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STATE OF THE AMERICAN CHILD: WHAT'S WORKING FOR CONNECTICUT'S CHILDREN

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN AND FAMILIES

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

ON

EXAMINING THE STATE OF AMERICAN CHILDREN, FOCUSING ON WHAT'S WORKING FOR CONNECTICUT'S CHILDREN

JULY 26, 2010 (New Haven, CT)

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C O N T E N T S

STATEMENTS

MONDAY, JULY 26, 2010

ADDITIONAL MATERIAL

STATE OF THE AMERICAN CHILD: WHAT'S WORKING FOR CONNECTICUT'S CHILDREN

MONDAY, JULY 26, 2010

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN AND FAMILIES,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
New Haven, CT.

The subcommittee met, pursuant to notice, at 9:30 a.m. in the Donald J. Cohen Auditorium, Yale Child Study Center, 230 South Frontage Road, Hon. Christopher J. Dodd, chairman of the subcommittee, presiding.

Present: Senator Dodd.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The committee will come to order. I guess I have a gavel. That is what the gavel is here for.

Let me welcome all of you here this morning. I see a lot of familiar faces and friendly faces out in the audience. I thank you all for being here this morning to be a part of this series of conversations we are having as the Health, Education, Labor, and Pensions Committee, the Subcommittee on Children and Families, which I have either chaired or been the ranking member of, for over the last 25 or 30 years.

We have done a lot of work together with many of you in the room on children's issues and family issues. And as I am wrapping up the next 6 or 7 months of my seat in the U.S. Senate, I thought it would be worthwhile to conduct a series of hearings on the status of the American child and to look at where we are today, what we have accomplished, and where we need to go.

We have had hearings already, led off by Alma Powell, General Colin Powell's wife, who has been very involved in children's issues for a long time, along with others. We are here today to talk about some solutions, things that Connecticut has done well over the years, although we all recognize we have a lot of work to do.

But I have always been very, very proud—a lot of the ideas that I have championed over the years as the chairman of the Subcommittee on Children and Families have come from this State, come from this very building. In fact, people like Ed Zigler, who have been just remarkable as a tutor and a guide for me over the years in dealing with children's issues. I have been very, very grateful to many others of you here today as well. And so, I have utilized the experience in Connecticut to try and help develop some national standards and ideas as well.

We will have a hearing later this week, Thursday, back in Washington again, to start talking about national ideas and solutions as well, with representatives from the major Cabinet officers that are coming together. And it will be wrapping up as well with some ideas on the establishment of a permanent council on the status of children, much as we have done here in Connecticut, along with the ideas of establishing something along the lines of a report card on an annual basis so we have a regular basis by which we have a structure in place to make determinations as to how we are doing, sort of tracking this without having to go back over and over, over the years.

I wanted to begin, I should have at the very outset here, to express my condolences—and all of you, I am sure, will join me in this—to remember the two firefighters in Bridgeport, by the way, who lost their lives over the weekend—Lieutenant Steven Velasquez and Michael Baik. They died while fighting a fire in Bridgeport on Saturday, and I know all of us want to express our condolences to their families and their brother and sister firefighters in Bridgeport and around the country.

What they do every single day, a remarkable group of people are firefighters. So I know all of us, we share in those thoughts.

Let me start with some opening remarks. I will introduce our panel, which is a very distinguished panel. I presume many of you in the audience know the people at this panel as well as I do and respect them immensely. But I wanted to share some opening comments and thoughts, and then we will begin this conversation about Connecticut and some solutions and ideas.

I would like to welcome all of you here this morning to our second in a series of hearings on the state of the American child. The first hearing, as I mentioned, in this series was held in June in Washington, DC, and we were lucky enough to have as our witness Elaine Zimmerman, with the Connecticut Commission on Children. And I look forward to hearing from additional Connecticut experts not only today, but in the weeks coming.

It is fitting that we have come together at the Yale Child Study Center, where so much good work has been done to investigate the problems that children face and to discover solutions to meet their needs.

I would also like to take a moment to thank Dr. Fred Volkmar, the head of the Yale Child Study Center, for hosting us this morning, and for all of the tremendous work he is doing for children in this State and around the country.

I would also like to thank Dr. Robert Alpern, Dean of the Yale School of Medicine, and President Rick Levin for their hospitality as well.

I have had the privilege of working on many of the different issues on behalf of the people of Connecticut for the last 35 years. But as I have said before, the most rewarding work, without any question whatsoever, that I have been involved in has been issues affecting children and their families.

And while it comes to helping each American child reach his or her potential, a lot falls on the shoulders obviously of parents, as I have come to learn as the father of a 5-year-old and an 8-year-

old over the last several years. I decided to have my own grandchildren is what——

[Laughter.]

But as parents, we all recognize parents can't do it alone, and the welfare of children in this country depends heavily on having education, healthcare, and economic policies that give families the resources and the support that they need.

We have learned a lot about what children need to succeed during my time in the Congress, and I am proud of the progress we have made in many areas. We have helped a generation of young children prepare for school through the Head Start program. We have worked to provide quality childcare facilities and afterschool programs to ensure that learning can truly be a lifelong pursuit, not just something that happens during the school day.

We have freed millions of parents from having to choose between the job they need and the sick children they want to care for through the Family and Medical Leave Act. And we have strengthened children's healthcare by reducing the number of uninsured children through the CHIP and Medicaid programs, preventing tobacco companies from treating our children as customers-to-be, spreading awareness of food allergies, and reducing premature births.

Most recently, as a result of a provision I worked closely on in the Patient Protection and Affordable Healthcare Act, an estimated 41 million American children and their families will receive preventive care, such as routine immunizations, regular pediatrician visits, and breast and colon cancer screenings at no cost.

But the fact remains that too many children are left behind at the starting gate through no fault of their own and through no fault of their parents. And as the chairman of the Senate's only body specifically focused on children and families, I have embarked on a series of hearings to examine where we are falling short and devise a strategy for improvement that can endure even after I have left the Congress.

We have recently learned that, tragically, nearly one in five American children live in poverty and that by the year 2012, it will be one in four, the highest rate since the 1960s. Right here in Connecticut, one of the wealthiest States in our country, 1 in 10 children grows up in poverty. In the city of Hartford, nearly half of all children live below the poverty line.

As we struggle to emerge from this devastating recession, the economic gap between the haves and have-nots is only growing. Even though Connecticut can rightly brag about its above-average performance on standardized tests, we have one of the country's highest achievement gaps as well. The two gaps are, of course, related. One survey of kindergarten teachers found that three in four children who couldn't go to preschool arrived at kindergarten lacking basic language, literacy skills, and basic fundamental math skills.

And while we have made great strides in keeping our children healthy, Connecticut manifests many of the problems with low birth weight and childhood obesity that plague our Nation as a whole. And like many cities, our neighborhoods and homes put children at higher risk for asthma.

In many ways, Connecticut is a good example of the problems we face nationally. Even in a relatively well-off State, too many children face overwhelming, even insurmountable, disadvantages.

And while we need to identify and talk about the problems, today I want to talk about solutions. I want to talk about what we need to do to build a framework for evaluating the efficacy of those solutions. Connecticut has lessons to teach the Nation in that regard as well.

Today, we have convened a panel of experts from around our State on different aspects of child development. We are going to hear about programs helping families who have lost their homes to foreclosure to find stable and affordable housing.

We will hear about an innovative program that works with high-risk children and families to help avoid the incidence of emotional disturbances, developmental problems, abuse, and neglect.

And we will learn about collaborations between Connecticut dentists and Head Start programs, initiatives for fathers, and a program that provides children with safe and stable environments after school and over summers. We will hear from a school superintendent working to address the varied needs of a low-income population in her city.

These programs have proven effective in our State. And if we can take the lessons that these leaders have learned and make them part of the national agenda and approach to children's issues, then I think we can make a difference.

This is just a selection, obviously. There are many brilliant and talented people who have done incredible work over many, many years, working for our children. I want to thank some of them who are here today.

Here at Yale, we have Dr. Walter Gilliam and Dr. Steve Marans—have I pronounced that correctly?—creating and evaluating innovative programs to prevent behavior problems in very young children and address childhood trauma. Dr. Scott Rivkees, who is doing tremendous work for children's health as the director of the Yale Child Health Research Center.

Edith Karsky and the Connecticut Association for Community Action are on the front lines working to prevent childhood poverty. And Jeanne Milstein, my great friend, and the Office of the Child Advocate, providing oversight and accountability on behalf of our children as well.

We are constantly learning new things about children and about what they need to reach their full potential. And we are constantly adjusting our policies to try and meet those needs. It is critical that we regularly and carefully examine the progress of children in America, so that we can assess our progress as policymakers as well.

That is why, at the very first hearing in this series, I announced plans to introduce legislation to create a national council, a permanent council on children to do just that. This body would gather data, analyze trends, issue an annual report on the state of the American child, and make policy recommendations for improving child well-being. We need a national and permanent body at the Federal level whose top priority, whose only priority are children

and their families, improving their lives and looking at their needs in a comprehensive manner.

It has been more than 20 years since the last comprehensive report on the status of children. That report made a significant contribution to the well-being of children and their families.

In fact, I was going back and looking and just saw the child tax credits, the SCHIP program, forerunner of the CHIP program. There were many ideas that the Clinton administration took from those recommendations, 1989 and forward, that became the law of the land and made a difference in children's lives. But it has been more than 20 years since we really had such a commission established and thus the idea to establish a permanent one.

On Thursday of this week, we will be back—this hearing will be back in Washington for the next hearing in our series on the state of the American child, which will look at the impact of Federal policies on children. We will have witnesses from the Departments of Labor, Health, and Education, as well as an economist team from the White House. And I look forward to taking the lessons we may learn from the innovative Connecticut programs back down to Washington, to working with my colleagues to turn those good ideas, I hope, into action.

So I thank all of you again for being with us here today.

Now let me briefly introduce our panel, and then I am going to ask them in the order that I introduce you to share some thoughts and comments with us. Then we will begin the discussion on some of these ideas and thoughts you bring to the table.

We have nine witnesses today, which is a lot of witnesses at a hearing. But I am very grateful to all of them. It is a big group, but everyone brings an important and unique perspective to the topic of today's hearing.

I will briefly introduce each of you, but given the time constraints, my comments will be rather brief. In introducing you, I don't want to shortchange you in terms of your wonderful contributions over the years. I will include the full biographies in the Congressional Record. How is that?

[Laughter.]

After I complete the introductions, what I will ask you to do is if you can each take 3 to 5, or 6 minutes or so—I am not going to gavel anyone down—to share your thoughts. Your full comments, any supporting data, and many of you included data with your testimony, I will make a part of the permanent record as well for the hearing room.

That way, we can get to the Q and A and the conversation with ourselves, and we may invite the audience as well to raise some questions and thoughts as we go forward. Not something we normally do with a congressional hearing, but this was sort of a different type of a setting anyway for us to be conducting this along the way.

We will keep the record open for 10 days, 2 weeks. I will make it 2 weeks. My other colleagues on the committee may have some questions as well to submit to people, and I ask you to respond to them.

Dr. Ed Zigler, my good friend, Director Emeritus, Edward Zigler Center in Child Development and Social Policy at Yale, has been

involved in early children issues for decades, as all of us in this room, I hope, are aware. And we all owe him a tremendous debt of gratitude for the incredible work that he has done on behalf of America's children.

Dr. Zigler's work has improved the lives of innumerable families, and we are honored to have you once again, Ed, with us here today to talk about childhood development and preparing children for school and success in life and the solutions he has implemented, beginning with Head Start, Early Head Start, whole school reform, and many other efforts over the years.

Jim Horan is the executive director of the Connecticut Association for Human Services in Hartford, CT. Jim is here to talk about child poverty and the solutions he has fought for as executive director of the Connecticut Association for Human Services to end child poverty, as well as to work as an Annie E. Casey KIDS COUNT grantee.

Jim has led the effort to better connect low-income working families with the services. And I was pleased to join him last March at one of the free tax preparation clinics that the Association for Human Services conducted, enabling parents to claim the earned income and child tax credits.

Dr. Darcy Lowell is the executive director of Child FIRST Connecticut of Bridgeport Hospital, which I had the privilege of visiting—where are you? There you are, over there. Visited not long ago. I spent an afternoon at the hospital, a great facility.

She is here to talk about preventing mental illness, developmental learning problems among kids, as well as child abuse and neglect and the solutions she has proven effective with Child FIRST, a model program in Bridgeport that brings pediatricians, teachers, and other community leaders together. And we thank you for your work as well.

Dr. Doug Keck is with the American Academy of Pediatric Dentistry's Head Start Dental Home Initiative in Madison, CT. Dr. Keck is here to talk about the oral health among low-income children and the solutions he is part of by leading Connecticut's Dental Home Initiative for children enrolled in Head Start.

This innovative program aims to develop a Connecticut network of pediatric dentists to provide quality dental homes for Head Start, Early Head Start children and train teams of dentists in optimal oral healthcare practices. He also serves on the clinical teaching staff at the Yale-New Haven Hospital and the Yale School of Medicine.

Abby Dolliver is the newly appointed superintendent of the Norwich Public Schools, Norwich, CT. And she is here to highlight the programs that meet the academic, physical, and social needs of the students in her district. I might point out Abby is, truth-in-advertising, the daughter of my long-term person around my office, Stanley Israelite. And in Connecticut—for those who know Stanley, and Abby is the superintendent of schools in Norwich today.

I lived in Norwich for a number of years, as my parents did as well, in a town of around 40,000 people, and you have all of the complex issues of a major urban area. And Abby will talk about what it is to grapple as a superintendent of schools today with all

of the issues that are identified here and trying to see that they get the proper education of how important that school setting is.

Before accepting the position of superintendent, Abby worked as a special education director, creating programs for students on the autism spectrum. Her understanding of the importance of developing the whole child stem from her work as a social worker for some 13 years prior to that as well.

Tammy Papa is the director of the Bridgeport Lighthouse Program. I have worked for many years with this program. Talk about afterschool education and the solutions that she has discovered through the Lighthouse Program. She has been actively involved in planning and implementing afterschool programs for 17 years and has done a remarkable job. Her dedication to the issue was acknowledged in 2005 when she was awarded the Children's Champion Award from the Connecticut After School Network. She also acts as an appointee member of the Connecticut After School Advisory Committee and co-chairs the Bridgeport After School Network.

Kellyann Day is the executive director of the New Haven Home Recovery in New Haven, CT, here in the city. She is here to talk about child homelessness and the solutions she has worked on with New Haven Home Recovery. She has worked with homeless children and families for 20 years, giving her key insights into what works and what doesn't. And again, when you read or hear her testimony today, the statistics are just daunting when it comes to the issue of what happens to children who are homeless.

She has served on numerous boards throughout the State, including New Haven Early Childhood Council, the Connected Coalition to End Homelessness, New Haven Mayor's Task Force on AIDS, South Central Behavioral Health Network, the city of New Haven's 10-Year Plan to End Homelessness, and many others.

Doug Edwards is the founder and program director of Real Dads Forever, Manchester, CT. This program teaches fathers the importance of home environment in child development and challenges them to examine their commitments to their families, themselves, and their personal success. He has consulted with Connecticut's Department of Social Services, Department of Education, Department of Children and Families, the Department of Public Health, and many other organizations. And we thank him.

Dr. Lisa Honigfeld—did I pronounce that correctly?

Ms. HONIGFELD. Yes, you did.

Senator Dodd [continuing]. Is the vice president for Health Initiatives for the Child Health and Development Institute of Connecticut, CHDI, in Farmington, CT. She oversees CHDI's efforts to strengthen the quality and accessibility of primary and preventive healthcare for children and families. In addition to numerous positions in health services research and pediatric primary care, Dr. Honigfeld also has a faculty appointment at the University of Connecticut School of Medicine.

Well, that was a lot to go through with all of you here. And as I said, that is the abbreviated version of their resumes. I spared you.

[Laughter.]

I mentioned earlier, just going back, and I kept a note on this. But just looking at some of the stuff that happened on that earlier

commission on children that started in 1987, didn't get underway until 1989, was charged with assessing the status of children and families. And from that blueprint, the Clinton administration enacted policies including the earned income tax credit, the child tax credit, the State Children's Health Insurance Program, and many others. Out of all that, came one blueprint. So it was very, very valuable that that worked some 20 years ago.

Well, again, I thank all of you for being here. Ed, we will begin with you and your thoughts and comments. Then we will move down in the order that I have introduced people, and then we will start the conversation.

Ed, thank you. You are going to have to pull this closer.

STATEMENT OF EDWARD ZIGLER, Ph.D., DIRECTOR EMERITUS, EDWARD ZIGLER CENTER IN CHILD DEVELOPMENT AND SOCIAL POLICY, YALE UNIVERSITY, NEW HAVEN, CT

Mr. ZIGLER. Thank you, Senator.

On behalf of all my colleagues at Yale, allow me to welcome you to Yale. I want to take 10 seconds of personal privilege and speaking not to you, but rather to your constituents here in the audience.

I know many of you, and as many of you know, I have worked in some capacity as a consultant to every administration since that of Lyndon Johnson. Over that 45-year period, I have witnessed a great number of Senators and members of the House, and I would just like to state for the record that in my own lifetime, I have never met a Congressperson who has been a more effective, active, and dedicated advocate for children and families than our own Senator Dodd, and I would like to congratulate him on that record.

Senator DODD. Thank you.

[Applause.]

Mr. ZIGLER. Now let me put on my professorial hat. I have been studying human development now for 55 years, and I have come to the conclusion that there are four major systems, all in interaction, so they are synergistic, four systems that are the primary determinants of the child's growth and development.

The first, and by far the most important, is the family. Then there is the health system, then the education system the child experiences, and finally, the childcare, where the majority of children spend the first 5 years of their life prior to school entry.

The family today is experiencing so much stress that it has difficulty in performing its primary child-rearing responsibilities. Thanks to Federal legislation like SCHIP, the health system has improved for children but is still far from perfect.

We have known that the education system in this country is far from excellent ever since the publication many years ago of "The Nation at Risk." Our Nation's non-childcare system actually harms millions of children, as I documented in my recent book, "The Tragedy of Childcare in America."

This morning, I would like to acquaint you with a whole school reform model that my colleague Matia Finn-Stevenson and I have now successfully put into place in this country. These new schools have been named Schools of the 21st Century. However, the 60 schools in Connecticut, mounted originally through the efforts of

John Larson, and the statewide system of schools in Kentucky are called Family Resource Centers.

The purpose of these schools was to positively impact each and every one of the four systems that we know largely determine the child's development. Given my long involvement with our Nation's groundbreaking Head Start program, unsurprisingly, the theoretical principles underlying the 21C school model are similar to those of Head Start. The schools adopt a whole child approach through which we attempt to positively impact the child's cognitive development, social-emotional development, and the child's mental and physical health.

Thus, like Head Start, our schools provide comprehensive services that go far beyond the standard provision of academic-focused education alone. Like Head Start, parents are viewed as the most important determinant of their children's growth, and parents are deeply and actively involved in each and every School of the 21st Century and Family Resource Center. This aspect of Schools of the 21st Century is very similar to that of the very successful Child-Parent Centers now to be found throughout the city of Chicago.

A particularly innovative aspect of 21C schools is that the child is enrolled in the neighborhood school as close to the child's conception as possible and no later than birth. Upon the birth of the child, the school sends a home visitor to the home, and these home visits continue for 3 years and employ the parents-as-teachers home visiting model, which has been implemented in every school in the State of Missouri.

These home visits focus on the parents' knowledge of human development, as well as in motivating parents to become as an effective first teacher of the child as possible. At the age of 3, the child physically begins attending school in a high-quality, 2-year preschool program rather than the 1-year preschool program that has become so commonplace in our Nation.

The preschool day is as long as the work day of mothers and fathers, rather than the usual half-day program or school day program, which usually ends around 2:30 p.m. or 3 p.m. Thus, one of our schools in Bridgeport is actually called the "6 to 6" school. This allows children to receive both preschool and afterschool care.

Thus, our preschools provide not only preschool education, but childcare as well. This before and afterschool care continues in the school until the child is approximately 12 years of age. Each school also mounts a health education component for parents and health services for children, which include improved nutrition practices.

Many of the children in the schools' catchment area are attending private childcare. Our schools are aware that these children will eventually come to the school at age 5. Thus, the schools provide outreach and training to these independent childcare centers, thus improving the childcare experience of these non-school enrolled children.

Our schools also act as brokers for human services that already exist in the community. Thus, each school is also a resource and referral center in order to satisfy the other needs that the school's families have.

From age 3 to age 12, 21C parents have the childcare they need for their children. This should reduce the stress that parents expe-

rience in dealing with the childcare problem, and our research shows that it does reduce stress in parents.

Research clearly indicates that the more parents are involved in their children's education, the better the child's educational performance. Like Head Start, parent involvement is a basic pillar of the Schools of the 21st Century. This model has grown exponentially since its introduction some 20 years ago.

It began originally in Independence, MO, with two schools. Thanks to John Larson, we began with three schools here in Connecticut, and we now have 60 in this State. Interestingly, when Governor Rell recently wanted to cut Family Resource Centers from the budget, parents of these schools rose up and demanded that the Family Resource Centers continue, and that is now the case.

These schools can now be found in over 20 States. This model has now been embraced by over 1,300 schools, making it the largest whole school reform model in America.

The primary catalyst for this program has been parents themselves. Once they become aware of a School of the 21st Century in the next district, they demand to have one in their own district. Kentucky has now gone statewide with this model, and Arkansas is also moving to a statewide program, having already put into place over 160 21C schools.

I am both a pragmatist and empiricist and a strong believer in accountability. Thus, from its inception, we have included a strong evaluation component into the Schools of the 21st Century.

The evidence of the value of these schools is contained in a series of positive findings associated with them. In addition to lower stress levels, we have found much less vandalism in our schools, and studies conducted both in Missouri and Arkansas showed students in 21C schools had superior performance across a broad array of academic abilities than did the comparison children.

