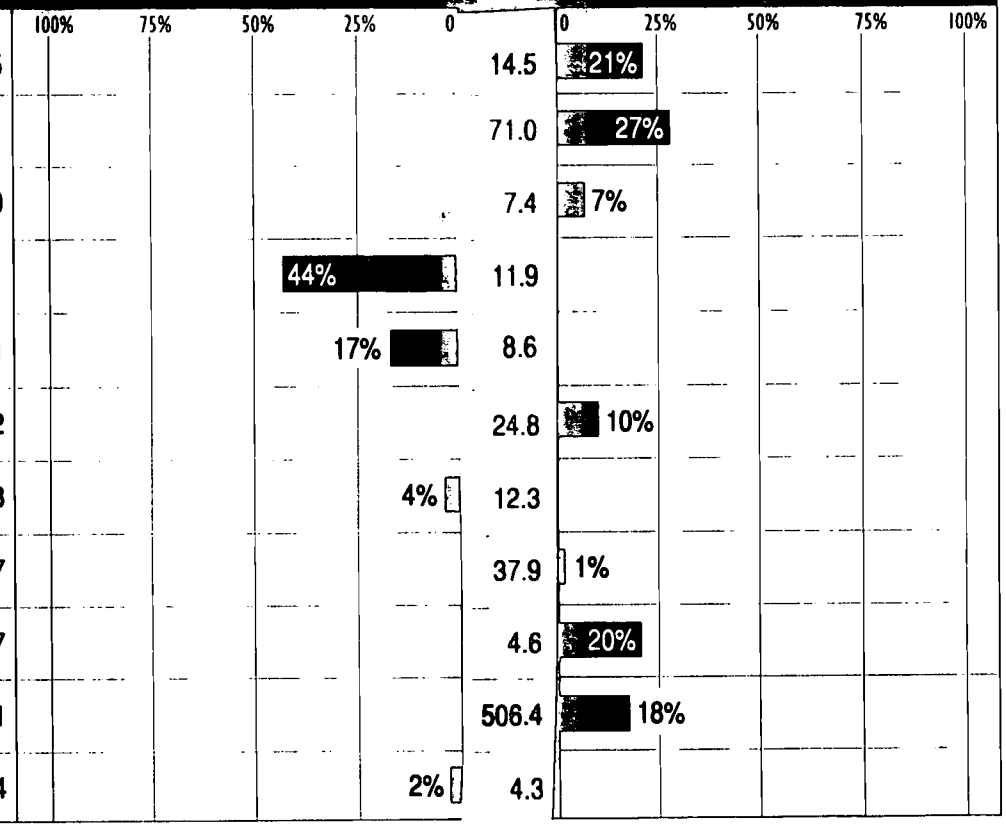
East Lyme
Groton
New London
Stonington
Waterford

| | |
|---|---|
| Total Number of Children | 27,066 |
| Percent of Total Population | 21.8 |
| Per Capita Income | $16,768 |
| Child Poverty | 9.2% |
| Living With Two Parents | 75.2% |

Children's Racial/Ethnic Background

| | |
|---|---|
| White | 83.5% |
| Black | 9.5% |
| Other Races | 6.9% |
| Hispanic (may be of any race) | 7.8% |

| Indicator | Region No. | Region Rate | State Rate |
|---|---|---|---|
| **Welfare Benefits** percent of all children receiving benefits, avg. 1995-96 | 3,027 | 11.5 | 14.5 |
| **Low Birthweight** per 1,000 births, 1995 | 90 | 52.1 | 71.0 |
| **Infant Mortality** per 1,000 live births, avg. 1993-95 | 12 | 6.9 | 7.4 |
| **Late or No Prenatal Care** percent of all births, avg. 1994-95 | 300 | 17.1 | 11.9 |
| **Births to Teen Mothers** percent of all births, 1995 | 175 | 10.1 | 8.6 |
| **Child Deaths** per 100,000 children ages 1-14, avg. 1993-95 | 5 | 22.2 | 24.8 |
| **Meeting CAPT Goal** percent of all tenth grade students, 1996-97 | 124 | 11.8 | 12.3 |
| **Well Below CAPT Standard** percent of all tenth grade students, 1996-97 | 395 | 37.7 | 37.9 |
| **High School Dropouts** percent of all students grades 9-12, 1995-96 | 166 | 3.7 | 4.6 |
| **Juvenile Violent Crime Arrests** per 100,000 children ages 10-17, avg. 1994-95 | 41 | 414.1 | 506.4 |
| **Child Abuse/Neglect** percent of all children, SFY 1995-96 | 1,155 | 4.4 | 4.3 |



# Terms

**Children:**
Throughout this book, we have used the term "children" to apply to persons younger than the age of 18. Where the available data uses a different age grouping, it is so noted.