For example, in the Independence School District of fourth grade students, over 70 percent of them had proficient scores or better on literacy tests, whereas the national average in this entire country is only about 33 percent.

In a recent unpublished study, we found that child abuse in the Independence district was reduced by two-thirds in comparison with another comparable school district in Missouri. Since child abuse is primarily a stress phenomenon, stress impinging on parents, this is not surprising since we discovered much earlier that 21C schools reduce the stress level of parents.

I conclude my testimony with a single recommendation. The Department of Education of this country should spend some of its school reform funds in bringing the 21C model to the attention of the Nation and provide grants to schools to provide the seed money necessary for startup activities.

I will conclude my testimony where I began. I would like to express to Senator Dodd my own personal deep gratification at having the opportunity to work closely with him and see all of his accomplishments over several decades.

Thank you.

[The prepared statement of Mr. Zigler follows:]

PREPARED STATEMENT OF EDWARD ZIGLER, PH.D.

There are four major synergistic systems that are the primary determinants of the child's development. The first and most important is the family. Then there is the health system, the education system the child experiences and finally child care where the majority of children spend the first 5 years of their life prior to school entry. The family today is experiencing so much stress that it has difficulty in performing its primary child rearing responsibilities. Thanks to Federal legislation the health system has improved for children but is still far from perfect. We have known that the education system is far from excellent ever since the publication of The Nation at Risk. Our Nation's non-child care system actually harms millions of children as I documented in my recent book *The Tragedy of Child Care in America*.

This morning I would like to acquaint you with a whole school reform model that my colleague Matia Finn-Stevenson and I have now successfully put into place in this country. These new schools have been named Schools of the 21st Century. However the 60 schools in CT (mounted originally through the efforts of John Larson) and the statewide system of schools in KY are called Family Resource Centers. The purpose of these schools was to positively impact each and every one of the four systems that we know largely determines the child's development.

Given my long involvement with our Nation's groundbreaking Head Start program, unsurprisingly the theoretical principles underlying the 21C school model are similar to those of Head Start. The schools adopt a whole child approach in which we attempt to positively impact the child's cognitive development, social emotional development and the child's mental and physical health. Thus like Head Start our schools provide comprehensive services that go far beyond the standard provision of academic-focused education only. Like Head Start, parents are viewed as the most important determinant of their children's growth and parents are deeply and actively involved in each and every School of the 21st Century. This aspect of Schools of the 21st Century is very similar to that of the very successful Child Parent Centers in the city of Chicago.

A particularly innovative aspect of 21C schools is that the child is enrolled in the neighborhood school as close to the child's conception as possible and no later than birth. Upon the birth of the child the school sends a home visitor to the home and these home visits continue for 3 years and employ the Parents As Teachers home visiting model which has been implemented in every school in the State of Missouri. These home visits focus on the parents' knowledge of human development as well as motivating parents to become an effective first teacher of the child as possible.

At the age of 3 the child physically begins attending school in a high quality, 2-year preschool program rather than the 1-year preschool program that has become so common place in our Nation. The preschool day is as long as the work day of mothers and fathers rather than the usual half-day program or school-day program which usually ends around 2:30 p.m. or 3 p.m. Thus one of our schools in Bridgeport is actually called the "**6 to 6**" school. This allows children to receive both preschool and afterschool care. Thus our preschools provide not only preschool education but child care as well. This before and afterschool care continues in the school until the child is approximately 12 years of age. Each school also mounts a health education component for parents and health services for children which include improved nutrition practices. Many of the children in the schools catchment area are attending private child care. Our schools are aware that these children will eventually come to the school at age 5. Thus the schools provide outreach and training to these independent child care centers thus improving the child care experience of these non-school enrolled children.

Our schools also act as brokers for human resources that already exist in the community. Thus each school is also a resource and referral center in order to satisfy the other needs that the school's families have. From age 3 to age 12 the 21C parents have the child care they need for their children. This should reduce the stress that parents experience in dealing with the child care issue and our research shows that it does. Research clearly indicates that the more parents are involved in their children's education the better the child's educational performance. Like Head Start parent involvement is a basic pillar of Schools of the 21st Century.

This model has grown expedientially since its introduction some 20 years ago. It began originally in Independence, MO with 2 schools. Thanks to John Larson we began with 3 schools here in CT and we now have 60. Interestingly when Governor Rell recently wanted to cut Family Resource Centers from the budget, parents rose up and demanded that the Family Resource Centers continue and that is now the case. These schools can now be found in over 20 States. This model has now been embraced by over 1,300 schools making it the largest whole school reform model in the Nation. The primary catalyst for this program has been parents themselves.

Once they become aware of the Schools of the 21st Century in the next district they demand to have one of their own. Kentucky has now gone statewide with this model and Arkansas is also moving to a statewide program, having already put into place over 160 21C schools.

I am both a pragmatist and empiricist and a strong believer in accountability. Thus from its inception we have included a strong evaluation component into the Schools of the 21st Century. The evidence of the value of these schools is contained in a series of positive findings associated with these schools. In addition to lower stress levels, we have found much less vandalism in our schools and studies conducted both in MO and AK showed students in 21C schools had superior performance across a broad array of academic abilities than did the comparison children. For example in the Independence school district, 4th grade students over 70 percent had proficient scores or above whereas the national average is about 33 percent. In a recent unpublished study we found that child abuse in the Independence district was reduced by two-thirds in comparison with another comparable school district in MO. Since child abuse is primarily a stress phenomenon this is not surprising since we discovered much earlier that 21C schools reduce the stress level of parents. I conclude my testimony with a single recommendation. The Department of Education should spend some of its school reform funds in bringing the 21C model to the attention of the Nation and provide grants to schools to provide the seed money necessary for startup activities.

Senator DODD. Thank you, Ed, very, very much.

[Applause.]

Jim Horan. Jim.

STATEMENT OF JAMES P. HORAN, EXECUTIVE DIRECTOR, CONNECTICUT ASSOCIATION FOR HUMAN SERVICES, HARTFORD, CT

Mr. HORAN. Good morning, Senator Dodd and distinguished guests. Thank you for the opportunity to testify on the state of the American child.

I am the executive director of the Connecticut Association for Human Services. This year, CAHS celebrates 100 years of advocacy to improve the lives of children and families in Connecticut, with a focus on policies and programs that create family economic success. I will summarize the written testimony that I have submitted.

First, thank you, Senator Dodd, for championing big-picture issues like healthcare and financial reform and issues that directly affect kids, like Head Start and Childcare and Development Block Grants. We will really miss your leadership.

Second, I want to emphasize the importance of timely, accurate data. As the Annie E. Casey Foundation's KIDS COUNT grantee, we know how important this is and what is now lacking. Thank you for sponsoring legislation to expand the National Survey of Children's Health and the Measuring American Poverty Act.

The Casey Foundation releases the National KIDS COUNT Data Book tomorrow. It includes data up until 2008, and it shows that improvements in the condition of children that began in the late 1990s stalled even before the current recession began.

Three data points on the current state of children in Connecticut. Child poverty was rising before the recession, from 10.5 percent in 2004 to 12.5 percent in 2008. That is despite Connecticut having the Nation's first child poverty target.

We know what to do to reduce poverty, including modeling that was done by the Urban Institute of top recommendations of the State's Child Poverty and Prevention Council. But the Governor and the legislature never made the necessary investments to reduce poverty.

On education, only 40 percent of Connecticut fourth graders are reading proficient, according to NAEP scores. That is the second-best in the Nation, but we need to raise proficiency for all kids. Connecticut is making modest progress in reducing the huge achievement gap between whites and kids of color, but it is not good enough.

The news is better on health, where SCHIP—HUSKY in Connecticut—has reduced the percentage of uninsured kids to just 5.4 percent, about half the level for adults. And this trend should continue with the passage of CHIP reauthorization; national health reform, which you led efforts on; and universal healthcare legislation in Connecticut.

Given the recession and indicators that are moving in the wrong direction, what do we do now? At the Federal level, we urge you to help extend Federal earned income tax credit, SNAP, and FMAP; reauthorize the Child Nutrition Act; focus on job creation. These investments will pay off.

In Connecticut, with a new Governor after November, we will try again to create a State earned income tax credit to reward low-wage work. On education, CAHS will soon release a report on reading success in the early grades, and we are working to expand the State's successful School Readiness program and to create a true system of early care and education in Connecticut.

We have created a New England consortium to reduce child and family poverty, working with our colleagues, and child advocates across the region to advocate for change at the Federal level. Since the recession began, CAHS has stepped up efforts to improve access to the Federal earned income tax credit, like the VITA site you visited in Bridgeport last year; food stamps, now called SNAP; and other benefits.

We use an electronic screening tool called EarnBenefits Online and work with partners and communities across the State. Last year, we started the Connecticut Money School, the country's second statewide financial education project with potential to become a national model. Information on all of these efforts is on our Web site, *www.cahs.org*.

Good results can come about if we all work together and engage those most affected by poverty and poor-quality education. We need the political will to make the changes that data and evaluation demonstrate will work.

You mentioned, Senator Dodd, that we are headed for the highest child poverty rate since the 1960s. Poverty rates at that time led to President Johnson creating the war on poverty. Poverty at that time in that year had decreased by 50 percent nationally. And even though the war on poverty is often considered a failure, in fact, many of the gains that we made at that time have been sustained.

You mentioned the council in the late 1980s and the recommendations that the Clinton administration helped to implement. There was a 25 percent reduction in child poverty during the 1990s. But those gains have not been sustained. We need a focused effort like the one you are talking about to help make good things happen, and we appreciate your leadership.

[The prepared statement of Mr. Horan follows:]

PREPARED STATEMENT OF JAMES P. HORAN

Good morning, Senator Dodd. I am Jim Horan, executive director of the Connecticut Association for Human Services. Thank you for the opportunity to testify at the second hearing in this series on the State of the American Child. This year, CAHS celebrates 100 years of advocacy to improve the lives of children and families in Connecticut, with a focus on policies and programs that create family economic success.

CAHS and other child advocates have long admired and appreciated your leadership in the Senate not only on financial and health reform, but on issues directly affecting children, including Head Start, Child Care and Development Block Grants, and Family and Medical Leave.

You have been a champion on children's issues throughout your distinguished tenure in the Senate, and these hearings help lay the groundwork for continued progress on issues critical to children, including the potential for a national Commission on Children, even after you leave the Senate. Connecticut's Commission on Children has done such important work over the past 20 years.

As the Annie E. Casey Foundation's KIDS COUNT grantee in Connecticut, CAHS gathers and releases data on child and family well-being to inform policymakers and our own advocacy work at the State Capitol in Hartford and in Washington. Therefore, CAHS understands the **importance of timely, accurate data**. We thank you, Senator Dodd, for your current sponsorship of legislation to expand the National Survey of Children's Health, and your lead sponsorship of the Measuring American Poverty (MAP) Act. We are very pleased that the Obama administration is working to address the latter issue with the Supplemental Poverty Measure (SPM).

The most recent available data is outdated. Right now, that means that we lack current data on the impact of the recession on children and families. Patrick T. McCarthy, president and CEO of the Casey Foundation, recently noted:

> "the reality is that we can only go so far without needed improvements to our data collection systems. None of us has a good grasp on the conditions facing America's children because State and Federal agencies collect data too infrequently, and often do not measure what really matters for kids."

The Casey Foundation will release the national Kids Count data book tomorrow. The most recent data available, from 2008, shows child poverty rising both nationally and in Connecticut. Overall improvements in child well-being that began in the late 1990s stalled in the years before the current recession began, both nationally and in our State.

Of course, the statewide picture of Connecticut does not tell the full story. Often, Connecticut looks better than other States in national rankings on the well-being of children. But when data is disaggregated by community and by race, it is clear that kids in Connecticut of color and in our larger cities fare poorly. That is why it is important to increase the sample size of the American Community Survey (ACS), to provide more precise data for urban neighborhoods, as well as rural communities.

I would briefly like to look at data trends in three areas, to show what is happening to children in Connecticut, including areas where government actions are helping, and where they were failing to do so, even before the recession began.

• **Poverty** in Connecticut was rising before the deep economic downturn. The child poverty rate was basically flat from 2000 to 2004, and then rose from 10.5 percent to 12.5 percent in 2008. This is especially disappointing since following the passage in 2004 of a State target to reduce child poverty in half, by 2014. This legislation, the first in the Nation, created good recommendations but practically no investment from the Governor and legislature. The increase of 13,000 kids in poverty will rise with the recession, as many parents have lost their jobs. And as previously noted, the relatively low rate of child poverty statewide masks the disturbing rates of child poverty in many urban communities. Hartford's child poverty rate of 46 percent in 2008 is among the highest of any city in the Nation, an increase from 41 percent in the 2000 census.

• In **Education** in 2009, Connecticut had the second highest level of fourth grade reading proficiency in the Nation, behind only Massachusetts, according to the National Assessment of Educational Progress (NAEP). Despite the high national ranking, only 40 percent of Connecticut fourth graders were proficient, compared to 32 percent nationally, showing how poorly Connecticut and all States are doing. And again, the data is worse when disaggregated. NAEP data show 53 percent of White Connecticut fourth graders were proficient readers, compared to 22 percent of Blacks and 15 percent of Hispanics. A small piece of good news in these distressing

data is that the gap between Black and White students narrowed in recent years, due to gains by Black students between 2003 and 2009.

• On **Health**, there is encouraging news that despite the decline in insurance provided by employers, the number of uninsured kids in Connecticut declined in recent years because of HUSKY, the State Children's Health Insurance Program. More kids were covered in 2009 than in 2003, and only 5.4 percent were uninsured, about half the rate of adults. The positive trends on children's health should continue, with the reauthorization of CHIP last year, and the passage of national health reform that you helped to shepherd through Congress earlier this year, Senator Dodd. Connecticut's passage of universal health care legislation in 2009 puts the State in a very good position for implementation of Federal health reform.

While the news is positive on health care, **a lot more needs to be done to reduce poverty and improve education for children in our Nation and State**. These are critical factors for children that underlie many other indicators, and affect them throughout their lives. We know what needs to be done to create better outcomes for children and families. We just need the political will and leadership to make it happen, in Washington, in Hartford, and in our communities.

With the indicators headed in the wrong direction, poverty is the toughest nut to crack. The American Recovery and Reinvestment Act (ARRA, the stimulus) stopped the recession from deepening. It also expanded SNAP (formerly food stamps) and the EITC, expansions that should be made permanent. While ARRA prevented the loss of millions of jobs, it has not yet resulted in the creation of many new jobs to replace those lost. This is crucial for poverty reduction. Congress must have the courage to continue stimulus measures, including additional FMAP Medicaid funding for States to avoid a $265 million in the current Connecticut budget. And new stimulus funding is needed for schools, to prevent significant local teacher layoffs, like those we're seeing in New Britain and towns across Connecticut. Pending reauthorization of the Child Nutrition Act, with more money for healthier school meals and after-school programs, will also help.

On education, Race to the Top prompted State education reform legislation this past year. More needs to be done, especially to close the achievement gap between whites and kids of color. Action is needed not only to ensure that every child achieves his or her full potential, but also so that Connecticut and the United States can compete in the global economy with a highly-educated workforce.

At CAHS, in partnership with our funders and other nonprofit organizations, we're taking action to improve the well-being of kids, with some positive results. To reduce child poverty, CAHS led efforts in 2006 and 2007 to create a State Earned Income Tax Credit, modeled on the very successful Federal EITC. This was a top recommendation of the Connecticut Child Poverty and Prevention Council, but Gov. Rell vetoed it twice. In 2008, CAHS was launching a broad-based "Opportunity and Prosperity Campaign." As the economy tanked, that no longer seemed viable. CAHS shifted gears to expand our Federal EITC and SNAP (formerly food stamps) outreach. Earlier this year, we launched *EarnBenefits Online*, a screening program that can complete applications for up to 13 State and Federal benefits, including SNAP, HUSKY, and the EITC. We are working with 13 community partners in five cities, with support from six foundations, using a tool developed by Seedco, a New York-based nonprofit.

Last year, CAHS started the Connecticut Money School, which offers financial education classes. This partnership with the United Way of Connecticut and nonprofits in our three largest cities is only the second statewide financial education project, and a potential national model. CAHS also started a multi-faceted family economic success program in Bridgeport with the support of the local United Way and banks.

On education, our primary focus is to close the achievement gap while raising the performance of all students, from early childhood through post-secondary. With support from the Graustein Memorial Fund, CAHS is working with advocates including the Connecticut Early Childhood Alliance, Connecticut Voices for Children, and Connecticut Parent Power, to regain Connecticut's former status as a national leader. New investments are needed, especially to expand the State's successful School Readiness program to more children in low-income communities, and to create a true system of early childhood education. CAHS has a forthcoming report with recommendations on how to help all students become reading proficient by the end of third grade. This is a major focus of the Annie E. Casey Foundation, which is partnering with philanthropies across the country, including the Graustein Memorial Fund in Connecticut. And last year, CAHS published a report on strengthening the role of Connecticut's community colleges in educating adult workers—because kids need parents who earn wages that can support their families.

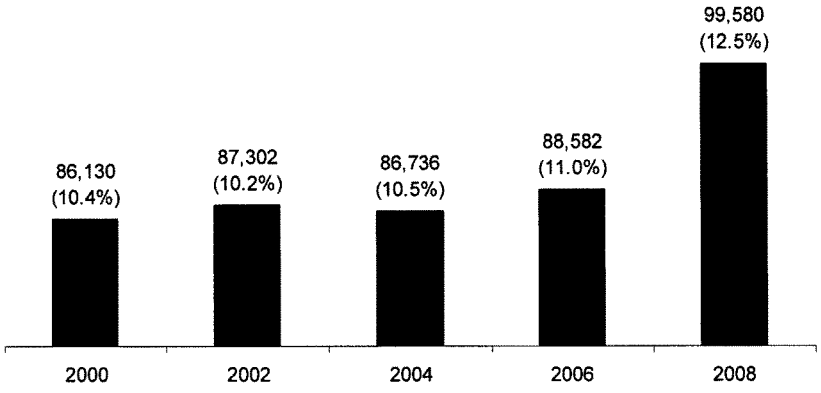
This work is not enough to reverse negative trends for kids in our State and country. Continued leadership at the Federal level is critical. Most recently, CAHS has teamed up with Connecticut Voices for Children and our Kids Count and Voices for America's Children counterparts across the region to create the **New England Consortium to reduce child and family poverty**. We're working together on data, policy solutions in our States, and an emerging Federal agenda. With our strong regional congressional delegation, we think this may be where we can make the greatest difference, and create a model for advocates nationally. You can check out our collective work at *www.endpovertynewengland.org*. We are moving beyond strengthening the safety net to creating real pathways to opportunity for children and their families.

The State of the American Child in 2010 is fragile and unacceptable. But there are actions the Federal Government can take, as it has done in the past and is doing now on health care, to improve child well-being, especially with regard to poverty and education. And there is a role for all of us—in State and local government, nonprofits, education, as parents and community leaders. We need to engage everyone, especially those most effected by the negative consequences of poverty and poor quality education, to make the necessary changes. Maintaining the status quo has serious negative consequences for these children and for the economy. As Harry Holzer and his colleagues at Georgetown University and the Urban Institute has written, child poverty has lifelong impacts on workforce productivity, crime, health, and ultimately on our Gross Domestic Product.

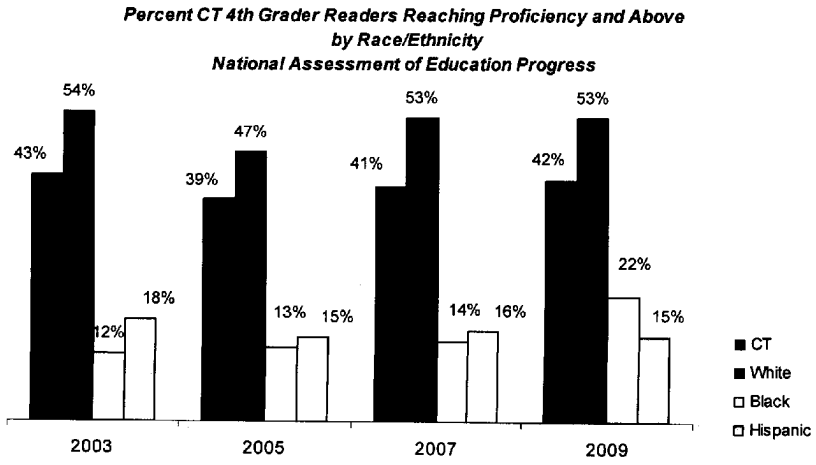
The challenges to improving child well-being seem daunting, especially in the midst of the Nation's most serious economic downturn since the recession. But the economy will recover, and we need to ensure that everyone will share in it. Working together, with good data and a clear focus on improving the future for our children, we can adopt policies and make investments that ensure that our country's brightest days are ahead of us.

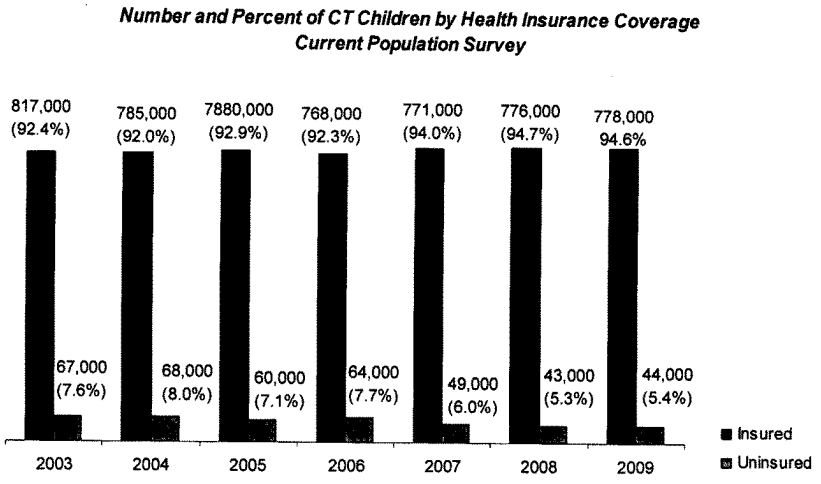
Thank you for holding this hearing, Senator Dodd, and inviting CAHS to testify. We look forward to continuing to work with you on this important initiative.

CT Children Living in Families with Income < 100% FPL



FPL is Federal Poverty Level. Data for 2000 are from the Decennial Census, Summary File 3, Table P87, Poverty Status in 1999 by Age. Data from 2002 are from the American Community Survey (ACS), Table P114, Poverty Status in the Past 12 Months by Sex and Age. Data for 2004, 2006, 2008 are from ACS, Table B17001, Poverty Status in the Past 12 Months by Sex and Age.





Senator DODD. Thanks, Jim, very, very much.
[Applause.]
Dr. Lowell.

STATEMENT OF DARCY LOWELL, M.D., EXECUTIVE DIRECTOR, CHILD FIRST CT, BRIDGEPORT HOSPITAL, BRIDGEPORT, CT

Dr. LOWELL. Good morning.

Senator Dodd and esteemed colleagues, I am extremely honored to be here testifying today. Senator Dodd, I want to thank you for all of the hard work you have done on behalf of children and families. It has made an incredible difference, and we will sorely miss you.

I am a developmental behavioral pediatrician. My name is Dr. Darcy Lowell. I am an associate clinical professor here at Yale School of Medicine and the executive director of Child FIRST Con-

necticut. I have been working with young children and families for over 25 years in this State.

I have been asked to focus my testimony on our work of Child FIRST, which is a new and innovative model and an approach to the extreme challenges that our children and families are facing today.

Child FIRST specifically targets the most vulnerable young children and families, prenatally through age 5 years, and these are children who have early behavioral and developmental problems. And we target the highest-risk families who suffer from maternal depression, substance use, domestic violence, poverty, homelessness, among many other risks. Our goal is to prevent emotional and behavioral problems, developmental and learning disabilities, and abuse and neglect.

We identify children at the earliest possible time, both through formal screening as well as through referrals from over 70 agencies in the greater Bridgeport area because of the strength of our collaborative process. Especially, when they come from pediatrics, from early care and education, from the schools, and from our Department of Children and Families.

We then provide a home visiting intervention to the child and entire family with an expert clinical team. Our approach is based on the most current scientific research on brain development, which has made it very clear that extreme stresses in the environment are toxic to the architecture of the developing brain. They cause damage that result in not just short-term, but long-term impairment in mental health, in learning, cognition, and in physical health as well. This does not go away.

Therefore, our intervention takes a two-pronged approach. No. 1, we connect families with comprehensive, well-coordinated, community-based services and supports, using all the rich kinds of services we have in our communities already. This system of care approach directly decreases the environmental stress and provides the growth-promoting experiences for young children.

So we get parents, if they need it, substance abuse treatment. If they need to find new homes, if they need job training, that is the kind of thing we get the parents. And for children, we will get them involved, of course, in early care and education, so critical, but in special ed services or birth-to-3 services, as necessary.

And then, No. 2, we provide parent-child therapeutic intervention to promote a nurturing, responsive parent-child relationship. The important thing is that this relationship has been documented to buffer or protect the developing brain from what Jack Shonkoff terms "toxic stress" and promotes strong social, emotional, and cognitive development.

Furthermore, our team also works in early care and education and the schools. So we take a very comprehensive approach. Now, how do we know this works? We have been working on this model for over 10 years, and we have conducted a randomized control trial, which is the gold standard for scientific research.

We have 12-month outcomes that have demonstrated that Child FIRST children had a very significant decrease in aggressive and defiant behaviors and improvement in language development. Mothers reported significantly less stress, depression, and anxiety.

There was a significant decrease in referral to DCF for child protective services, and the Child FIRST intervention families were able to access 91 percent of desired services, as opposed to 33 percent in our usual care controls. These outcomes will significantly contribute to closing our achievement gap.

Based on the strength of this research, the Robert Wood Johnson Foundation has provided $3.2 million toward funding a public-private partnership with Connecticut State government and philanthropy to replicate the Child FIRST model. We are now in five cities across Connecticut, including some of our most challenged—Hartford, New Haven, Waterbury, and Norwalk.

From a cost-benefit perspective, if we just compare the cost of Child FIRST services for a single family, which is $5,000 to $6,000, with the cost for psychiatric hospitalization for a single child for a year, which is well over $700,000, our return on investment is very clear. Child FIRST is a very promising, evidence-based model that can address ethnic, racial, and socionomic disparities with a goal of closing the achievement gap.

We have the knowledge. We must now develop the will to restructure systems and target our resources so that our most vulnerable children and families can succeed.

Thank you so much.

[The prepared statement of Dr. Lowell follows:]

PREPARED STATEMENT OF DARCY LOWELL, M.D.

Senator Dodd and esteemed colleagues, I am extremely honored to be testifying today on efforts to improve the lives of the most vulnerable young children and their families in Connecticut. My name is Dr. Darcy Lowell. I am a developmental and behavioral pediatrician, executive director of Child FIRST CT, an Associate Clinical Professor of Pediatrics and the Child Study Center here at the Yale University School of Medicine, and Section Chief of Developmental and Behavioral Pediatrics at Bridgeport Hospital. I have been working with high risk, very young children and their families for 25 years.

Many of Connecticut's young children and families are suffering. With the recession, greater numbers are not only experiencing poverty, but the number and complexity of accompanying environmental risks appear to be rising rapidly. We need to be alarmed. Those children who make up the largest proportion of the achievement gap in our State are precisely those whose home environments have multiple, recurrent, and unrelenting challenges. The most current neuroscientific research has made it clear that stresses in the environment, like maternal depression, substance use, domestic violence, homelessness, and child abuse and neglect, are toxic to the architecture of the developing brain, causing damage that results in lifelong impairment in mental health, learning, and physical health. It is therefore imperative that we intervene as early as possible with comprehensive, intensive approaches based on scientific knowledge and proven outcomes.

CHILD FIRST MODEL

Throughout the country, policymakers and providers have been struggling to find models to address the needs of our highest risk, most vulnerable, and most costly children and families. Today, I am going to speak briefly about a model intervention system developed in Greater Bridgeport, CT, called Child FIRST. This stands for Child and Family Interagency, Resource, Support, and Training. Child FIRST specifically targets the most vulnerable young children, prenatally through age 5 years, and their families to prevent emotional and behavioral problems, developmental and learning disabilities, and abuse and neglect. By identifying these children at the earliest possible time and providing comprehensive, intensive, home-based intervention, we hope to address the racial and ethnic disparities in health and education and help close the achievement gap.

Child FIRST developed from the ground up, based on community need, first beginning approximately 12 years ago. Children with developmental and emotional problems were "falling through the cracks." Families wanted to do their best, but

had overwhelming challenges and were not getting the services or supports they needed. Providers delivered quality services, but they were narrow and categorical, without resources to attend to—or even recognize—the intensity and breadth of family problems. It was clear, however, that one could not address the needs of the child without attending to the challenges and stresses experienced by the whole family. Only then could parents be available to nurture and support the development of their children.

Child FIRST is a new model for an early childhood intervention system. It has two essential components, which are based on what we know about the developing brain:

(1) Comprehensive, integrated services and supports are wrapped-around the child and family. This "system of care" approach directly decreases the environmental stress (e.g., through housing assistance, domestic violence intervention, substance abuse treatment) and provides growth promoting experiences for the child (e.g., through early care and education, early intervention for developmental delays);

(2) Direct intervention with the child and parents to promote a nurturing, responsive, parent-child relationship. This relationship has been documented to buffer or protect the developing brain from "toxic stress," at the same time that it leads to strong social-emotional and cognitive development.

Children in need of Child FIRST intervention may be identified directly by caregivers or by any child or adult community provider (e.g., Department of Children and Families, early care and education, pediatrics, domestic violence shelter, adult mental health provider) serving either children or their parents. Families are usually referred because a child has emotional, behavioral, or developmental problems or because the family is struggling with serious challenges that interfere with the ability of the parent or caregiver to nurture and support the child's development. These challenges include maternal depression and anxiety, substance abuse, domestic violence, child abuse and neglect, homelessness, unemployment, illiteracy, cognitive limitations, food insecurity, health problems, single and teen parenting, incarceration, among many others. About 95 percent of these families have evidence of poverty (e.g., TANF, HUSKY, SNAP), and approximately 90 percent are of ethnic minority. In addition, Child FIRST in Bridgeport has established more formal screening in the Bridgeport Hospital Pediatric Primary Care Center and in Head Start.

Identified children and families are referred to the Child FIRST home-based intervention, which consists of weekly home visits by a multi-ethnic, multi-lingual team of a licensed, Master's level developmental and mental health clinician and a Bachelor's level care coordinator/case manager. Our families are often extremely wary and mistrusting of the social service system. Our approach is different. We believe that parents want the best for their children. Our initial goal is to engage our parents and build trust and mutual respect. Without building that relationship, no work can be done. A comprehensive, assessment of the strengths, priorities, culture, and needs of the family leads to a collaborative, family-driven plan of care, which includes services and supports for all members of the family. Our care coordinator provides hands-on assistance to help families connect with services and problem solve with them if there are barriers to access. These services are extremely broad, including early care and education, early intervention, special education, pediatric providers, nutrition, dental providers, adult medical specialists, substance abuse providers, adult mental health providers, domestic violence providers, parenting groups, home visiting, family resource centers, housing, shelters, HUSKY, WIC, SNAP, SSI, food pantries, clothing, job training, literacy providers, etc.

Most of our children and families need parent guidance and parent-child psychotherapy. This is to build the protective buffer of the secure, nurturing parent-child relationship, which is so often missing. This is not surprising, as so many of our parents were abused, neglected, or suffered from violence or extreme stress in their own lives. It is through the expert interventions of our clinical staff that we are able to begin to repair these early relationships, leading to healthy social-emotional development, strong language and cognitive development, and physical well-being. In addition, we work in the early care and education classrooms to help the teachers understand the child's behavior and develop strategies to promote healthy social-emotional development not only for the identified child, but frequently extending to other children in the classroom as well. The Child FIRST home-based intervention usually lasts between 4 and 12 months, but it is entirely driven by the unique needs of the child and family.

Collaboration among community agencies (both State and local) is a key component of our Child FIRST system of care model. Our goal is to help community providers understand and recognize the broad challenges of the children and families

that they serve, and for them to seek help from Child FIRST if the needs of the families are beyond their unique expertise. At the same time, Child FIRST uses the strengths of the many community resources as the source of services for the children and families. Through collaboration, we can ensure that a seamless array of comprehensive, well-integrated services and supports is provided to the family. An Early Childhood Community Council provides community oversight for the model.

CHILD FIRST RANDOMIZED TRIAL

Child FIRST has conducted a randomized controlled trial to determine the effectiveness of our model, funded as part of the Substance Abuse and Mental Health Services Administration's Starting Early Starting Smart—Prototype. Families who participated had multiple challenges, which included receiving public assistance (93 percent), unemployment (64 percent), lack of high school diploma or GED (53 percent), unmarried (67 percent), maternal depression (54 percent), family substance abuse history (44 percent), and history of homelessness (25 percent).

Data was analyzed by an independent team of doctoral level, university-affiliated psychologists. Results of the comparison of outcomes between the Child FIRST Intervention and the Usual Care Controls demonstrated the strong positive impact of the Child FIRST Intervention at 12 months. In Child FIRST children, there was a very significant decrease in aggressive and defiant behaviors (Odds ratio = 4.8), and improvement in language development (Odds ratio = 4.2). Mothers reported significantly less stress and fewer depressive symptoms, anxiety, and other mental health problems. There was a very significant decrease in referral to the Department of Children and Families (DCF) for child protective services, as reported by mothers (Odds ratio = 4.1), which was further documented by DCF records at 3 years (Odds ratio = 2.1). Intervention families were able to access 91 percent of desired services as opposed to 33 percent in Usual Care.

The results of this research were accepted for publication in *Child Development* in a special issue: "Raising Healthy Children: Translating Child Development Research into Practice."

CHILD FIRST REPLICATION

As a result of the strength and consistency of these outcomes, the Robert Wood Johnson Foundation provided $3.195 million toward funding a public-private partnership with Connecticut State leadership (including the Early Childhood Education Cabinet and the Department of Children and Families) and 12 other Connecticut philanthropies to replicate the Child FIRST model. An intensive training through a Learning Collaborative and on-site supervision is ensuring fidelity to the model. Five Connecticut cities, including Hartford, New Haven, Norwalk, Waterbury, and New London County, now have Child FIRST models, with the intention of further replication in each DCF area office throughout Connecticut.

COST-BENEFIT ANALYSIS

A cost-benefit analysis is currently being conducted, but there appears to be clear and immediate cost savings in special education, protective services and foster care, and parental productivity. Future savings in mental health services and juvenile justice are likely to be enormous. The Child FIRST intervention costs an average of about $5,000 for a family of four. When compared to conservative estimates of $96,000 per year for a level two group home for a child with serious emotional disturbance, over $450,000 per child per year for the State juvenile training school, and over $700,000 per child per year for psychiatric hospitalization, the tremendous return on investment is very clear.

POLICY IMPLICATIONS

Policy implications are very extensive. A few of those most pressing include:

(1) Medicaid and EPSDT (Early Periodic Screening and Diagnosis and Treatment): Child FIRST is the only early childhood home-based intervention in CT to receive Medicaid reimbursement for diagnosed children. However, we cannot and should not wait until a child has a diagnosable disorder before offering treatment. The opportunity to identify and prevent later disability is enormous. One has only to look at the known consequences of maternal depression or violence exposure—including serious emotional disturbance, academic failure, and abuse and neglect—to know that it is essential to treat before the symptoms are severe. EPSDT is part of Medicaid law specifically enacted to provide children with medically necessary treatment in order to identify, prevent, and intervene before serious problems develop. Full utilization of EPSDT, consistent with the intent of the law, could provide

significant Federal funding for Child FIRST implementation. In addition, EPSDT could fund screening for emotional and behavioral problems, mental health consultation services in early care and education, and services for maternal depression within the home.

(2) CAPTA (The Child Abuse Prevention Treatment Act): CAPTA requires that infants and toddlers who are victims of substantiated child maltreatment be referred by child protective services (DCF) to early intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA). The children in DCF are our highest risk young children. Surprisingly, while the numbers of substantiated children have not increased in CT during the recession, the severity of the needs of the children and families appear to have increased. CAPTA gives us an opportunity to ensure that this very vulnerable, already identified population receives the developmental assessments and intervention that are needed. If these children have emotional, behavioral, or relationship challenges, they can then be referred to Child FIRST with its unique expertise. It is imperative that States fully enact this law so that our highest risk children can be served.

(3) Early Childhood System of Care: While there are many excellent early childhood services in CT, they are fragmented and categorical. Many have no evidence-base. We need to build a comprehensive system, developed from interlocking, well integrated services and programs within and across State agencies and at the local and regional level. This would create an infrastructure that could provide direct, individualized, and seamless assistance to all families.

Child FIRST is a new and innovative, home-based model that addresses the most vulnerable children and families at the earliest possible time. It combines comprehensive, integrated, family-driven, community-based services with parent-child intervention to facilitate the nurturing relationship. The strength of the neuroscientific literature and the Child FIRST randomized trial establishes Child FIRST as a very promising model that can address ethnic, racial, and socioeconomic disparities with the goal of closing the achievement gap. We have the knowledge. We must now develop the will to restructure systems and target resources so that our vulnerable children and families can succeed.

Thank you very much!

Senator DODD. Thank you very much, Doctor.

[Applause.]

Doctor, thank you.

Dr. Keck.

STATEMENT OF DOUGLAS B. KECK, D.M.D., M.S.H.Ed., CONNECTICUT STATE LEADER, AAPD HEAD START DENTAL HOME INITIATIVE, MADISON, CT

Mr. KECK. I have a pretty loud voice. So thank you, Senator Dodd and the Subcommittee on Children and Families.

I am pleased to have the opportunity to testify at this hearing to describe an exciting project that is helping to improve children's oral health in the State of Connecticut. I am a practicing pediatric dentist in New Haven and Madison, and I teach part-time at the Pediatric Dentistry Residency Program at Yale-New Haven Hospital.

I am testifying today in my role as the Connecticut State leader of the American Academy of Pediatric Dentistry Head Start Dental Home Initiative. The American Academy of Pediatric Dentistry believes that every child deserves a healthy start in life and that good oral health is integral to the healthy development of all children.

This may come as a surprise, but dental caries is the most common chronic disease of childhood, much greater than asthma, and low-income children are three to five times more likely to have untreated tooth decay compared to children of more affluent families.

National statistics indicate that 28 percent of all preschoolers between the ages of 2 and 5 suffer from tooth decay. However, in Head Start programs, decay rates often range from 30 to 40 per-

cent in 3-year-olds and 50 to 60 percent for 4-year-olds. Head Start has reported that access to oral health services is the No. 1 health issue affecting Head Start programs nationwide.

In October 2007, the American Academy of Pediatric Dentistry signed a 5-year contract with the U.S. Office of Head Start that hopes to improve the access to care for the over 1 million children that are enrolled in Head Start and Early Head Start programs annually throughout the United States. Through this partnership, we are developing a network of pediatric and general dentists to provide dental homes to children in Head Start across the Nation. A dental home means that each child's oral healthcare is provided in a comprehensive and ongoing way by a dentist.

Here in Connecticut, approximately 9,000 children are enrolled in Head Start programs each year. Through the efforts of our regional oral health consultants and State leaders, which is my role in Connecticut, we are capitalizing on the willingness of dentists to improve access to quality dental care for underserved children. In Connecticut, I have recruited over 40 dentists to partner with Head Start programs across the State directly.

Since most Head Start children are eligible for Medicaid, it is important that Medicaid dental programs are adequately funded and properly administered. Over the past 2½ years, the number of providers that treat Medicaid recipients in our State has increased from 300 providers to approximately 1,100. I would be remiss not to mention that the key driver in these Medicaid dental program improvements was the 2008 increase in payment for Medicaid services to market-based rates as a result of settlement of litigation against the State.

An example of how my State leader role helps move the initiative forward is that I work closely with the New Haven Board of Education Head Start grantee and its delegate, LULAC. I have met with the superintendent of schools of New Haven, the grantee, and its delegate in order to finalize a program for Yale's pediatric dentistry residency program that will provide dental homes to all the New Haven Head Start students that need one.

This project is slated to reach nearly 1,000 students and their families, while providing a tremendous learning experience for our dentistry residents at Yale-New Haven Hospital.

Once again, I would like to thank Senator Dodd for allowing me the opportunity to testify, and I look forward to answering any questions about the program.

[The prepared statement of Mr. Keck follows:]

PREPARED STATEMENT OF DOUGLAS B. KECK, D.M.D., M.S.H.ED.

I am pleased to have the opportunity to testify at this hearing to describe an exciting project that is helping improve children's oral health in the State of Connecticut. I am a practicing pediatric dentist in New Haven and also teach part-time at the pediatric dentistry residency program at Yale/New Haven Hospital. I am testifying today in my role as the Connecticut State leader for the American Academy of Pediatric Dentistry-Head Start Dental Home Initiative.

The American Academy of Pediatric Dentistry [1] believes that **every** child deserves a healthy start in life and that good oral health is integral to the healthy, physical,

[1] Founded in 1947, the **American Academy of Pediatric Dentistry (AAPD)** is a not-for-profit membership association representing the specialty of pediatric dentistry. The AAPD's

Continued

social-emotional and intellectual development of all children. Unfortunately, many children in America suffer from poor oral health and lack access to quality oral health care. In the U.S. Surgeon General's 2000 Report on Oral Health in America, it was noted that not only is dental caries the most common chronic disease of childhood, but that low-income children are 3–5 times more likely to have untreated tooth decay compared to children of more affluent families. National statistics indicate that 28 percent of all preschoolers between the ages of 2 and 5 suffer from tooth decay. *However, in Head Start programs, decay rates often range from 30 percent–40 percent for 3-year-olds, and 50 percent–60 percent for 4-year-olds*. These decay rates are common for children of low-income families. In fact, Head Start directors, program specialists, staff and parents have reported that access to oral health services is the No. 1 health issue affecting Head Start programs nationwide!

In October 2007 the American Academy of Pediatric Dentistry (AAPD) signed a 5-year contract with the U.S. Office of Head Start (OHS) to confront the oral health challenges that Head Start children and Head Start programs have faced for over 30 years. This contract represents a partnership with OHS to improve access to care for the over 1 million children enrolled in Head Start and Early Head Start programs annually throughout the United States.

This partnership represents years of hard work by both the dental community and Head Start centers across the country to improve the oral health of children who have struggled for far too long to obtain care that many Americans take for granted. *Through this partnership, we are developing a network of pediatric and general dentists to provide dental homes to Head Start children*. A **dental** home means that each child's oral health care is provided in a comprehensive, ongoing, accessible, coordinated, family-centered way by a dentist. This partnership also empowers parents, caregivers and Head Start staff by providing the latest evidence-based information on how they can help prevent tooth decay and establish a foundation for a lifetime of oral health.

Early Head Start and Head Start are comprehensive child development programs which serve children from birth to age 3 (plus pregnant women) and 3 to 5, respectively, and their families. In addition to providing educational services, Head Start grantees also provide parent education and case management services. Services are provided for parents and caregivers to enable them to provide safe and nurturing environments for their children that support each child's physical, social-emotional and intellectual development, and emphasize opportunities for parent involvement.

Head Start recognizes that every child must be healthy and well-nourished to learn and develop to his or her full potential. Preventive health services are central to Head Start's comprehensive array of services. *Head Start also understands that oral health is vital to overall health and well-being*. In recognition of the fact that poor oral health can interfere with a child's ability to learn and develop, the Office of Head Start has made oral health a priority. Over time, OHS has provided funding to support a variety of oral health initiatives and programs to address barriers to oral health care for Head Start children. The current partnership with the AAPD holds great promise to overcome the greatest unmet health care need for Head Start programs across the country, because this initiative is all about linking dentists to Head Start programs. *See the attached fact sheet for more information about the national scope of the initiative*.