**Race/ethnicity:**
We have reported race and ethnicity using the categories established for the 1990 U.S. Census and used by state agencies providing the data. People of Hispanic origin may be of any race.

**Fiscal year data:**
Most data presented here are for calendar years. Where data collected by state or federal authorities was available only by fiscal years, it is noted as SFY (state fiscal year, July 1 to June 30) or FFY (federal fiscal year, October 1 to September 30).

# Methodology

**Number:**
For each indicator, we include the number of "events" for a given time period, for example, the number of high school students who dropped out during the 1995-96 school year.

**Rate:**
For 14 of the 15 child well-being indicators, we include rates as well as numbers. A rate is a measure of the likelihood of an event and is calculated by dividing the number of events by the number of persons that are "eligible" for that event. For example, the high school dropout rate is the number of students who dropped out in a given year divided by the number of students enrolled. A percentage is a rate per 100. Other rates included here are per 1,000 or 100,000. Rates can be used to compare between regions for a specific indicator. Rates were not calculated if the number of "events" was less than 5. The regions with rates worse than the statewide rate are highlighted on each table. Meaningful rates could not be calculated for the teen deaths measure at the local level because of a lack of reliable data on the number of teenagers to use as a denominator. In addition, estimates could not be made because of the narrow age range.

**Rounding:**
For the purpose of improving readability, percentages are rounded to the nearest whole number in the text, except in rare cases where smaller differences were deemed crucial. Some of the statistics cited in the text were only available rounded to the nearest whole number. Those who are interested in a particular statistic at a more detailed level should call CAHS for more information. Please note that because of this rounding, percentages may not always add up to exactly one hundred percent.

In the charts, all rates are calculated to the nearest tenth of a percent for greater accuracy. The percent change in rates over time is rounded to the nearest whole number.

**Sources:**
Sources for all data are listed on each page in the order in which they appear in the text.

**Notes:**
Technical information, formulas for calculating the data in the charts, and any limitations of the data are found in notes at the bottom of a page.

**Selection of indicators:**
Many different indicators could have been used to measure the well-being of children. The compilation of these indicators for our first book was a function of 1) results of a survey of members of the Children's Future Panel (a group of more than forty individuals who are advising this project), 2) relation to national KIDS COUNT indicators, 3) how directly the indicator measured children's well-being, and 4) availability of data.

**Regions:**
For the purposes of this report, we have divided Connecticut into 27 regions (towns or groups of towns) based on the public use microdata areas established by the Census Bureau. The use of regions allowed us to calculate rates where the population would have been too small at the town level. Each region has a population of more than 100,000, and no town is split between two regions. The five largest cities, Bridgeport, Hartford, New Haven, Stamford, and Waterbury, are regions unto themselves. The raw data for the tables was collected originally for each town, and then towns were grouped into regions. Regional school districts sometimes enrolled students from more than one of the regions for the high school dropout data used in this report; a list of the regions to which these school districts were assigned can be found on page 37. Indexes to towns and regions and a map are located on pages 34-36.

**Comparing regions to statewide rate:**
On the regional tables, the rate for each indicator is shown as a percent better or worse than the statewide rate. Because this percentage varies with each measure, one should look at the child well-being indicator tables to see how a region compared to others on that measure. For example, a region could have a high school dropout rate that is twice the statewide rate.

**Comparing regions to one another:**
This report makes no attempt to combine indicators into an overall score for any region. Given the diversity of the indicators and their measurement, and the wide diversity of demographics across regions, we felt it best to view the indicators individually and form a more holistic view of how well children in each region were doing.

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