Here in **Connecticut**, approximately 9,000 children are enrolled in Head Start programs each year. Through the efforts of our Regional Oral Health Consultants and State Leaders—which is my role in Connecticut—we are capitalizing on the willingness of dentists to improve access to quality dental care for underserved children. *In Connecticut, I have recruited over 40 dentists to partner with Head Start programs across the State, increasing both access and utilization of dental services for families who have traditionally struggled to obtain dental services*.

Since most Head Start children are eligible for Medicaid, it is important that Medicaid dental programs be adequately funded and properly administered. *Over the past 2½ years, the number of providers that treat Medicaid recipients in our State has increased from 300 to approximately 1,100*. This is due to the efforts of the Connecticut State Dental Association, the Department of Public Health, the De-

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7,700 members are primary oral health care providers who offer comprehensive specialty treatment for millions of infants, children, adolescents, and individuals with special health care needs. The AAPD also represents general dentists who treat a significant number of children in their practices. As advocates for children's oral health, the AAPD develops and promotes evidence-based policies and guidelines, fosters research, contributes to scholarly work concerning pediatric oral health, and educates health care providers, policymakers, and the public on ways to improve children's oral health. For further information, please visit the AAPD Web site at *www.aapd.org.*

partment of Social Services, the Connecticut Dental Health Partnership (ASO), and—with a little help from me. As State Leader for the AAPD-Head Start Dental Home Initiative, I work closely with the Connecticut Department of Public Health, WIC and various Boards of Education to enhance public awareness of the importance of oral health for our State's most vulnerable children. But I would be remiss not to mention that the key driver in these Medicaid dental program improvements was the 2008 increase to market-based rates as a result of settlement of litigation against the State.

Let me provide one example of how my State Leader role helps move the initiative forward. I work closely with the New Haven Board of Education Head Start grantee and its delegate LULAC, as a member of their Health Advisory Team. I will be meeting next week with the Superintendent of Schools of New Haven, the executive directors of the grantee and its delegate, as well as the Health Managers of both programs, to finalize a new program for Yale's pediatric dentistry residency program to provide dental homes to all the New Haven Head Start students that need one. This project is slated to reach nearly a thousand students and their families. In addition, it will provide a tremendous learning experience for our pediatric, as well as general dentistry residents, at Yale-New Haven Hospital.

The AAPD, through this initiative, is also empowering parents and Head Start Staff through the development of educational materials. These materials, which include videos, will provide them with solid, evidence-based information about early childhood caries and how they can protect their children from this disease.

I want to thank Senator Dodd for allowing me the opportunity to testify, and look forward to answering any questions about this exciting initiative.

ATTACHMENT.—AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

HEAD START DENTAL HOME INITIATIVE

Creating partnerships between the dental community and Head Start to provide dental homes for Head Start children across the United States.

Every child deserves a healthy start on life, but when it comes to oral health many children face significant challenges. Young children in low-income families tend to have higher rates of tooth decay and have greater difficulty accessing ongoing basic dental care. Key points that highlight the severity of the problem include:

- Tooth decay is the most common chronic childhood disease—five times more common than asthma—and the #1 unmet health care need among Head Start children.
- Twenty-eight percent of all preschoolers between the ages of 2 and 5 suffer from tooth decay, but decay rates often range from 30 percent–40 percent of 3-year-olds and 50 percent–60 percent of 4-year-olds in Head Start programs.
- Dental care for children in Head Start generally is covered by Medicaid, however dentists' dissatisfaction with Medicaid programs often results in low levels of dentist participation and limited access to comprehensive dental care for Head Start children.

Challenges that Head Start programs face in securing access to quality dental care include those related to the availability of dental services as well as community, family and cultural factors:

- Reluctance by many general dentists to provide services for preschool-age children;
- Dentists' lack of familiarity with HS/EHS program goals, objectives and resources;
- Transportation, language and cultural barriers; and
- Educating parents about oral health and motivating them to follow up with treatment their children need.

AAPD and Head Start are partnering at the national, regional, State and local levels to develop a national network of dentists to link Head Start children with dental homes. A **dental home** means that each child's oral health care is delivered in a comprehensive, ongoing, accessible, coordinated, family-centered way by a dentist.

A **national network** of pediatric dentists and general dentists is being created to: provide quality dental homes for Head Start (HS) and Early Head Start (EHS) children; train teams of dentists and HS personnel in optimal oral health care practices; and assist HS programs in obtaining comprehensive services to meet the full range of HS children's oral health needs. Regional consultants are assisting State leadership teams in development of collaborative **networks** throughout each State. **Local networks** engage local dentists and HS personnel as well as other commu-

nity leaders to identify strategies to overcome barriers to accessing **dental homes**. This partnership also provides parents, caregivers and HS staff with the latest evidence-based information on how they can help prevent tooth decay and establish a foundation for a lifetime of oral health.

The 5-year plan relies on five key components:

- Providing project leadership, administration and organizational support;
- Providing oral health expertise and technical assistance;
- Developing networks of dentists to provide access to dental homes;
- Training dentists to enhance their capability to meet the oral health needs of young children and their understanding of HS/EHS programs; and
- Enhancing HS/EHS oral health staff training and parent education programs.

For additional information contact: Jan Silverman, AAPD Head Start Dental Home Initiative Project Manager at *jsilverman@aapd.org* or visit *http://www.aapd.org/headstart/*.

SUCCESS STORIES

Formalizing Relationships

North Dakota State Leader Brent Holman on facilitating discussions between Head Start Centers and IHS clinics: I was amazed that just by scheduling a meeting with IHS Dental staff and HS staff, they very quickly start discussing common problems and solutions for the benefit of better care for their HS kids. We mostly listened and guided them in developing strategies to solve their problems. *Although they communicated previously, this was an opportunity to talk about issues that were only informally discussed after a problem with a particular case*. It was inspiring to see their commitment to their mission despite the many challenges.

Parent Empowerment

Connecticut State Leader Doug Keck on talking with parents: At the Health Advisory Committee, parent representatives of the local Head Start were amazed from a consumer standpoint that there are differences between dentists and how it is important to seek better oral health care than what they are accustomed to.

Recruiting Providers

North Dakota State Leader Brent Holman: Surveys have been sent out to ND dentists to determine their willingness to see HS kids and/or serve on HS Advisory Committees. The early returns have been amazing with **most dentists expressing their eagerness to serve in any capacity.** We also helped an HS program "re-recruit" a dentist that decided to quit seeing HS kids, in an area that had few other dentist options.

Telamon Migrant and Seasonal Head Start, TN: Dr. Pitts Hinson, TN State leader has been working closely with the Head Start State Collaboration Director and individual Head Start grantees to identify dental homes for Head Start children throughout Tennessee who did not previously have access. According to J. Davis, State Director, Telamon Corporation,

> "The initiative is working throughout the State—not just here. The whole idea of dentists talking to each other is phenomenal—we're seeing it work. This has changed everything. All five Telamon programs traditionally have had a hard time finding dentists. For the first time in over 20 years, all five centers have partnerships with dentists."

New York State Leaders, Dr. Amr Moursi & Dr. Courtney Chinn have recently created a **NYC Pediatric Oral Health consortium for Head Start.** This consortium has support from 14 of the 15 pediatric dental residency programs in the NYC area. The consortium will link participating dental residency programs with Head Start programs.

Collaboration

Maureen Short, RN, Assistant Head Start Director, UCAN Head Start on regional collaboration meetings sponsored by AAPD HS Dental Home Initiative State Support Grants: The Southern Oregon Regional Meeting was a wonderful opportunity to begin lasting relationships between Head Start, pediatric dentists and the dental health organizations. The relationship building will be the foundation for many future positive experiences, this is a huge success. . . . Maureen Short RN.

Michael E. Jones, executive director, Oklahoma Association of Community Action Agencies on collaborating with the Pediatricians: Active and key

pediatrician involvement in the HS DHI State Leadership Team was accomplished this quarter. The representatives of the medical community have the capacity to influence physicians' decisions to participate in cross-sector education and training opportunities to be made available through the HS DHI support grant.

Senator DODD. Very excited about your project.

[Applause.]

Abby, thank you for being here.

STATEMENT OF ABBY I. DOLLIVER, SUPERINTENDENT, NORWICH PUBLIC SCHOOLS, NORWICH, CT

Ms. DOLLIVER. Thank you. I want to thank you, Senator, for inviting me and giving me this honor to testify on such a critical topic for our State and our country.

I know that you know that I have watched you throughout your career, making decisions that have improved the lives of our children and their families, and I thank you for that.

Senator DODD. Thank you.

Ms. DOLLIVER. As a fairly new superintendent, I don't see myself as the voice for all of my colleagues. However, I will speak to you about some of our programs and services. I can't really do that without also addressing some of our needs. I am sure that our story mirrors that of many of our cities and towns in Connecticut.

Norwich is an urban center now. We weren't probably when you lived there before, but we are of about 38,000 citizens. Our median household income is about $48,000, based on 2009 data.

Our district is 3,800 Pre-K to 8 students, with the majority of our high school students attending Norwich Free Academy, which is our designated high school. We do have our own Alternative High School and Clinical Day Treatment Programs, which are the types of programs that are helpful and important to the success of many of our high school students. Not all students benefit from a comprehensive high school experience.

Our schools are very diverse. There are 29 languages spoken there. We house five bilingual centers within our schools. These centers are critical for the success of our students with English as a second language. Many of our students arrive in school without speaking any English. There are 465 students with English as a second language throughout our district.

We are fortunate to be part of a program as a partner with UCLA in California called Project Excell. This program teaches our teachers strategies for our classrooms and dealing with students who do not speak English. We have also had several years of training for staff in a program called Courageous Conversations, which gave us the opportunity to have discussions about items related to race, our feelings about the differences, and how to manage them in a very diverse environment.

Seventy-nine percent of our students qualify for free or reduced meals in school. This federally funded program is critical to our district, as we feed our students breakfast, lunch, and snacks. Without this, many would be hungry, and we know how adversely hunger affects our students' abilities to focus in school.

During last summer, 2009, we provided 11,185 breakfasts and 21,654 lunches throughout our community, and I expect that this year's numbers will be higher. Our students and their families need these programs.

Norwich has 845 students who meet the criteria for special education services. While we know that many of the mandates for special education have not been ever fully funded, we were able to provide specialized programs for students on the autism spectrum, and I know that there is much research going on currently about autism, and the numbers of students who qualify for these programs continues to grow.

In addition, older students also are required to have programs now that transition them to be able to be successful and independent after high school. We are able to use some of our ARRA funding to support both of these important initiatives, as well as others. We do need to provide these programs in the future.

We provide several integrated preschool opportunities. These are all possible through Title I, School Readiness, and IDEA funding. We also have Family Resource Centers in several of our schools. Even with limited space, we are committed to finding ways to keep these centers in our schools. They provide affordable before and afterschool care and supports for families. We all know how important early intervention is to future student success.

Increasing parent involvement is one of our goals. We provide opportunities to partner with them to work together for student success. One example is the FAST Team, which is Families and Schools Together. This grant came through the Connecticut Parent Advocacy Center, and they helped us to focus on opening doors and bridging communication gaps with our parents. Each of our schools finds ways to engage parents who are very busy and hard-working.

Since 2007, we have expanded afterschool opportunities to our K to 8 students with a 5-year 21st Century Learning Center grant award. We were able to serve over 450 students from afterschool until 5 p.m. This had a positive impact on students, with enriched academic and cultural opportunities, service learning projects, and recreational activities. During the summer months, we were able to provide service learning, enrichment, and structured recreational activities for students, bringing academic success from one year to the next, a very necessary bridge.

After school tutorial programs through grant funding enriches students' math and literacy skills. Learn and Serve America funds support community partnerships with students. Community pride and involvement is critical to student and community success.

Three school-based health clinics offer students and families access to essential health and counseling services. This program has helped students with obtaining physicals and immunizations and ongoing healthcare. We have a wellness committee that oversees initiatives for healthy staff and students. We take advantage of a fresh fruit and vegetable grant so that we set the example for students on healthy eating and lifestyles.

The Positive Behavior Support Program is being implemented in our schools to address school climate and culture. We have seen a significant decrease in disciplinary referrals as a result of this program.

This is all part of our Scientifically Research Based Intervention Programs that provide tiered interventions to address both academic and emotional and behavioral needs of our students. Several

of our schools have developed Character Counts initiatives, which provide positive reinforcement for good citizenship.

Those programs that I have mentioned are just a sampling of all that we do. I am proud to say that we are making progress. Even with a nearly flat-funded budget for the third year in a row and with having to close two schools this year coming up and laying off 70 staff, we are making progress.

We have not closed the achievement gap. We are one of the districts in need of improvement in Connecticut. Yet with all of these program opportunities and our committed staff, we open the doors to our students and their families with programs and services that address their academic, social, and health needs. Providing emotional and academic support is critical to student success, and we need this success as the foundation for our future.

[The prepared statement of Ms. Dolliver follows:]

PREPARED STATEMENT OF ABBY I. DOLLIVER

I want to thank you Senator Dodd, for providing me with the honor of testifying today on such a critical topic, *Connecticut's Children*. I am proud to say that I have watched you throughout your career making decisions that have improved the lives of our children and their families, and I thank you for that.

As a fairly new Superintendent, I don't see myself as the voice for all of my colleagues; however I will speak to you about some of our programs and services. I can't really do that without also addressing some of our needs. I'm sure that our story mirrors that of many of our cities and towns in Connecticut.

Norwich is an Urban Center with about 38,000 citizens; our median household income is $48,000 a year based on 2009 data. Our district has 3,800 Pre-K to 8 students, with the majority of our high school students attending Norwich Free Academy, our designated high school. We do have our own Alternative High School and Clinical Day Treatment Program which are the types of programs that are helpful and important to the success of many high school students. Not everyone benefits from a comprehensive high school experience.

Our schools are very diverse. There are 29 languages spoken there. We house five Bilingual Centers. These centers are critical for the success of our students with English as a second language. Many of our students arrive in school without speaking any English. There are 465 students with English as a second language throughout our district. We are fortunate to be part of a partner program with UCLA in California, Project Excell. This program teaches our teachers strategies for their classrooms for our students who do not speak English. We have also had several years of training for staff in a program called Courageous Conversations. This program discussed issues related to race, our feelings about these differences and how to manage them in a very diverse environment.

Seventy-nine percent of our students qualify for free or reduced meals in school. This federally funded program is critical to our district as we feed our students breakfast, lunch and snacks. Without this, many students would be hungry and we know how adversely hunger affects students' abilities to focus in school. During the summer of 2009 we provided 11,185 breakfasts and 21,654 lunches. I expect that this year's numbers will be higher. Our students and families need these programs.

Norwich has 845 students who meet the criteria for special education services. While we know that many of the mandates for Special Education have not been fully funded, we are able to provide specialized programs for students on the autism spectrum. I know that there is much research going on currently about autism and the numbers of students who qualify for these programs continues to grow. In addition, older students also are required to have programs that provide a transition for them to be able to be successful and independent after high school. We are able to use ARRA funds to support both of these important initiatives as well as others.

We provide several integrated preschool opportunities. These are all possible through Title 1, School Readiness, and IDEA funding. We also have Family Resource Centers in several of our schools. Even with limited space we are committed to finding ways to keep these centers in our schools. They provide affordable before and afterschool care and supports for families. We all know how important early intervention is to future student success.

Increasing parent involvement is one of our goals. We provide opportunities to partner with them to work together for student success. One example is the FAST Team (Families and Schools Together). This grant through the Connecticut Parent Advocacy Center helped us to focus on opening doors and bridging communication gaps with our parents. Each of our schools finds ways to engage our very busy and hard-working parents.

Since 2007 we have expanded afterschool opportunities for our K to 8 students with a 5-year 21st Century Community Learning Center grant award. We are able to serve over 450 students from the end of the school day until 5 p.m. This has had a positive impact on students, with enriched academic and cultural opportunities, service learning projects and recreational activities. During the summer months we are able to provide service learning, enrichment, and structured recreational activities for students, bringing academic success from one year to the next, a very necessary bridge.

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The Positive Behavior Support Program is being implemented in our schools to address school climate and culture. We have seen significant decrease in disciplinary referrals as a result of this program. This is all part of our Scientifically Research Based Intervention Programs that provide tiered interventions to address both the academic and behavioral needs of our students. Several of our schools have developed character count initiatives which provide positive reinforcement for good citizenship.

Those programs that I have mentioned are just a sampling of all that we do. I am proud to say we are making progress. Even with a nearly flat funded budget for the third year in a row and with having to close two schools and lay off 70 staff, we are making progress. We have not closed the achievement gap yet but with all of these program opportunities and our committed staff, we open the doors to our students and their families with programs and services that address their academic, social and health needs. Providing emotional and academic support is critical to student success and we need this success as the foundation for our future.

Senator DODD. Very good, Abby. Thanks so much.

[Applause.]

Tammy.

STATEMENT OF TAMMY PAPA, DIRECTOR, BRIDGEPORT LIGHTHOUSE, BRIDGEPORT, CT

Ms. PAPA. Good morning. On behalf of our partner agencies and the children and families we serve, I would like to thank you for the opportunity to submit testimony today on what is working for Connecticut's children.

A very special thank you to you, Senator Dodd, for all that you have done for Bridgeport children. We truly appreciate it.

The Lighthouse Program serves approximately 2,700 children a day in 24 public schools, and we know we are impacting the whole child when we hear from a teacher who tells us,

> "My students were doing poorly in math, struggling with basic math concepts. Since participating in the Lighthouse mathematics program, the girls have come a long way and are now doing so well that they are helping other students."

Or when student Amanda Lopez writes, "The Lighthouse Program has helped me in so many ways, but most importantly, it helps me stay out of trouble after school."

And yet another student, Cecily Morales, writes, "Lighthouse has given me opportunities for new things like ballroom dancing. For me, this has helped me be more confident."

Or when a parent from Edison School comments that,

> "The Lighthouse Program treats each and every child like a member of its own family. I feel comfortable leaving my child there on a daily basis. It is a wonderful program, and I see a big change in my son's behavior."

Through tutoring, partnerships with local universities, regular contact with daytime teachers, state-of-the-art curriculum in reading and math, as well as activities that focus on critical thinking skills, the Lighthouse Program is making strides to close the achievement gap.

Our latest independent evaluation, conducted by Dr. Phil Zarlengo of MRM, former director of the Lab at Brown University, reports that,

> "2009 findings for Lighthouse participants are significant for reading, writing, and math when compared to the rest of the district. The average CMT mathematics score of Lighthouse students exceeded the district score in grades 3 through 8, and the average reading and writing score exceeded the district score in grades 3, 5, 7, and 8."

We address the physical, social, and emotional well-being of Bridgeport children by offering them activities in a judgment-free zone in which pressure to perform is taken out of the equation. Through various partnerships for extracurricular activities, the Lighthouse Program is working with some of the district's most challenged students, and daytime teachers are reporting positive changes in behavior.

They indicate that, "72 percent of students had good to excellent relationships with peers, and 83 percent had good to excellent relationships with teachers." Furthermore, "86 percent of Lighthouse participants are rarely or never referred to the office for disciplinary reasons, and 79 percent rarely or never require in-class discipline," resulting in fewer disruptions and more time on task.

Through these activities, the Lighthouse Program is also addressing the serious obesity rate among our young people. Joseph Mahoney, Ph.D., associate professor of psychology at Yale University during the time of the research—he has since moved—and at the time under the direction of Dr. Zigler, noted that "childhood obesity is a significant problem in this Nation and in the city of Bridgeport. When the children in this study were only 5 years old, nearly one quarter of them were clinically obese. However, over time, children participating in afterschool programs showed a less marked increase in their body mass index and lower rates of clinical obesity.

> "In particular, by the second year of the study, 33 percent of children who did not participate in afterschool programs were obese, compared to only 21 percent of those who did."

His study further concluded that

> "Children in Bridgeport's afterschool program had higher expectations of success and more socially acceptable behavior

when compared to children in self care, parent care, or relative care."

And that,

"For those children exposed to high rates of crime and violence in their neighborhoods, participation in the afterschool program appeared to buffer them from exposure and significantly reduce the likelihood of developing academic and behavior problems in school."

In a city like Bridgeport, where 95 percent of public school students are considered economically disadvantaged, we need to do all we can to assure that children are productive during their out-of-school time. We need to appeal for more funding that provides children, who tend to suffer greatly during tough economic times, with opportunities to participate in quality afterschool and summer programs because we now know that they work.

We need to make sure that current sources of funding, like the 21st Century Community Learning Centers program, remain intact and that the funds for such are not diverted.

While we have been fortunate over the years to grow the city's Lighthouse Program, we still have much to do to ensure that every child that wants or needs access has it. As program providers, we appreciate opportunities in which we can share our successes and humbly ask that we continue to safeguard the future of every American child by continuing to support high-quality afterschool and summer programs like Bridgeport's Lighthouse Program that partners with the school district and our community-based organizations to help students learn, succeed in school, become college- and career-ready, and thus productive members of society.

Thank you.

[The prepared statement of Ms. Papa follows:]

PREPARED STATEMENT OF TAMMY PAPA

Good morning. My name is Tammy Papa and I am the director of the city of Bridgeport Lighthouse Before, AfterSchool and Summer Program. On behalf of our partner agencies and the children and families we serve, I would like to thank you for the opportunity to submit testimony today on what is working for Connecticut's Children. A very special thank you to you Senator Dodd for all you have done in support of our program over the years. Without your leadership along with Senator Lieberman, former Congressman Christopher Shays, and Congressman Himes, we would not have been in a position to serve over 2,700 children per day for the past 17 years.

History: Partnership that began in 1993 between the city of Bridgeport, Board of Education, and numerous faith and community-based organizations, as well as institutions of higher education at a time when our young people were being shot and killed on our streets in broad daylight, afterschool, and within yards of our public schools. Then Mayor Joseph Ganim along with former Superintendent James Connelly called upon some of the larger non-profits and faith-based organizations within the city to work together on a solution to curb the violence. The city was coming out of bankruptcy and was only able to contribute a small amount. Other agencies did what they could as well. With approximately $100,000 in seed money, three schools in critical neighborhoods and a few community centers extended their hours. With the start of the new fiscal year in July 1993, an influx of Education Cost Share funding allowed the city through the Board of Education to expand programming into 17 summer and afterschool sites. The program was scaled back to 11 sites the following year maintaining a budget of approximately $850,000 where it remained until receiving its first 21st CCLC grant in 1998 and an increase of $400,000 from the city. Former Mayor John Fabrizi and current Mayor Bill Finch have both maintained the city's investment in afterschool which today totals $1,350,000 annually. From 11 afterschool sites, the program has grown to 24 sites

and the need to open two additional schools in the fall and spring of 2010 and 2011 respectively is evident. The program receives Federal, State, local, private foundation, and parent fees. It's 2010–11 budget totals $4,000,000.

Currently Serving: 2,700 Bridgeport children daily in grades K–8 during the school year from 3 p.m.–6 p.m. and during the summer for 5 weeks from 9 a.m.–5 p.m. employing over 300 individuals.

Percent of Public School Student Population Served: Approximately 12 percent for the 2009–10 school year.

In addition to providing a **safe** place for children who might otherwise go home to an unsupervised setting, the Lighthouse Program also addresses the following issues:

Achievement Gap—Through tutoring, partnerships with local universities, regular contact with daytime teachers, state-of-the-art curriculum in reading and math as well as activities that focus on critical thinking skills, the Lighthouse Program is making strides to close the achievement gap. Our latest independent evaluation conducted by Dr. Phil Zarlengo, former director of the Lab at Brown University reports that:

> "2009 findings for Lighthouse participants are significant for Reading, Writing, and Math when compared to the rest of the district. Students in all but 5th grade are performing at proficiency or above in reading and math. The average CMT Mathematics score of Lighthouse students exceeded the district score in grades 3–8 and the average Reading and Writing score of Lighthouse students exceeded the district score in grades 3,5,7, and 8."

This evidence is further backed by the research conducted over a 2-year period by Deborah Lowe Vandell, University of California, Irvine and her team titled, "The Study of Promising Practices," which Bridgeport's Lighthouse Program was part of. She found that "those elementary school students who regularly attended the high-quality afterschool programs demonstrated significant gains." We are hopeful that subsequent evaluations will show further growth and anticipate the completion of the 2010 report shortly. In the meantime, we continue to research new, innovative, and cost-effective approaches that engage children in activities that promote learning.

• **Physical, Social and Emotional Well-Being**—By offering children activities in a judgment free zone in which pressure to perform is taken out of the equation, they adapt and rise to the occasion. Through partnerships with the Kennedy Center, the Lighthouse Program is working with some of the districts most challenged students during afterschool hours and daytime teachers are reporting positive changes in behavior. Activities that encourage team approaches like those offered through First Tee, USTA's Quick Start, and Cal Ripken's Healthy Choices, Healthy Students among a host of other activities like ballroom dancing, chess, organized basketball clinics, drama, etc. indicate Lighthouse children's physical, social, and emotional needs are being met. Daytime teachers reported that "72 percent of students had good to excellent relationships with peers and 83 percent had good to excellent relationships with teachers." Furthermore, "86 percent of Lighthouse participants are rarely or never referred to the office for disciplinary reasons and 79 percent rarely or never require in class discipline" resulting in fewer disruptions and more time on task. Through these varied activities, the Lighthouse Program is also addressing the serious obesity rate among our young people. Joseph Mahoney PhD. Associate Professor of Psychology at Yale University during the time of his research on the Lighthouse Program, noted that:

> "Childhood obesity is a significant problem in this Nation and in the city of Bridgeport. The condition is known to predict a range of serious health problems. When the children in this study were only 5-years-old, nearly one-quarter of them were clinically obese. However, over time, children participating in afterschool programs showed a less marked increase in their body mass index and lower rates of clinical obesity. In particular, by the second year of the study, 33 percent of children who did not participate in afterschool programs were obese compared to only 21 percent of those who did participate in afterschool programs."

By providing Lighthouse children with healthy snacks, rotating them from activity to activity, and encouraging a minimum of 20 minutes of exercise per day, the program is making strides to curb this most serious epidemic. Dr. Mahoney's study further concluded that:

> "children in Bridgeport's afterschool program had higher expectations of success and more socially acceptable behavior when compared to children in self care, parent care or relative care."

This is especially critical because all the research shows that student expectations of his or her performance have a direct correlation to his or her rates of success.

• **Community Violence**—Research shows that exposure to criminal activity over time can hinder one's ability to focus in school and most often times creates problem behavior. With the rise of gang activity on our streets it is critical that we keep our children in supervised settings and away from danger until a parent or guardian can be there. We use this time productively to help build relationships between local law enforcement and students. Raising awareness about the negative impact of joining gangs and what to look for in their community is reducing their risk of becoming involved in illicit activities or being victimized. In his study of Lighthouse Program participants over 4 years, Dr. Mahoney concluded,

> "for those children exposed to high rates of crime and violence in their neighborhoods, participation in the afterschool program appeared to buffer them from exposure and significantly reduce the likelihood of developing academic and behavior problems at school."

Since the Lighthouse Program is not exempt from the current recession, it has become even more critical that we constantly measure our success and look for new ways to engage not only our K–8 population, but also our high school youth who suffer greatly from a lack of employment opportunities. There can be no time, effort, or money wasted on unsuccessful activities as needs grow during tough economic times and tend to have a devastating effect on the young and elderly alike. Therefore, in addition to our annual independent evaluation which collects both quantitative and qualitative information, we are conducting additional site visits, asking site coordinators to conduct periodic self assessments, keeping in regular contact with principals, and asking for community feedback. In this manner, we are poised to attract additional funding opportunities that will enable us to bring current programs to scale and replicate services throughout the district.

The Impact of AfterSchool on Bridgeport and the Region

- **Economic Development**
  - Employs over 300 certified teachers, para-professionals, college students, youth, and adults.
  - Allows approximately 1,800 families to work full days.
  - Higher employee productivity levels.
  - Incentive for company relocations.
- **Higher Test Scores**
  - Reading, Writing, and Math.
- **Lower Crime Rates and Less Exposure to Crime**
- **Transition from Early Childhood Initiatives**
- **Lower Obesity Rates**
  - Reduced health care costs.
  - Improved Self Esteem.
- **Less Discipline Referrals**
- **Higher Attendance Rates**

Again, thank you for the opportunity to speak before you today.

Senator DODD. Thank you.

[Applause.]

Kellyann.

STATEMENT OF KELLYANN DAY, EXECUTIVE DIRECTOR, NEW HAVEN HOME RECOVERY, MANCHESTER, CT

Ms. DAY. Good morning, Senator Dodd, and distinguished guests. It is an honor to be here, and thank you for inviting me to speak.

Contrary to the stereotype of men sleeping in doorways or pushing overloaded shopping carts, families now comprise 40 percent of the homeless population in the United States. The percentage is closer to 50 percent in the State of Connecticut.

I have submitted many pages of information in my written testimony for your review, but I just want to emphasize one thing. Of the 130 children that we sheltered this past year, 35 percent were between the ages of 6 and 12, and 45 percent were under 6.

Of the 15 programs that New Haven Home Recovery operates, I would like to highlight two. The first is the Family School Connection, funded by the Connecticut Children's Trust Fund. It operates out of the Fair Haven K–8 School, which has the highest number of homeless families in the city.

The FSC is an intensive home visiting program that provides parent education and student advocacy. Children who are at risk of neglect because of excessive tardiness, truancy, or academic and behavioral challenges are referred to the program. Young children who are frequently tardy, absent, and disconnected from school are likely to be living in circumstances where family issues are interfering with their participation and opportunity to learn and achieve.

The outcomes of our program this year, to name a few, a significant drop in DCF referrals were made by the school, an increase in parental involvement was documented, and a 15 percent increase in grades for the students who were enrolled in the program was shown.

On a cold morning in March during the CMTs, the FSC staff received a phone call from the school requesting assistance. When staff arrived, they found a third grade boy was selling his Christmas toys to classmates to help his dad pay for rent and food.

A backpack full of food, a Stop and Shop gift card, toiletry items, warm clothing were all provided to the child that day to bring home. Subsequently, the family was informed about the program and enrolled. As of today, dad is employed, engaged with the school, and accessing community resources. The child is excelling socially and academically.

This is a highly successful program, and we have many families on the wait list.

The second program is the Homeless Prevention and Rapid Re-Housing Program, funded by HUD. The program provides financial assistance to people lining up for shelter beds or for those that are in the shelter.

For example, Jack and Diane were evicted from their home of 5 years. Jack is a self-employed contractor. Diane is a stay-at-home mother of six. Upon eviction, the family moved into a local homeless shelter, but one of their children's asthma became so severe that they needed to move to a motel.

After two apartments fell through, the family finally found a house to rent. Unfortunately, the timing was off. They had reached their limit on their credit card at the motel and were being put out on the street. Their only choice was to sleep in their car. HPRP prevented this from happening by providing funding for the motel for a few days and ultimately relocating them to the home.

Lastly, Juan and Julia, both college graduates, moved to New Haven from Puerto Rico in order to seek medical care for their son. Their 1-year-old was ill and had recently undergone open heart surgery at Yale-New Haven Hospital. In addition, the boy was recovering from liver disease and other infections.

The family was living at the Ronald McDonald House during the baby's hospitalization but had no place to live upon discharge. A stay at a shelter would have compromised the boy's fragile health.

They considered going back to Puerto Rico, but funding was limited, and they needed to remain close to necessary medical care.

HPRP was able to assist them in finding housing, paying for security deposit and rental assistance. The family is stably housed, and Juan and Julia are currently looking for work.

Thank you for allowing me to tell you about these families, and thank you for all the work that you have done.

I know I did submit lots of facts and figures in my written testimony.

Senator DODD. They were great.

Ms. DAY. And I would be happy to talk about those after.

[The prepared statement of Ms. Day follows:]

PREPARED STATEMENT OF KELLYANN DAY

Good morning Senator Dodd and distinguished guests, it's an honor to be here. Thank you for inviting me to speak and thank you for great work on family and children's issues.

Contrary to the stereotype of men sleeping in doorways or pushing overloaded shopping carts stuffed with their worldly belongings, families now comprise 40 percent of the homeless population in the United States. The percentage is closer to 50 percent in the State of Connecticut.

Just 30 years ago, child and family homelessness did not exist as it does today. The numbers of homeless families in the United States are increasing at a rapid rate. According to the National Alliance to End Homelessness' Web site,

> "Approximately 3.5 million individuals experience homelessness each year—about 600,000 families and 1.5 million children. An additional 3.8 million adults and children are residing in doubled-up, overcrowded, or otherwise precarious housing situations."

CT Faces a significant and growing challenge of family homelessness, with a steadily increasing number of homeless families with children. We saw a 13 percent increase in homeless families from 2007 vs. 2008 and a 33 percent increase between 2008 and 2009!

Available shelter and housing for homeless families is decreasing. There is a rising demand for shelter and housing at a time when State and local government are unable to support the operations of shelters and are cutting budgets. The development of affordable and supportive housing has slowed significantly. Public housing authority lists are long and rarely open for new names.

In 2007, the nationwide average shelter stay for a homeless family was 5 months. With the economy worsening in 2008 and 2009, the length of stay has been increasing. At NHHR we have seen a 17-percent increase in the number of days a family is living at the shelter.

In a nationwide survey, 87 percent of homeless families cited a lack of affordable housing as the primary cause of their homelessness. Although most homeless families are headed by a single parent, families in 36 of the 50 States must work at least two full-time jobs in order to afford Fair Market Rent for a two-bedroom unit.

- Overcoming homelessness is almost impossible without steady employment.
- Over two-thirds of homeless parents are unemployed.
- Fifty-three percent of homeless mothers do not have a high school diploma.

In 17 of 50 States, households must earn over $16/hour to afford the Fair Market Rent for a two-bedroom unit. According to the National Center on Family Homelessness' Stat Report Card, the minimum wage in CT is $8.25. The average wage for renters is $16.53, but the hourly wage needed to afford a two-bedroom apartment is $21.11. That means someone working full-time at minimum wage earns only 39 percent of what is needed to afford the average two-bedroom apartment.

Homeless children have less of a chance of succeeding in school. This year 35 percent of the 130 children sheltered in NHHR shelters were between 6 and 12 years old and attending school.

- Homeless children are more likely than housed children to be held back a grade.
- Homeless children have higher rates of school mobility and grade retention than low-income housed children.
- Frequent school transfers are the most significant barrier to the academic success of homeless students.

Homeless families are more vulnerable to serious health issues. While homeless, children experience high rates of acute and chronic health problems. The constant barrage of stressful and traumatic experiences also has profound effects on their development and ability to learn.

Children experiencing homelessness are:

- Four times more likely to show delayed development.
- Twice as likely to have learning disabilities as non-homeless children.
- Sick four times more often than other children.
- Have four times as many respiratory infections.
- Have twice as many ear infections.
- Five times more gastrointestinal problems.
- Four times more likely to have asthma.
- Go hungry at twice the rate of other children.
- Have high rates of obesity due to nutritional deficiencies.
- Have three times the rate of emotional and behavioral problems compared to non-homeless children.

Violence plays a major role in the lives of homeless children.

- By age 12, 83 percent had been exposed to at least one serious violent event.
- Almost 25 percent have witnessed acts of violence within their families.
- Homeless parents and their children are more likely to have experienced violence.
- Domestic violence is the second most frequently stated cause of homelessness for families.
- One out of three homeless teens have witnessed a stabbing, shooting, rape, or murder in their communities.

Among youth aging out of foster care, those who subsequently experience homelessness are more likely to be uninsured and have worse health care access than those who maintain housing.

Over 50 percent of all homeless mothers have a lifelong mental health problem.

Homeless adults in family shelters, when compared to the general adult population, have three times the rate of tuberculosis and eight times more HIV diagnoses.

Homeless parents and their children are more likely to be separated from each other. Homelessness is the most important predictor of the separation of mothers from their children.

- Thirty-four percent of school-aged homeless children have lived apart from their families.
- Thirty-seven percent of children involved with child welfare services have mothers who have been homeless at least once.
- Sixty-two percent of children placed in foster care come from formerly homeless families.

The deck is clearly stacked against homeless and the unstably housed. How do we focus on education when we don't have a stable place to sleep? Forty-five percent of the homeless children sheltered at NHHR shelters were under 6 years old. We have new born babies at the shelter, often!

Of the 15 programs that NHHR operates I'd like to highlight two.

The first is the Family School Connection (FSC) program, funded by the CT Children's Trust Fund. It operates out of the Fair Haven K–8 School, which has the highest number of homeless families in the city. FSC is an intensive home visiting program that provides parent education and student advocacy. Children who are "at risk" of neglect because of excessive tardiness or truancy and/or academic or behavior challenges **are referred to the program**.

Young children who are frequently tardy, absent, and disconnected from school are likely to be living in circumstances where family issues are interfering with their participation and opportunity to learn and achieve.

Outcomes:

- Significant drop in DCF referrals by the School (comparable to last year).
- An increase in parental involvement.
- Fifteen percent increase in grades for students enrolled in the program.

On a cold morning in March, during the CMT's the FSC staff received a call from the school requesting assistance. When staff arrived, they found that a 3d grade boy was selling his Christmas toys to classmates to help his Dad pay for rent and food. A back pack full of food, a Stop and Shop gift card, toiletry items and warm clothing were provided to the child to bring home that day. Subsequently the family was informed about the program and enrolled. As of today, Dad is employed, engaged with the school and accessing community resources. The child is excelling socially and

academically. This is a highly successful program and we have many families on the wait list.

The Family School Connection program conducts universal screening of all its families. The program is prevention-based, and therefore, screens clients to make sure the State Department of Children and Families (DCF) is not involved with the family. The program also screens children for social and emotional development and refers those at risk for help.

The vision of Family School Connection is that every child will be raised within a nurturing environment that will ensure positive growth and development.

The mission of the Family School Connection (FSC) program is to work in partnership with parents of children ages 5 to 12 years old who are frequently tardy, absent or disconnected from school in order to strengthen the parent-child relationship, home-school relationship and the parent's role in their child's schooling.

GUIDING PRINCIPLES

- Young children who are frequently tardy, absent, and disconnected from school are likely to be living in circumstances where family issues are interfering with the child's participation and opportunity to learn and achieve.
- Developing a trusting and productive relationship between the program staff and the family is the foundation for strengthening a vulnerable family.
- Consistent and reliable contacts are the most effective way of establishing a supportive and helpful relationship between the program staff and the family.

The goals of the Family School Connection program are to:

- Enhance nurturing parenting practices.
- Reduce stress related to parenting.
- Increase parental involvement in the child's education.

The program works to achieve these goals by meeting the following objectives:

- Increase primary caregiver's parenting skills, attitudes, and behavior.
- Increase primary caregiver's ability to use community resources.
- Increase communication between primary caregivers and school personnel.
- Increase primary caregiver's involvement in the child's education and presence in the school.

A growing body of intervention evaluations demonstrates that family involvement can be strengthened with positive results for children and their school success. To achieve these results, it is necessary to match the child's developmental needs, the parent's attitudes and practices, and the school's expectations and support of family involvement. Three family involvement processes for creating this match emerge from the evidence base:

- ***Parenting*** consists of the attitudes, values, and practices of parents in raising young children.
- ***Home-School Relationships*** are the formal and informal connections between the family and educational setting.
- ***Responsibility for Learning Outcomes*** is the aspect of parenting that places emphasis on activities in the home and community that promote learning skills in the young child.

The Family School Connection Program encompasses these processes in the design and structure of the program through three components aimed at reducing the risk of child abuse and neglect and increasing positive results for children and their school success.

HOME VISITATION

Home visiting based on the concept of "family-centered" practice is the foundation of the Family School Connection program. This practice is designed to engage families as partners and is essential to the success of the program. Research has found that parents enrolled in the home visiting component experienced less stress, developed healthier interactions with their children, and became more involved in their children's academic lives during the time they participated. The program results also suggest that this home visiting is a promising way to decrease child abuse and neglect in families with school-aged children.

Program participants are offered weekly home visits for as long as the family feels the visits are beneficial or until the child ages out of the program. At any time the frequency of the visits can be changed based on the family's needs and preferences. The first objective of the home visitor is to establish a relationship with the family. Often this is accomplished by addressing immediate and concrete needs identified by the family such as employment, child care, transportation, basic necessities, and

other issues that might be making it difficult for the parent to attend to the child's need to be in school.

The second objective is to establish a plan for assisting the family. The home visitor works with the family to create and implement a Family Action Plan that draws on the family's strengths, community resources, and the skills of the home visitor to:

- strengthen parent-child relationships;
- create linkages for the family to community resources;
- support the parent in meeting their family's basic needs;
- support the parent in attaining their own aspirations and needs; and
- support the overall social-emotional needs of the parent and child.

The Clinical Supervisor works with the home visitor to assess the family's needs and support the home visitor and parent in the creation and implementation of the family action plan. The Clinical Supervisor can also provide clinical intervention for the family if the need arises.

HOME-SCHOOL TEAM

The program supports families by helping both the parent and child make a positive connection with the child's school. Program staff help the family connect with a host of school and community services. Program staff also work with school personnel to help the school better understand and support the needs of the family. Parent school involvement is an essential piece of the program and is encouraged by program staff at every opportunity.

FAMILY LEARNING

Traditionally, school officials have found it challenging to get parents involved, especially in areas that have a large non-English speaking, immigrant population. This has been due, in large part, to language and cultural barriers experienced by non-English speaking parents. In order to accommodate this population, parent engagement strategies are modeled after those used by Brein McMahon High School in Norwalk, CT, where there is also a large immigrant population. Communication is also crucial to getting parents involved. Parents may not get involved because they lack direct and helpful information. Information needs to be provided consistently and in different formats to ensure the information is delivered in a clear and supportive style. Resources should be provided to parents who want to learn more about their children's education and activities. The FSC staff aid school staff trying to increase involvement by implementing these strategies.

Program staff work with families help them understand and take responsibility for their children's learning outcomes. This is the aspect of parenting that places emphasis on activities in the home and community that promote learning skills for children. Responsibility for learning outcomes in the elementary school years falls into four main areas: supporting literacy, helping with homework, managing children's education, and maintaining high expectations.

Program staff work in partnership with the school, community organizations, and arts and cultural institutions to engage families in family learning opportunities. Family learning opportunities can range in scope and service but are all intended to extend to help the parent understand and under-take their role as the child's first and most important teacher. The home visitor works with the family to enroll them in a family literacy program, before and afterschool programs, tutoring services or parent workshops on topics that support and extend a child's learning to the home and community.

Highlights this year:

- Between October 2009 to May 2010, 316 books were read by FSC enrolled students.
- The FSC program was able to purchase school uniforms for children within the FSC program. FSC has become an active investor of Fair Haven School's "uniform is unity" policy.
- FSC families participated in New Haven Home Recovery's holiday program, Adopt-a-Family, were 32 FSC families were adopted and given Christmas gifts this holiday season.
- The FSC program co-sponsors the RIF program with The Fairhaven School to promote reading as well as connect families with the school. FSC staff and families participate in this school-wide presentation.
- The FSC program participated in the Fair Haven School Advisory Program (Grades 7–8). The advisory program is an arrangement whereby one adult and a small group of students have an opportunity to interact on a scheduled basis in

order to provide a caring environment for guidance and support, everyday administrative details, recognition and activities to promote citizenship. The purposes of advisory are to ensure that each student is known well at school by at least one adult who is that student's advocate (the advisor), to guarantee that every student belongs to a peer group, to help every student find ways to be successful, and promote coordination between home and school.

• The FSC program had six target children graduate from the Fairhaven K–8 and all are registered to attend high school in the fall. In addition, as a result of FSC involvement, parents reported school successes with their children.

• All FSC families participated in the Homework Contract campaign. This assists families with becoming involved in their children's academics and build on parent-child-school relationships.

• During the fiscal year ending, June 30, 2009, FSC families participated in a series of family field trips with transportation and admission sponsored by NHHR. The field trips include: Duckpin bowling, Movie night Lake Compounce, Roller Magic Rink, Beauty and the Beast at the Chevrolet Theatre, Lighthouse Park, Norwalk Aquarium and Beardsley Zoo.

FSC annual data:

• 107 Families have been referred.
• 53 Families were enrolled.
• 85 Children participated.
• 211 People total.

The Second Program is the The Homeless Prevention and Rapid Re-housing program, funded through the American Recovery and Reinvestment Act provides funding and services to families and individuals. NHHR serves families who are at imminent risk of homelessness, or who are literally homeless. Examples of assistance that may be provided include:

Financial Assistance

• Rental assistance, including back rent.
• Security and utility deposits.
• Assistance with utility payments, including utility arrearages.
• Moving cost assistance (not furnishings).

General Assistance

• Referrals to other agencies/shelters when appropriate.
• Legal services to assist appropriate person's to stay in their housing (not assistance with mortgages).

Populations To Be Served

Programs will target people who would be homeless "*but for this assistance*."

• *Rapid Re-Housing:* Includes people who are literally homeless (ex: living in a shelter, a motel, a car, etc.) who require more permanent housing.

• *Prevention with Re-location:* Includes people who are at imminent risk of becoming homeless (ex: notice to quit, in the process of an eviction, institutional discharge, housing has been condemned, etc.), who are unable to repair their current housing situation and will need to relocate.

• *Prevention In Place:* This includes people who are at risk of becoming homeless (ex: behind on rent, temporary loss of income, etc.), but who intend to stay in their current housing situation.

The following is the program breakdown of those served through HPRP:

HPRP

	Households	Total in Household
Admitted	15	56
Discharged	40	41
In progress	183	569
Total	238	766
Denied	138	438

For example, Jack and Diane were evicted from their home of 5 years. Jack is a self employed contractor. Diane is a stay at home mother of six children. Upon eviction, the family moved into a local homeless shelter, but one of their children's

asthma became so severe they were forced to move to a motel. After two apartments fell through, the family finally found a house to rent. Unfortunately the timing was off and they had reached their limit on the credit card at the motel and were being put out on the street. Their only choice was to sleep in their car. HPRP prevented this from happening by providing funding for the motel and ultimately relocating them into a home.

Mike and Gina were being evicted on the day they came to NHHR for help. Gina is pregnant and was recently laid off from her job. The couple has three young boys and Gina's elderly, disabled mother living with them. Dad was working and Gina had found an apartment to rent but they did not have the security deposit. The CT Department of Social Services has closed the security deposit guarantee program. NHHR's HPRP program was able to pay the security deposit and part of the first month's rent into order to avoid this family moving into a shelter.

Lastly, Juan and Julia, both college graduates, moved to NH from Puerto Rico in order to seek medication care for their son. Their 1-year-old was ill and had recently undergone open heart surgery at Yale New Haven Hospital. In addition the boy was recovering from liver disease and other infections. The family was living in the Ronald McDonald House during the baby's hospitalization, but had no place to live upon discharged. A stay at a shelter, would have comprised the boy's fragile health. They considered going back to Puerto Rico, but funding was limited and they needed to remain close to necessary medical care. HPRP was able to assist them in finding housing, paying for security deposit and rental assistance. The family is stably housed and Juan and Julia are currently looking for work.

These two program are examples of excellent programs that need to and should continue.

Please feel free to contact me with any questions or concerns regarding this testimony.

Senator DODD. No, they were great. I would just say I wish others would look at the testimony, but just the statistics on housing, on healthcare, on education, I am just alarmed. I went the other night to—Nancy Pelosi's, Speaker Pelosi's daughter Alexandra made a movie which HBO supported, and we went to it at the Press Club. I introduced it the other night.

And it is about children, homeless children living in motels outside of the gates of Disneyland in California and just what their lives are like and what they go through. But the statistics, the numbers are just breathtaking and growing.

Ms. DAY. From 2007 to 2008 here in Connecticut, family homelessness increased by 13 percent.

Senator DODD. Yes.

Ms. DAY. Between 2008 and 2009, it was 33 percent.

Senator DODD. Yes. There is about a 20 percent increase in kids in school who are homeless, and one quarter—only one quarter of homeless children graduate from high school nationally.

Mr. Edwards.

STATEMENT OF DOUG EDWARDS, FOUNDER AND PROGRAMS DIRECTOR, REAL DADS FOREVER, MANCHESTER, CT

Mr. EDWARDS. Thank you, Senator Dodd. It is a pleasure to spend some time with you and with the rest of the members of the panel.

Approximately 40 to 60 percent of children in Connecticut go to bed without a dad at home at night. Father absence is connected to high out-of-wedlock birth rates, the inability of some men to form an emotional connection to their children, and high levels of separation and divorce among parents, which has been exacerbated by high unemployment and the recession.

Research shows us that children who are securely attached to their fathers have better outcomes socially, emotionally, and aca-

demically. Fathers, the proverbial "bread winners," get their self-worth largely from performance, and in the absence of work, psychosocial dynamics wreak havoc with their relationships, even with their children.

The recession has triggered an increased emphasis on job preparation, education, training, job retention, and the development of relationships with employment resources. In addition, programs have found ways to support fathers trying to navigate their relationships with their children in the present difficult environment.

Connecticut formed the Fatherhood Initiative as a result of legislation in order to "promote the positive involvement and interaction of fathers with their children." There are presently six sites in the State that have passed a rigorous certification process in 2006 and are currently in the process of recertification. Five more sites have applied for new certification. Connecticut is the only State in the country that has a certification process for fatherhood programs.

Representative John S. Martinez, who passed away in 2002, was the deputy majority leader serving New Haven's 95th Assembly District. He was especially instrumental in sponsoring the Fatherhood Initiative of Connecticut legislation, which was passed by the legislature in 1999. In his honor, on July 9, 2003, Public Act 03–258 was signed into law and is now—the Fatherhood Initiative is now called "The John S. Martinez Fatherhood Initiative of Connecticut."

The six fatherhood sites provide comprehensive fatherhood program services to low-income, noncustodial fathers, including preparation for the legal, financial, and emotional responsibilities; the establishment of paternity at childbirth; fostering their emotional connection to and financial support of their children; workforce skills development; and father support services.

There are 30 to 40 other fatherhood programs in Connecticut in Head Start schools, prisons, churches, and communities that provide one or more of the services mentioned.

In addition to providing some of these services, my program, Real Dads Forever, supported by the Connecticut Department of Public Health, developed a curriculum called Prenatal Early Attachment for dads supporting mom and the baby during the pregnancy and after birth. We are about to begin our second cohort, a collaboration with Fair Haven Community Health Center, right here in New Haven, and Centering Healthcare Institute's Centering Pregnancy in Cheshire, a group prenatal national model, which is being evaluated by UCONN.

We have experienced very promising short-term results—increased caring and emotional attachment to mom; more consistent, timely prenatal visits by both mom and dad; greater understanding of prenatal development; a commitment to breastfeeding by mom with dad's support; an emotional attachment by dad to his unborn child; and a dramatic increase in communication between dad and mom, mostly initiated by dad.

Research shows us that if these elements are in place early on, moms are healthier, babies are more likely to be full-term. There is a better chance co-parenting will be successful for the long-term. Our evaluation team is designing protocol to follow up these families over time to substantiate the research.

There is a wealth of research that underscores the value of early prenatal father involvement, but a dearth of comprehensive programming that specifically targets fathers during the prenatal period. Fathers are especially vulnerable, open to learning, and welcome the group experience along with mom.

My work with fathers, over 5,000 of them since 1996, in small groups over several sessions has taught me that adults sometimes still have a yearning for that father-child relationship embedded in their subconscious since childhood. This—what I call "yearning, churning, and burning"—impacts their social/emotional development, education, and relationship navigation for decades.

This observation of residual emotional disease led me to want to begin to find ways to address father absence issues from a standpoint of prevention rather than intervention, making it essential that we start as early as possible.

DPH has succeeded in forming a collaboration of agencies, including the Public Health Foundation of Connecticut, the Hartford Health Department, in the 5-year HHS Federal grant to Connecticut DPH to expand access to healthcare in Hartford for women nearing childbirth to ensure newborns get a healthy start. Real Dads Forever, with its Prenatal Early Attachment Program, is one of the community partners.

Upon further evaluation, this program will be replicated after proper training and certification of facilitators. As part of our evaluation, we will also focus on the return on investment of this program. At its heart, it is prevention. And we know, especially in this challenging economic environment, prevention is a more fiscally sound investment than intervention.

I have also been involved as facilitator and trainer with the Parent Leadership Training Institute, Parents Supporting Educational Excellence, both as part of the Commission on Children. They are two very successful programs, preparing parents to advocate for and lead their children and to partner with schools for school improvement.

Thank you for the opportunity to share my work, concerns, hopes, and dreams for the present and future children of Connecticut.

And thank you, Senator Dodd, for your many years of service to our State. In my opinion, there is no finer way to end your Senate career than having our children close to your heart.

Senator DODD. Thank you.

[Applause.]

Terrific job, Mr. Edwards. Thanks very much.

Doctor.

STATEMENT OF LISA HONIGFELD, Ph.D., VICE PRESIDENT FOR HEALTH INITIATIVES, CHILD HEALTH AND DEVELOPMENT INSTITUTE OF CONNECTICUT, INC., FARMINGTON, CT

Ms. HONIGFELD. Senator Dodd, thank you for the honor to testify before you this morning.

As you noted, I am the vice president for Health Initiatives at the Child Health and Development Institute, or CHDI. CHDI is a not-for-profit organization that is dedicated to improving the health and mental health systems for children here in Connecticut.

As part of my responsibilities at CHDI, I have the privilege of participating in the implementation and the dissemination of a successful Connecticut-grown system for identifying young children at risk for developmental delay and connecting them to intervention services, many of which you have heard about this morning, which will allow them to receive services at the youngest age possible, which is when we know that interventions are most effective.

Help Me Grow, originally developed as a pilot program in Hartford by Dr. Paul Dworkin, physician-in-chief of the Connecticut Children's Medical Center, brings together funding and resources from four State agencies that address children's developmental needs. These include the Department of Public Health, the Department of Developmental Services, the Children's Trust Fund at the Department of Social Services, and the Department of Education.

Through a single point of entry, families are linked to a variety of health and community services. Highly trained care coordination staff at United Way's 2-on-1 Child Development Infoline field calls, perform intake, and connect children and families to a variety of programs, thereby facilitating access to valuable community-based services that promote healthy development.

Several of these services are funded through Federal dollars, including Part B preschool special education services, Part C early intervention services, and services for children and youth with special healthcare needs that are funded through the Maternal and Child Health Bureau's Title V block grant dollars.

Child Development Infoline also integrates hundreds of community programs, some of which we have heard about this morning, that are part of the Help Me Grow inventory of services. By centralizing access to all of these programs under a single point of entry, at-risk children who are ineligible for the federally funded, State-mandated programs can receive, through Help Me Grow, linkage to geographically and culturally appropriate programs and services.

Help Me Grow's statewide triage program is supported by regional child development liaisons who locate services and maintain regional resource inventories and facilitate access for children and families. In addition, Child Development Infoline educates pediatric and family medicine providers about early identification of children at risk for developmental delay and their connection to interventions through Help Me Grow and Child Development Infoline.

Help Me Grow Child Development Infoline is an exemplary model of blended funding supporting a multi-sector system that cuts across State agencies and includes community-based programs to ensure access to services for all children for whom there are concerns. More than 8,000 families have used this system over the past 4 years, and 80 percent of them have been successfully connected to services.

When we consider that only 1 in 5 children nationally who are identified with the behavioral health concerns receive services, the success of Help Me Grow Child Development Infoline is evident. Help Me Grow and Child Development Infoline's success has led to generous support, initially from the Commonwealth Fund and, most recently, the Kellogg Foundation, to Connecticut Children's Medical Center for national replication of this model system.

Two sites—Polk County, IA, and Orange County, CA—have Help Me Grow in place. Five others—Colorado; western Oregon; Greenville County, SC; and the greater metro Louisville, KY area—are developing systems with technical assistance from the Connecticut Help Me Grow team. The Help Me Grow replication team will select 10 additional sites for replication over the next 3 years.

All of these sites, their States, as well as the remaining 33 States, would benefit tremendously from Federal support for Help Me Grow. More specifically, since Help Me Grow Child Development Infoline's success depends on the blending of Federal, State, and local resources to effectively and efficiently address the needs of young children, we look to Federal support of States to develop and implement Help Me Grow systems throughout the country.

The Connecticut Help Me Grow replication center stands ready to partner with your committee and Federal agencies in building the capacity in all of our States to ensure that children are connected to the services that can ensure their healthy development and can begin school healthy and ready to learn. As your committee considers how to support programs that will ensure children's success, I urge you also to consider legislation that will enable States to develop systems like Help Me Grow for linking children to available community opportunities.

Thank you, and if you believe that the Help Me Grow national replication team from Connecticut can provide you with additional information or assistance, please don't hesitate to call on us.

Senator DODD. That is great. What a great story.

[Applause.]

What tremendous stories here that are going on in our own State. And with all the identifying of the problems, and yet to hear these wonderful efforts that have been made throughout Connecticut certainly is a source of pride as well. So I commend all of you for your work, and I thank you immensely for it.

I should mention, by the way, that I have some wonderful staff who do tremendous work here, and I want to mention Averi Pakulis. Averi is here as well. Averi, thank you for your work.

And Tamar Haro is the chief of staff of the committee. And Tamar, thank you immensely for your work.

And Ben Nathanson is here. Ben, are you here? Yes, you are. Ben is a new member of the staff and does a great job.

Margot Crandall-Hollick as well is at the table over there, and Megan Keenan, is Megan here? Back in the back of the room as well. I know Brian is here, and who am I missing—Meg Benner.

So I thank all of them for being with us here. There are others from the staff as well, but these are principally the people who work on the staff of the Labor Committee.

Well, today is the 25th anniversary, by the way, of the Americans with Disabilities Act, ADA. And so, there are some questions we should have, I guess, about the difference the ADA has made with children with disabilities. And maybe just to begin right where we left off, Lisa, with you, how has the ADA helped in all of this?

Ms. HONIGFELD. Senator Dodd, the Americans with Disabilities Act and, more specifically, the act that allows very young children to be connected to intervention services has an enormous potential

to provide intervention at a time when, as Dr. Lowell told us, when the developing brain is most amenable to developing resiliency and other skills that will be important.

And so, these services—the Americans with Disabilities Act, as well as IDEA—for connecting the very youngest children really call on us to ensure that children with or at risk actually for developmental delay are identified as soon as possible and connected to effective programs.

Senator DODD. Well, Doctor, let me ask you as well on that because one of the issues that strikes me is how do we identify early on? Instead of waiting for the problem to emerge, obviously, we can all—I mean, you don't need to have a Ph.D. to spot that. But what does require some sensitivity is identifying those problems as early as possible.

Dr. LOWELL. Yes. I actually think that that is probably one of the most critical things we can do because the brain is really very malleable then and that we know that that is the time when the architecture of the brain is developed. And that what happens in those early experiences are going to determine what that architecture looks like, and it is going to be there forever.

I mean, we can hope to make changes, and it is not that we can't in the future. But really, it forms the foundation. So what do we do? I think that there are several things. One is that we have to have strong collaborations in communities. We have to have strong connections because, for instance, in Bridgeport, where this model developed, many of the children—actually, in the beginning, all of the children were referred from other community providers.

And so, by educating them to understand the early signs of problems, both within the child developmental problems, but especially our early care and education sites were seeing social, emotional, and behavioral problems. And so, one, we have to be able to identify those. But I would say at least, if not more important, is to understand what the environments these children are growing up in and, as Dr. Zigler said, the stresses in the environments.

Because we have a lot of knowledge now about toxic stress. We know about maternal depression and homelessness and substance abuse, domestic violence, and other risks that are going to create environments where the child's brain is actually going to be damaged by the stress they experience. So by finding those families who are experiencing that stress early on, we can refer them to programs which can both address the stress and address the relationships. It is a two-pronged kind of comprehensive approach.

The other thing we can do is have screening, much more formal screening that we have actually established in our pediatric primary care center. And I know actually the Child Health and Development Institute has done a lot of work in Connecticut around that as well, but also in our early care and education sites. And again, the screening has to be more than just for development. We have to look at emotional issues and problems, and we have to look at what are the challenges that our families are facing because that is where our identification can be so powerful.

Senator DODD. I wrote, along with Lamar Alexander, the infant screening legislation, which was designed primarily to deal with some of the—I think were eight originally. There are a lot more

now, around 32 or 34. But these are more developmental issues that if you can pick them up early enough and they become recessive, that actually you can avoid some of the neurological issues——

Dr. LOWELL. Right, right.

Senator Dodd [continuing]. That would develop into a lifelong threat. In fact, there was only one facility in all of New England, in Massachusetts, where you could do the screenings. Now we do it here, and the resources are provided elsewhere.

But you are talking about something else, and I am wondering whether or not we have the capacity. I know it is ideal to do it. Do we have the capacity to identify these kind of developmental issues beyond the ones that we normally associate with neurological issues?

Dr. LOWELL. Yes, I think that we do have the capacity. I think it takes education of providers to understand why it is important and how to identify those families at risk. And it takes will. It takes believing that if we can get there early and work very intensely with families that we really can make a dramatic difference and prevent not only problems for those parents, but really prevent problems, long-term problems for those children.

And I think that when we look at it from a cost-benefit analysis, that we will save money even within the first year of doing that kind of intervention because special education itself, DCF referrals, foster care, all of this. When we get services for families, we avoid homelessness. We avoid later on incarceration and very serious problems with hospitalization for psychiatric disabilities.

So we have to believe that, get there early, and prevent many of these disabilities.

Ms. HONIGFELD. Can I just add one point?

Senator DODD. Certainly.

Ms. HONIGFELD. Darcy and I have worked together on this for a long time, and I can't overemphasize the role of formal screening in all of this. We know from pretty rigorous studies that child health providers, when they determine a child has a developmental delay or is at risk for a developmental delay, they are 95 percent correct.

However, if they used a formal screening tool, they would identify 67 percent of children at an earlier age than if they waited to just use their clinical judgment. So I know, Darcy, Child FIRST has done really an excellent job in screening, and I think that that speaks to its success, and I think that is why the interventions have been so successful.

Senator DODD. Dr. Keck, do you have any comments on this at all?

Mr. KECK. Actually, I do. I learned a whole lot about Head Start once I started this project, and Head Start facilities, actually 10 percent of the students in each facility are required to have either developmental delays or disabilities or things of that nature.

And the interesting thing to note is children with special healthcare needs is a very rough definition to actually get your hands around because asthma could be a special healthcare need. It doesn't need to be physical disability, developmental disability.

There is a lot of things that go into the idea of children with special healthcare needs.

But from the perspective of being a teacher at Yale, the facilities at Yale and the University of Connecticut I think do a very good job at least with oral health for children with special healthcare needs. Adults with special healthcare needs is a different issue altogether. But I think we are doing a good job in the State of taking care of children's oral health.

Senator DODD. I want to come back to that. Your testimony about the oral health of children, I want to come back to it in a minute.

But, Ed, let me ask you, I was impressed. You got 20 States that are now involved with 21st Century schools, and you mentioned the number, 60 schools in this State, some 1,300 around the country that are involved. Why only 26? What has happened? What are the obstacles that States are having?

And I was impressed that Kentucky and Arkansas have developed school-wide systems. I mean, I say this respectfully of Kentucky and Arkansas, but I don't normally think of them as being so on the forefront of some of these issues. That will probably get me in a lot of trouble now——

[Laughter.]

Senator Dodd [continuing]. That headline blaring. But they did. They have gone ahead—to their great credit, they have gone ahead and done this. And why not other States? What have been the problems?

Mr. ZIGLER. They keep growing. California has just come onboard. But the problem is there are so many things that could be done that is not that visible. That is why I would say it would need some kind of Federal push, either legislation or some dedicated stream of money. It is the startup money that is the only problem.

Our discussion that we have just had rings a bell with me, too. I agree with my colleagues. Get in there, I mean, Nobel Laureate Heckman has now pointed out that you get your biggest payoff for any kind of a program the younger the child.

I am sure that you have helped, but the Obama administration has been very forthcoming. For the very first time in all these years—home visiting has been around for at least 35 years that I have been cracking it. For the very first time, the Obama administration has come up with a stream of money to let home visiting take place.

There is home visiting in every one of these schools, but one of the important aspects of home visiting pertains to your previous question. One of the most important pieces of work that the home visitors do is not just work with the parents, but screen the children to pick up these kinds of mental health, physical health problems as early as possible and act as a broker for the services these children need.

Senator DODD. I have used it so many times. I have said it so many times over the past 30 years. But with Head Start, the requirement from the earliest days, when you go back to 1965, that your Head Start program insisted upon parental involvement with children. And I think we get about 80 percent involvement. These are the numbers I use. I don't know if I am right or not.

But by the first grade, the parental involvement drops generally across the country to less than 20 percent. And so, the importance of it, obviously, is clear. What a difference it makes. But it does drop off, and anything that can be done to increase that parental involvement I think is just huge.

Abby, I don't know if you want to talk about that in the Norwich school systems. I know you talk about it. Let me say, too, I have always sensed—and I come from a family of teachers. My sister just retired after 41 years of teaching in Connecticut, and my father's three sisters taught for 40 years apiece in the public high school system of the State. There is always some resistance, and I understand why parental involvement, interference, teachers trying to do their job. And all of a sudden, it is annoying parents that are showing up and pushing, nudging, doing everything else, and their kids.

You always get this feeling that it is not a warm-fuzzy relationship, generally speaking, between parents and teachers. And I am curious as to how you can start to break that down. It seems to me while you can call for it, you could require it, but if it isn't part of the seamless relationship that that teacher sees that child arrive, you don't see just a child walk in the door. You see a family walk in the door.

To what extent can our educational system—and teachers, rightfully, bemoan and say, "Wait a minute. You trained me to be a teacher. Now you want me to be a guidance counselor, a minister or a rabbi. You want me to be a policeman. All of these jobs you are asking me to do beyond trying to teach a child. So you are loading me up as well."

It seems to me this is pretty basic, what Mr. Edwards talked about, and the first rule of any of these relationships is that parental relationship, the role of fathers in this relationship. Every one of you have mentioned, I think, to one degree or another, the importance of that relationship. But we don't seem to be doing a very good job of it. Now how do we do a better job?

Ms. DOLLIVER. I mean, all that you talk about is what I see. Unfortunately, it is a lot of what I see. We work really hard to open doors to parents. But it is a culture that you have to change that I am here to teach. You give me your kids. They are mine. I will have them for this day, and then they go back to you.

We are trying to do more and more programs to invite parents in, not just to fund raise or to have activities, but to be part of what is happening. For example, at one of our middle schools, they have a breakfast where they honor students quarterly. It doesn't just mean you are the top of the class. Doesn't just mean you are on the honor roll, if you have good conduct.

We find reasons to award kids, and we invite parents in for breakfast to be part of that. So those kinds of things. So it is not just the call, oh, so and so is not behaving today, or they are failing. We are trying to do positive interventions with parents to open doors.

Senator DODD. Yes.

Ms. DOLLIVER. And really, you know, I have to model that for the staff that you have to talk to parents. You have to listen to them,

and you have to hear where they are at and who they are. And then it is their family who we are educating.

Senator DODD. A lot of the times, the parents that you wanted to reach are the ones whom themselves had bad experiences necessarily in schools. And so, they are less than willing to walk into an environment that was hostile in many ways. Probably dropped out in many cases themselves.

In the case of homeless kids and so forth, they do not have the warmest relationship necessarily. So getting that home visiting. I mean what Ed talked about, including your testimony—beginning with conception. I would like to know how you figure that one out.

[Laughter.]

I can see the trouble you would be in on that one. A Federal program here. I can see the tea party now talking about that.

[Laughter.]

What the Federal Government is up to here requiring you to report on those statistics.

But the idea of getting involved early on, obviously, is important. And being at the home setting, which is the hardest thing to do because it is labor intensive. There is sometimes just a cultural question of walking in, what does it mean? How good is the information you are going to get, people showing up at a house, all the nervousness that can pose.

I mean, all of the problems, and yet I have got to believe, having listened to a lot of people, including yourselves, there is nothing better than if someone is familiar with that home environment, to some extent. Anyone want to comment on that?

Ms. DAY. I just wanted to comment. I think you are right. I think the engagement of the family is critical and in a positive way, as you were mentioning. Not just getting the calls when something is wrong. Not just making referrals to programs because the child did something wrong.

I also agree that we have a program in our shelters where we advocate for students who are homeless in the New Haven Public Schools, and what we found out is that many of the parents were very fearful to tell the teachers that they were living in a homeless shelter. Well, who more importantly needs to know that that child is living in a homeless shelter than the teacher?

Senator DODD. Yes.

Ms. DAY. But parents were afraid. They were afraid that people were going to assume they were bad parents because they were poor and homeless. People were afraid that they were going to get a DCF call because they were homeless.

So I think that the connection between the school and the family is critical, and education of the parents and outreach to them in a positive way is very important.

Senator DODD. Jim Horan, why don't you talk—I was curious because you have talked about this as well in getting services and programs, parents involved, community involved. The recession obviously hasn't helped with more people out of work.

Mr. HORAN. Yes. That is one thing I was thinking about, listening to the other panelists right now. The recession really has hurt this a lot. You mentioned, as superintendent in Norwich, I think

70 layoffs. I think there are 122 in New Britain and more in New Haven and other cities all around the State.

I think that that really does hurt because a lot of times school districts around the State are making cuts, and they have to cut wherever they can. I know in West Hartford, where I live, 2 years ago the magnet school resource officer was cut, and part of her role was integrating the role of foreign language speaking parents in the schools. And that was eliminated.

Now I will say the PTO has really stepped up, and there are parents who are translating to bring in other parents to help them out. But that is difficult. And it is just as you said, too. A lot of the parents who are the ones we most want to get involved are the ones who have had poor experiences themselves when they were students. You know, they dropped out or had other issues in school.

So we really need to try to change the culture in the schools, and I think that is the role starting from the superintendent down, and it also has to be kind of from the bottom up, with parents pushing and teachers who do feel comfortable pushing to make that happen. But it does become harder in a time of limited resources like we are facing now, as districts are laying off some of the folks who were involved in these roles.

Senator DODD. Yes.

Mr. EDWARDS. If I may just add? There recently has been funding by the Parent Trust Fund for parent leadership training here in Connecticut. And Parent Leadership Training Institute, which Elaine Zimmerman is involved with, and Parents Supporting Educational Excellence are both programs that prepare parents to have a relationship with schools.

They are taught about how schools work. They are taught about how government works. They are taught about how to be strategic in the development of addressing problems that relate to their children and others and how to advocate for their kids. They are also taught how to read reports that come out from the schools about progress and the achievement gap.

So that is a lot of preparation that is going into working with parents. I just recently heard from a principal who said that her teachers—the biggest fear of her teachers is a conversation with parents. So I think from what I hear, and I haven't verified this, but in higher education, there doesn't appear to be a lot of emphasis on teaching future teachers how to develop relationships with parents.

Some teachers do it intuitively, and they do a wonderful job. But there are others that may need a little help, just like parents do. So if parents can be more prepared to kind of do that dance with schools, with teachers, children will certainly benefit from it.

Senator DODD. That is an interesting comment. I would be curious to know whether or not any of our schools of education have any kind of emphasis at all, even slight emphasis on that role. I suspect they don't.

Mr. Edwards, you seem to indicate they don't. I don't think they would. Any further comment on this particular point? Yes?

Dr. LOWELL. I just wanted to comment that you had indicated that parents who have had bad experiences themselves are going to be more afraid actually to engage with schools. But I mean, even

more so, they are very hesitant to engage with any kind of social service program. So the engagement process becomes so fundamental, the building of the relationship with the parent so that there is really trust there.

So instead of seeing whoever this helper is as someone who is going to take my child away or will it be a negative consequence can see, for instance, our Child FIRST clinical team as these are people who are there for me. These are my partners. They are going to help me. They are going to make a difference.

We have had parents so many times say, "You know what, no one ever cared what I thought before. No one ever listened to me." And so, the whole move to have things that are parent empowering, that help a parent be the one to be the driver in terms of what kinds of services and supports are going to make a difference makes a huge difference.

So the PLTI movement in terms of helping parents understand this, but every single relationship that we build with parents which helps to build them up, to empower them for their children, becomes really very essential in terms of the long-term outcomes, when we are no longer there for them.

The other thing I would say just about the relationships in the schools is that we have to help teachers really have empathy for the conditions of some of the children. Instead of seeing children's behavior as "bad behavior" and, therefore, it is the parents' fault. Instead to really try to understand why is a child acting like that, to help them take a much more what we call reflective stance to think about what is going on inside the child and what is going on inside the parent. What are the challenges they are experiencing?

So that, instead, they can feel like they can be a partner and help the parent. That is a real shift and so that they can be—we want them to be partners together instead of——

Senator DODD. That was one of the things they are doing. And again, as you are watching now, particularly in preschool and kindergarten and first grade is having a continuum in a lot of public schools where that teacher moves with the class. So in these early stages, you are getting—my 5-year-old is going to kindergarten next year in a public school in Washington, her preschool teacher will be her kindergarten teacher next year.

Dr. LOWELL. Well——

Senator DODD. And that is great, so there is that sense of having that same person. She is very excited about having Ms. Burke next year.

[Laughter.]

In about a month, to go back in. So that continuum in that early stage where they really got to know, in that public school, Ms. Burke now knows those 21 children. She knows those families that live in our neighborhood, in a very diverse neighborhood in Washington. And so, it is really going to be—I can see that already having a positive impact on the children in that classroom and the parents.

Ms. DOLLIVER. Well, that is called looping, and we don't do it a lot, but we do it a little. Now we just have to cover classrooms with the shortage of numbers of classrooms that we have. However, we did it in our middle school with special education students, and it

was a big deal for the teachers to think, now I have to learn the curriculum of eighth grade if I was in seventh, or I have to learn the seventh grade if I was in sixth.

But we have done it for 2 years, and it has had a positive impact.

Senator DODD. It has had a positive impact, yes.

Ms. DOLLIVER. They know the kids and their needs and their families, and they can continue the relationship. A lot of it, so much is about relationship.

Senator DODD. You wanted to say something, Tammy?

Ms. PAPA. Yes. Just real quickly, in terms of afterschool, because it is a less structured environment than the daytime happens to be, we have found that we can involve parents in a number of ways. And obviously, the most basic way is to involve them in at least one activity throughout the course of each semester, the fall and the spring, if you will, and ask them to participate with us.

Most of them will do that, and they feel a little bit more comfortable coming in in a less structured environment. But we also require that the parents come into the school every single day to sign their child out. So they can't beep the horn. The kids can't run out. They have to come into the school.

So it gives our teachers an opportunity to talk to them. Not run up to them and say, "My God, your child today." But to approach them in a more positive manner, maybe about something great that their child has done and really focus on words of encouragement as opposed to disappointment as to what the child's behavior might have been for that particular day.

But we also, as part of the 21st century grant, they encourage you to do family activities. So, monthly, we do a regularly scheduled evening activity, where we provide dinner and the opportunity for parents to come into the school, and most of our principals will stay for that activity, which really helps build the relationships. And have the afterschool staff, along with some guest speakers, things that are critical to families, whether it is financial literacy, or whatever it might be.

It may be an activity that they can do with their children, but we invite the entire family in, provide them with dinner and an opportunity to work together on that activity. And that has been pretty successful. In a school where maybe we serve about 100 children, we may get upwards of 70 families that come in for that particular event, and that happens one night during the month.

And then, on the flip side of that, we do need to educate our teachers a little bit more. So we provide quite a bit of professional development on how to approach parents, how to make the schools more welcoming. I know the State Department of Education does quite a bit of professional development on this topic.

So I think all those things combined will help bring parents into the school and make teachers a little bit more comfortable with approaching them.

Senator DODD. Let me ask a naïve question in a sense, and it goes to what you are talking about as well, and that is I am always struck with the fact—and again, on the Lighthouse Program, which we have worked very closely with over the years, and I am a great supporter of it. But it takes some initiation on the part of parents to get in the program.

And a lot of these things we have talked about here require parental initiation. And yet the very people we are talking about that are the most in need are the ones where that is less likely to occur. We are not serving but a fraction of the population. What, at Head Start, what are we? One in four, Ed, to this day even? One in four of the eligible Head Start population in the United States being served by Head Start?

Mr. ZIGLER. The eligible population is about 45 percent.

Senator DODD. And we are serving?

Mr. ZIGLER. Forty-five percent of the kids that are eligible after 45 years of Head Start.

Senator DODD. Yes. So, again, it takes someone to step up and to seek to be enrolled. And many times, it is the most vulnerable families that just don't take the step. And so, it is always frustrating to me because the ones who, to their great credit, do try to get into those programs, want to be in that afterschool program, want to be in these things. And even though they are very poor, they deserve a great deal of credit for fighting on behalf of their children and their future.

But so much of the most vulnerable kids and families just don't even know how to navigate this at all, and that is a——

Ms. HONIGFELD. Can I make a comment to that?

Senator DODD. Yes.

Ms. HONIGFELD. I think that is absolutely true, and that is why we really need to exploit the child health system because every family needs to take their child to the doctor or they are not going to go to Head Start. They are not going to go to school. They are not going to go to camp. They are not going to go to other childcare. And I think that is a system we really need to exploit in terms of doing a better job educating child health providers to encourage parents and actually to use systems like Help Me Grow to link parents to all the programs that are available for their engagement.

Senator DODD. I am very impressed on how much of that has been replicated.

Dr. LOWELL. Also, I couldn't emphasize enough because the engagement process is very difficult, and it is very costly. I mean, I can't tell you how many children in families who initially—who we find, who are interested, who are very high risk, but from the time that they are identified to the time we can actually engage them in services sometimes takes over a month of persistence, of calls, of letters, of dropping them notes at their door, if necessary, to before they are really willing to have us actually come in.

And so, we are really about engaging the very highest risk children and families. And actually, our research, one of the things about the way we did our research, which was the randomized trial, we actually did randomize into a control group and an intervention group so that we could see where we disproportionately were losing the high-risk children.

And what we found is if you are persistent and if you also take a nurturing stance that we are there to help you, but you have to be—I mean, it is not short-term. It is not three strikes and you are out. You have to really be there and be willing to keep at it. You can engage these families because they want the best for their kids.

And when they feel like you are there for them, they are willing to—and something about what Lisa said, just one family comes to mind so really prominently. We had a family who came in, a little 3½-year-old girl and a very proud mom. And physical exam was normal, but we had done screens.

And the screen was positive only for maternal depression. Nothing else was positive. And we had a clinician who is embedded in our pediatric primary care center who said to this mom after her visit, before she left the pediatric clinic, you know, I was wondering, is there anything we can do to help you? Because I see that you said that sometimes you feel life is so hard you don't even know if you can continue.

And it was based on that, this mom looked at our clinician, who is just the most warm, wonderful person, and she had dark glasses on. She took them off, and she started to cry. And it was that connection that never would have been made. It ended up there was a domestic violence situation. They had an apartment. They had no beds. They had no table. Her child was being evicted from childcare.

I mean, there was a multiple risk family. We never would have found them without that pediatric screening. But it took us 6 weeks from the time she said "yes, come" before we actually got in the home. So it says persistence makes a difference.

Senator DODD. It is labor-intensive.

Ms. DAY. Well, and you also bring up a good point. I mean, there are 1.5 million families that are homeless or unstably housed, and those are the ones we know about. Many of them are in motels or doubled up, and we don't know——

Senator DODD. There is 1.5 more that is—the number is stacked. Yes.

Ms. DAY. Correct. And how can you pay attention to anything if you don't have any food, clothing, or shelter?

Dr. LOWELL. That is right. You can't.

Ms. DAY. You are not going to go to the doctor. You are not going to pay attention to whether your kid is behaving or not behaving. The stressors on the family and the parents are so high that that is what makes the engagement difficult, too.

I mean, I think we really need to pay attention to our families' basic needs in order to be able to provide what Dr. Zigler talked about, the family, health, education, and childcare. You can't have any of that unless you have food, clothing, and shelter.

Dr. LOWELL. Stabilization. You have to have that first.

Senator DODD. Let me jump to Dr. Keck. I want to—because I was stunned by your statistics. Thirty percent of 3- to 5-year-olds in Head Start have tooth decay?

Mr. KECK. I can testify to that because, as part of the program that we are developing, last year we started examining the Head Start children in the schools. It goes along with the whole idea that getting active participation from the parents can sometimes be very difficult.

So we have gone out to the schools to conduct the initial examination. And we didn't get through all 900, but with the 150, that statistic is true. This is a national statistic, but it holds true in the State of Connecticut.

The second thing that we have learned since starting the project, at least in the State of Connecticut, is for the program to work, we have done a good job about getting the children examinations. But the follow-through to future care, getting the cavities treated—and it is probably the same in pediatrics—and follow-through is a big issue.

There is a person called the family service worker that is responsible, sadly to say, for about 35 to 40 families, students in the class that do go out and do the home visitation. And we are trying to make it a part. We have been educating the Head Start staff to particularly the family service workers, when they go out to the homes, to make oral health a part of the family health partnership agreement, as well as several different things.

Usually you can only have so much of things on a list. I agree that home and food and all that is important, but we are trying to move oral health up on the list.

Senator DODD. Well, I just want to tell you, I think it is so important. To me, oral health, and this is such a window on so many of the problems. And for years, it has been just so neglected. And to me, if you had to pick at just one area, the oral health thing is huge to me.

Mr. KECK. In my private practice, we also see Medicaid patients, Head Start patients as well, and the amount of dental decay is certainly not decreasing. My partners and I go to the hospital once a week to do two or three cases a week. I know the residency program at Yale does probably 10 cases a week of underserved children who have multiple cavities in their mouth and are younger than the age of 3 because they can't be treated realistically in a normal dental environment.

Senator DODD. Well, and I noticed the community health centers. I was in New Britain. We have about 12 or 13 community health centers in the State, which are great, and one of the things we did in the healthcare bill is just expand tremendously the number of resources to expand community health services. And in New Britain, the facility there, they had the mobile dental clinic that goes to schools.

Now this is not Head Start, this is——

Mr. KECK. Correct.

Senator Dodd [continuing]. I presume kids in elementary or middle school or high schools, and that mobile dental chair to get around was part of the student health, which I am impressed with. I think it is impressive. But this is far beyond, what you are talking about.

Mr. KECK. Well, the thing that we have also been trying to carry through not just from Head Start, but through the State as far as dentistry goes, with the increase in the number of providers, patients that are on HUSKY A, HUSKY B aren't necessarily relegated to go to safety net facilities anymore. There are plenty of private providers.

And we also have to educate parents because many of them fear going into a private practice environment other than a safety net or a clinic, as you are talking about.

Senator DODD. Yes.

Mr. KECK. I think education, and that is a part of this——

Senator DODD. You have 40 dentists in Connecticut. I am impressed you got that many.

Mr. KECK. Well, it is actually——

Senator DODD. Connecticut magazine this month has the list of all the 100 best dentists in Connecticut.

Mr. KECK. The list is actually greater than that. Those are 40 that I have personally gotten to work directly with Head Start. But as I said, there are many, many dentists, both pediatric and general, that have chosen to help and treat young children.

Senator DODD. Yes. Well, good. How you take that program nationally could be very important.

Mr. KECK. The Head Start program, it is a 5-year contract, and at this point in time, there are approximately 35 States that it has rolled out. It has been over a 5-year period. Connecticut was one of the six States that started this initiative. So we are kind of well on our way, and many States, like California, Texas, are going to have more of an issue. Sheer size is part of it.

Senator DODD. Let me ask, and this is something that Ed Zigler and I have talked about over the years and the difficulty of attracting and retaining good staff. Again, what we pay childcare workers has been a historic set of issues, afterschool staff. All the difficulty of how you keep people, how you—we have upped the matter over the years to bump the educational levels, but also the compensation for Head Start workers and the like so you don't end up with that turnover that we have all the time.

How do you retain your staff? How do you retain your staff at your Lighthouse Program?

Ms. PAPA. We employ just about 300 people through our subcontracts with community agencies like the YMCA, ABCD, some of our colleges. Professional development to really help them do their jobs and listening to them as to what they need in terms of professional development. I think in any given year, we will do about 30 different workshops for staff to come to.

We do pay them well. Our certified teachers who work with us get between $28 and $32 an hour, and the coordinators that actually operate the program get anywhere from $32 to $36 an hour. But I can tell you through conversations with these individuals for going out to the individual sites, they don't stay because of the money. They stay because they truly, truly enjoy what they do.

And when we find somebody that is there because of the money—and everybody needs to make a little bit of extra money—we never begrudge anybody that. But when we find that that is the primary reason, then we work with that person to try and change that attitude toward his or her job.

If they don't, then they are probably really not cut out for the type of work we need them to do because, for us, the child does need to come first, and his or her needs need to come first. But having said that, it is just really keeping that open line of communication, working with principals and other daytime staff to really determine who within the school might be best suited for these positions. It is a long day for people.

And we don't just recruit from within the school. But certainly the connections that we can make within the school and getting some of the staff from within the school really help to build the

academic portion of our program and really help to link school day and afterschool.

But even working with our agencies, it is really recruiting the right type of person to begin with.

Senator DODD. Ed, you wanted to comment on that? We have wrestled with this for years.

Mr. ZIGLER. Just be aware, Senator, that what you have just heard is a model that I wish we could replicate everywhere in the country. It is not standard. Most schools, their problem is how do you pay these afterschool workers? Never mind what you pay a teacher and that. Salary is a huge problem.

Let me point out to you one of the biggest problems with the 21st century children's learning centers. And perhaps you remember when I worked with Senator Specter, your colleague on the Children's Caucus, to try to reverse President Bush's attempt to cut the 21st century learning centers?

Senator DODD. Sure.

Mr. ZIGLER. We were successful, thanks to Senator Specter. But that flow of money is the only flow of money there is to the schools to provide afterschool care. None of it is as good as this model we have just heard about. We are delighted to have you here.

Ms. PAPA. Thank you.

Mr. ZIGLER. But the fact is after 5 years of getting that money, they have to start weaning themselves away from it, and there is no fund of money. So once you go 5 years in that program, you are through. And so, getting money to pay people—this is true in Head Start, too. The reason we are only serving 45 percent of eligible kids after four decades is not because we can't—parents don't bring their kids, there isn't any money in Head Start to serve more kids than that.

So no one knows better than you that every one of these problems we are discussing is always a problem of money, money, money. And you know, your new effort, you are going to find what we already know. Compared to the rest of the world's advanced, industrialized countries, kids in the—according to the World Health Organization, the United States is at the absolute bottom. Part of it is the high poverty rate, but the bottom. And it is always a matter of money and priorities.

You spent your life trying to make children and families the priority they ought to be in this country. But after my own decades-long effort, we have not succeeded. It is simply a matter of getting the Congress to provide the money for Head Start, for afterschool, dental care, wonderful programs, every program we have heard this morning. But where is the money to do these? And that is the basic issue.

Senator DODD. Yes, and we are going to face, as we look at the arguments again, significant cost reductions in a lot of these areas as well. So the problems are going to surmount. And we have only really in the last, well, 45 years have been involved in much of this at all. Up until 1965, Title I, the Federal Government was not involved at all in education, except on a marginal basis.

Dr. LOWELL. Addressing the money issue, we have some wonderful legislation that I think is really not used optimally, and I would specifically talk about EPSDT, which is Early Periodic Screening,

Diagnosis, and Treatment. Here we have talked a lot about getting children early and prevention, and that is a law which is specifically targeted for prevention.

It says if you can find them early enough and if you can give them what they need, you can avoid serious problems. And they can be health problems. They can be mental health problems. But they really define "health" quite broadly in that legislation.

And yet we have not been able to use it, both in Connecticut and elsewhere, effectively to meet the needs of children early, and yet that is why it was created.

Senator DODD. Why haven't we been able to?

Dr. LOWELL. Well, I think one of the reasons is States can define what they consider medical necessity individually. We have defined medical necessity as diagnosis. But diagnosis means you already have a disorder.

So, in a sense, we are not using the bill appropriately. If you look at the bill itself, it doesn't talk about you need a diagnosis to treat. It talks about you need medical necessity to treat.

For instance, look at children who—infants of depressed mothers as an example. An infant of a depressed mother is not going to be showing us symptoms until they get pretty severe, the child is in pretty severe straits. The mom, we know—if she is seriously depressed, we know the consequences for that child.

So we should be able to get into that home, in the home, not ask mom to come to an agency because she won't come. We know that. We have lots of data that says that is not the way to approach these moms. But we need to go in the home and treat the mother and treat the mother and child together. Make a huge difference.

You could use EPSDT funds to do that, and yet we don't. We don't have the codes to be able to do that. I mean, even though the legislation says the State does not have to have this as part of their Medicaid policy, nonetheless, you do have to have a way to actually do the billing. And many States have resorted to lawsuits because of these issues.

We haven't in Connecticut. I hope we never will. But I think we do need some changes because it is a huge possibility for the Federal Government to be paying 50 cents on the dollar to help us with these.

Senator DODD. Yes. Jim, do you want to comment on this?

Mr. HORAN. Yes. I will echo Dr. Lowell's support for prevention and getting in early and saving on the back end. But we have made some really bad decisions in public policy over time. Just talking with a colleague before we started here this morning. We imprison four times the number of people today in Connecticut than we did in 1980.

We found the money to build those prisons and to pay for the correction system over time, and yet the issues of childcare workers and early care and education workers not being paid adequately or not reaching all kids that qualify for Head Start or other programs, that hasn't changed. So a lot of it has to do with public will and the will of our elected leaders.

We, all of us are responsible for helping to make that happen. We are really going to miss your leadership in the Senate because

you have been terrific on these issues over the decades, and there are not many other leaders like you.

And so, it is really up to all of us and all of our colleagues and the people we know to get active and to get everyone empowered to do what they need to do and to get our leaders to do the right things. Because going back to the issue of corrections, Connecticut is one of only two States in the country that spends more on corrections than on higher education. I mean, how wrong-headed is that?

And yet we have allowed that, as voters in Connecticut, to occur over the decades. And we have to reverse that and get the investments made in the right places if we want to see the results for kids.

Senator DODD. And you are preaching to the choir.

Ms. HONIGFELD. Just also before we really talk down on our State that much, I do want to say that there is tremendous duplication in terms of services provided and ensuring people's access to services. And it really behooves us to start looking at the funding that we do have here in Connecticut and putting that together in the best ways to serve families and children.

Senator DODD. Yes. Good point.

Mr. Edwards, tell me a little bit, because I was so impressed with what you are doing, and it seems so basic in all of this, the role of fathers in all of this. And again, working on the presumption that men want to be good fathers, just as parents want to be good parents. And tapping into that very natural instinct. It is not an adverse instinct.

Any other thoughts you have on how we can do a better job of that? And again, we are looking at maybe thinking of it again with Jim talking about the number of people incarcerated and, of course, the number of—obviously, the overwhelming majority being males, a lot of them fathers, obviously. Totally distanced from their children.

So there are so many issues surrounding the role of fathers and their absence in the development of a child. What additional thoughts do you have for us?

Mr. EDWARDS. Well, I have done several groups with Head Start and fatherhood programs in Head Start schools, and there has been a wonderful reception on the part of the fathers—and of the mothers and of the teachers—to get fathers engaged early on, to let them realize how important they are in the lives of their children in terms of making the connection between father involvement and academic achievement for kids.

So we do 10 weeks of 2.5 hours each with the dads, and we talk about all of those things. It gives them a desire to connect with their children. We want them to be really alert to the fact that, you know what, you are the architect of your child's life. You are the construction manager. You are building something. You are the custodian of your child's life.

The scary part about being a parent, you can set them up for success, but you can also set them up for failure. So we want to get that message into them really early on, get them connected with the type of agencies that will provide the help. Get them to be really, really thoughtful about their unique and distinct way

that they are as dads is very different than mom, and what those qualities and values are as a dad.

So that their relationship with their child will continue even if they are not in a love relationship with mom. So we want to plant the seeds of co-parenting really, really early.

Senator DODD. Have you tried anything with—I am curious whether or not, for instance, where instead of having parents' time, you just have father time. So there are only fathers invited?

Mr. EDWARDS. Yes. That is mainly what we do, mainly what we do. Most of the work with Head Start is only fathers. So, Head Start, I may do a program for 4 weeks, 6 weeks or 8 weeks, depending on the funding for the school. And the first week, we start off with mom and dad because we want mom to know what is going on with the program.

The second week is dads, and they bring their kids. And we eat dinner for half an hour, and then we spent an hour and a half with dad. So there is just a group of dads in the room, and that continues on.

The last week, we bring mom back, and there is a celebration and a dinner. And we line the dads up, and the kids hand them their certificates of completion for the program to celebrate. So the kids get the idea that my dad is a lifelong learner. He went to school, and he learned something. That is modeling.

So that is what we like to see with that. And the dads, I hear stories from the moms about how not only has he changed in his relationship with the child, but he has also changed as a man in relation to mom. So it is just the more we can plant those seeds really, really early to make dads aware of their potential——

Senator DODD. Well, that is Ed's point. That is Ed Zigler's point.

Mr. EDWARDS. Yes, the better off we will be.

Mr. ZIGLER. There at conception.

[Laughter.]

Senator DODD. He is still fighting for conception here. I will leave that to the next Senator from Connecticut. I won't take on that issue.

Mr. ZIGLER. Those first 9 months of life are such a wonderful time because the mother and the father are totally involved in this process and prenatal care and all the things that you have heard about. We think birth is early enough. It is not. It is conception on.

Senator DODD. Yes, I agree.

Mr. EDWARDS. One other thing is that we also talk to them about the first 1,000 days of that child's life and how very important that is in terms of brain development, in terms of lowering the risk factors, in terms of creating a wonderful, warm, positive environment that is a rich language environment and they are getting the healthcare that they need. That, hopefully, will start to get them in tune to the fact that this is a long-term commitment that I just have to do.

Senator DODD. Yes. I literally could spend all day with you. I can't tell you how proud I am of what goes on in my own State, to hear these terrific things that are being done by people here. I know the hard work and the people who work with you and how much time they spend and the efforts they make. And your point,

Dr. Lowell, of just 6 weeks in that one family just to get her in the door and how that magical moment occurred.

Dr. LOWELL. It made a big difference.

Senator DODD. And how hard this is to achieve, but it is worth the effort. The future belongs 100 percent to them, and that is why Arlen Specter and I, almost 30 years ago, started the Children's Caucus in the Senate. We had a caucus for every imaginable constituency in America that you could think of except the 1 in 4 Americans who are under the age of 18.

We started with that, and over the years, we had rump hearings. We couldn't even get funding for hearings. I was telling a group of the interns the other day in the office, I remember Paula Hawkins, who was my new Senate colleague from Florida. She came to a hearing. She wanted to come and testify, and it sounds rather routine today. But 30 years ago, to have a woman U.S. Senator come and talk about how they were being sexually abused as a child was banner headlines across the country in terms of just unprecedented news.

And what she did, though, just by that and how she opened up the door for a lot of other people to talk about what had been going on, obviously. I mean, just things like that. We had hearings with Bill Bradley on afterschool programs in New York at the time. And so, it has been tremendously rewarding, and there has been improvement.

And obviously the challenges grow, and each generation poses new ones. But this has been tremendously helpful, and I literally could spend all day with you. I have so many questions to ask. But I am getting notes from my staff that I am already approaching 3 hours of your time here this morning.

So it is running out your patience. I know you have other work to do. But it has been tremendously helpful. And I am going to leave the record open because I have some additional questions we may submit to you in writing.

The testimony was terrific. I just can't tell you how compelling it was to go over it yesterday, reading all of your various suggestions and ideas and statistics. Particularly, I must tell you, on the homeless, it was just breath-taking. I was reading it to my wife this morning about 6:30 a.m. and with our 5-year-old sitting there, talking about predilection for separation between parents and children who are homeless. It was a very moving number to me, very sad to see that happen.

I thank everyone who is in the room, and so many of you do so much every day. I promised you I would let you ask some questions, but I think we have run out of time. But if you have some additional questions, let us know and we will try and submit them to people here at the panel. And we will move on and then try to build some support for this permanent council.

Again, I have talked to people at the Yale Child Study Center about the IDEA law, maybe with Save The Children on developing that report card so we can start looking each year at where we are headed and when we are stepping back a bit.

That may help my colleagues and others, Ed. It may give them some sense of this instead of having to wait every 20 years to get some report how things are to know the trim lines because I have

got to believe again—I mean, this is—again, this ought to be an issue that transcends any ideology of politics. I can't imagine a subject matter in which there ought to be a greater sense of common interest than figuring out how we do a better job with all the pressures on families that are tremendous today.

And the stress that you point out, Ed, and everyone has mentioned here is just huge. And it isn't just on the poorest of families. Hard-working middle-income families are all of a sudden watching a dad at age 50, watch them lose a job and wondering where the next one comes from, and the kind of pressure that is associated with that, and the long-term effects.

Ben Bernanke, the Chairman of the Federal Reserve, was appearing before me the other day in my other hat as the chairman of the Banking Committee, and he has written extensively on the long-term effects of recessions like this and beyond just the immediate loss of job, but what it does. The long-term implications, behavioral effects that it has on families and individuals, felt long after recessions are over with statistically. When work comes back and people are re-employed and the economy begins to improve, there are residual effects of these downturns economically that are felt for years and years and years afterwards.

So beyond all the numbers we talk about, in terms of gross domestic product and unemployment numbers and foreclosures and all the other things, there are other things occurring out there that are far more difficult to calibrate on a daily or weekly or monthly and annual basis that we are going to live with for a long time. And we are experiencing them already.

So these issues are going to be with us for a while, and we just need to do a better job of addressing them. And you have been a great help this morning, and I thank all of you. How about a round of applause for our witnesses?

[Applause.]

Thank you, Ed.

And they brought this gavel up. So I will use it one more time.

[Laughter.]

The committee is adjourned. How is that?

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF DEBRA P. HAUSER, PH.D., M.S.W.

I cannot convey my depth of gratitude to Senator Dodd for his decades of enlightened leadership on behalf of children. His early support of children and their families, years before it became chic and before he had children of his own, exemplifies his compassion, wisdom, and courage.

Thank you for allowing me the honor of participating in these historic hearings on the State of the American Child and inviting me to present written testimony.

Facts

- Since 1958, infant mortality has risen to 7 percent, doubling among minority groups.
- In 2005, 2,642 Connecticut children were homeless and 34,428 people—including children—were turned away from homeless shelters for lack of room.
- As of 2006, 17 percent of children were obese and 22 percent were food insecure.
- In 2007, 85,530 or 10.6 percent of Connecticut's children under 18 lived in poverty, costing $11,800 per child per year of poverty in lost future productivity.
- On average, in the United States, only 20 percent of children who require mental health services receive them as the result of a profound shortage of youth therapists, prohibitive waiting lists in community clinics, ignorance or lack of awareness of symptoms (i.e., seeing troubled kids as bad rather than in need of help), and a long-standing social stigma related to mental illness.
- Under our current criminal justice system, the number of prison cells needed in the United States can be predicted by calculating how many fourth grade boys cannot read.
- Among juveniles in detention, 70 percent are mentally ill, 50 percent have been exposed to or are victims of trauma, and 90 percent cannot read above the sixth grade level.
- The achievement gap puts minority youths 4 years behind non-minority students; yet even the best U.S. students are 2 years behind their international counterparts.
- Formerly a world leader in high school graduation rates, today the U.S. ranks 18th among the top 24 industrialized nations.
- Closing the U.S. achievement gap would increase our GDP from 9 percent to 16 percent and up to $1.8 trillion.

INTRODUCTION

The problems besetting America's children have significant negative consequences for our Nation's overall potential and productivity. But solving those problems is complicated by significant State-by-State differences in how children are faring as well as a lack of a coherent national children's policy. A national commission on children might begin laying the groundwork to provide that vision by coordinating, evaluating, and initiating effective public policy.

I thoroughly support Senator Dodd's proposal to initiate a U.S. Commission on Children and America's Young People. Establishing such a national body focused on the policy issues facing American children and youths is an exceptional and much-needed step. I hope and pray it will have real authority to fundamentally improve the lives of American children. I also hope this body can be more than a study commission or academic clearinghouse. I would like it to be given legal authority and fiscal responsibility over U.S. domestic policy related to children and youth. To ensure this, I suggest that the Director of this body become a cabinet secretary with direct access to the President.

The U.S. Commission on Children and America's Young People could establish standards of well-being for American children, coordinate Federal policy affecting young people, and oversee program evaluation and funding.

The following remarks address the structure, scope, and authority of the proposed commission and outline possible directions of first-year initiatives for the committee's consideration.

STRUCTURE OF NATIONAL COMMISSION ON CHILDREN

I recommend that the commission have a national director, who would be a member of the President's cabinet, and five or six regional deputy directors. Each State should have a State director responsible for recruiting qualified people with expertise in a range of areas—people who are also gifted, energetic, and committed to

children and their issues. State directors should be responsible for gathering and synthesizing information about issues facing children and their families within their States; they should also be responsible for doing in-State program evaluations. State directors should also review outcome data to inform future funding decisions.

As America undergoes rapid economic changes, it is imperative that this national body has fluid bottom-up and top-down communication capacities. It is likewise essential that the commission's leadership and board have access to the varied perspectives of parents, educators, physicians, psychologists, social workers, community workers, athletic coaches, child advocates, lawyers, religious leaders and others who have ongoing and direct contact with children and can knowledgeably develop benchmarks for children's well-being, evaluate strengths and weaknesses in existing services, and offer suggestions for addressing unmet needs.

The commission would be well-served to have a racially and culturally diverse board from a wide range of backgrounds—including businesspeople as well as community members knowledgeable about their regions' problems—who can help establish a policy agenda.

SCOPE OF THE NATIONAL COMMISSION ON CHILDREN

Science now acknowledges that brains in both females and males do not develop fully until the mid-twenties. Thus, to be effective, the age range addressed by the commission should be broad, perhaps from birth to age 25. The length of time it takes to reach adulthood in an advanced industrialized nation suggests that young people need to be supported by policies through college or young adulthood. The current legal cut-off age of support and services for youth at 18 now seems arbitrary and out of sync with reality. Investing in the well-being of America's young people for an extended period would likely significantly increase their economic success.

INDICATORS OF CHILDREN'S WELLBEING

Indicators of children's well-being should include both physical and psychological milestones. These indicators should also include other relevant educational statistics: grade level reading; number of disciplinary actions per year; and hours devoted to sports, creative activities, or community involvement. Indicators should also address rates of youth violence and crime, teen pregnancy, and high school dropouts. Information from a number of wraparound indicators will provide a more useful, three dimensional assessment of how children are actually doing. It may be prudent to access milestones every 2 years in order to stay abreast of the state of children and make policy course corrections as needed.

The following indicators are examples of ways to think about well-being from multiple perspectives. As a clinical psychologist, my view of children's well-being in infancy is often demarcated by a baby's ability to lift his or her head, learn to suckle, and form an attachment with the primary caregiver. In toddlerhood, normal behaviors may include brief interest in exploration away from the primary caregiver and the capacity to play. For elementary school children, some indicators of success could include accessing growing imagination and school competency. Identity exploration, an ability to think abstractly, and a preoccupation with friends could be considered markers for teenagers, while the knowledge of one's career interest and romantic involvement may be the notable hallmarks of the early twenties.

TECHNOLOGY AND MILESTONES

How Are the Children Doing Today?

Investments should be made in developing the capacity to gather information and chart how America's children are doing at a given time. Developmental markers, once determined, need to be entered into a centralized database. Data could be obtained from schools, mental health settings, hospitals and doctors' offices, as well as the offices of DCF, juvenile justice and probation. Milestones without the technology to track and analyze the condition of America's children will be meaningless. This need for data may also provide an impetus for the use of electronic medical records, which should simultaneously improve the delivery of overall health care—including mental health care—for all children and their families.

With a databank infrastructure in place, the national commission could evaluate wellness and the needs of American children and provide a State-by-State report card at the end of each year, as well as an aggregate measure of U.S. progress or failure. This national grade could be periodically compared to other developed countries to estimate how American children are doing compared to their global counterparts on a number of indicators across time.

THE NEXUS OF EDUCATION, MENTAL HEALTH, AND JUVENILE JUSTICE

At five to nine times the world average, the United States has the highest incarceration rates in the developed world. This reflects the upside-down nature of investments whereby America over-funds its prison programs and under-funds its education and mental health programs. This topsy-turvy approach to setting policies is exacerbated by the lack of a coherent frame of reference for addressing the needs of child and youth. We have no means of coordinating young people's policy across agencies. And previously, we seem to lack the political will to keep all our children out of harm's way.

INVESTMENTS THE UNITED STATES NEEDS TO MAKE IN OUR CHILDREN

1. Attend to the Basic Needs of Food and Shelter First—Eliminate hunger, food insecurity, and homelessness in America. Homelessness and hunger must no longer ravage the lives of American children. A child who is living with chronic instability, fear, and hunger will be unable to develop normally or learn appropriately.

Invest in affordable housing.

Invest in universal childcare.

2. Expand Children's Health Care to Include Dental Care—Dental care is essential to ongoing good health for children and adults.

3. Expand Children's Health Care to Include Mental Health Care—Improve access to effective mental health services, beginning in pre-school. Early detection and treatment of troubled students is much cheaper than the costs of incarceration, lost wages and taxes, and welfare.

Develop a comprehensive public education campaign, akin to the anti-smoking campaign, to reduce the stigma connected with mental illness, emotional problems, learning disorders, and other problems of the human experience.

End law-and-order education policies—zero tolerance, expedient suspensions, and drop-of-the-hat expulsions—by training school personnel to have greater psychological awareness and by providing administrators with abundant alternative solutions, such as access to mental health services in schools and in the community.

Offer incentives (such as college loan forgiveness) for therapists to learn how to treat children appropriately in order to address the profound shortage of qualified professionals.

Stop using jail as the answer to children's social, emotional, educational, and economic problems. Stop warehousing poor, illiterate, and/or emotionally disturbed children in juvenile detention centers. Give them the help they need treating their problems and remedying their underlying causes.

Dramatically expand mental health services by increasing access, offering incentives for college students to study child modalities, improving quality of treatment, and disseminating information about effective, evidence-based practices by means of publications and electronic media in clinics and therapist's offices, and unifying requirements for continuing education for all clinicians treating children.

4. Expand the Definition of Trauma, Acknowledge its Ubiquity, and Provide Early Treatment—In our increasingly violent world, trauma has been traditionally viewed as exposure to violence, as either a witness or a victim, that occurs in the home (domestic violence), in the community (school or gang violence), in the context of combat or torture, and in a natural disaster. The definition of trauma should now be expanded to include significant losses in childhood, and appropriate treatment should be made available. Trauma criteria should now include: the loss of a first-degree relative due to death, illness, divorce, military service or incarceration; threats to bodily integrity, such as with cancer, severe illness, accidental injury or violent crime; and the chronic deprivation of poverty, physical or sexual abuse, and homelessness. Trauma could also be defined as any unexpected event in which one feels overwhelmingly threatened and helpless, such as with a sudden job loss.

There is a deeply concerning U.S. trend whereby there is at once greater tolerance of violence and greater violence in homes and communities. There are several well-known, but chronically ignored studies on the desensitizing effects on children who play violent games or watch violent electronic media, such as television or online videos. There is little that is positive, redeeming or inspiring on mainstream media outlets. The popularity of aggressive, so-called reality TV shows illustrates the level of American interpersonal competition and tolerance, even taste for aggression.

5. Support Effective and Lasting Education Reform—Develop and implement a voluntary, consensus-driven national curriculum to ensure consistent educational standards across State lines.

Emphasize the importance of a strong system of support and resources that includes curriculum guidelines and professional teacher development. Be cautioned

against jumping directly from developing the standards to administering aligned assessments.

Require U.S. students to meet international standards of learning and student performance.

6. Give Juveniles Genuine & Age-Appropriate Justice—Treat problems early. Small children have small problems; big kids have big problems.

Detention centers need to be rehabilitative—not punitive. Except for those who are very ill or dangerous, the practice of keeping young people in juvenile detention centers must be abolished.

Provide readily available alternatives to detention when necessary, including residential treatment and respite for caregivers.

Widely expand community services and recreational facilities and make them available from early childhood through young adulthood.

Invest heavily in after-school programs and trade school training programs, especially for at-risk youth.

CAUTIONARY NOTES ON CHILDREN

NEW MEDIA

Hillary Clinton noted that America was undergoing the largest experiment on children in history regarding their long hours of exposure to computers, video games, and cell phones—an exposure that leads to addiction for some. Despite the negative effects on weight associated with the sedentary nature of sitting in front of computer or TV screens for extended periods, the effects of over-stimulating images and interactions, often violent or gratuitously sexual in nature, and the immediate gratification of computer interaction (faster and faster) on short- and long-term physical and mental development in children are virtually unknown and largely unexplored.

It would be in the best interest of children and young people to have a comprehensive and rigorous series of studies examine the possible effects of children's exposure to and interaction with current, new, and emerging media formats and products.

Leverage the power of new media for productive uses.

As part of its policy innovation, the national commission should find ways to promote and prevent contagious behaviors through leveraging the viral nature of online media.

TELEVISION AND MARKETING

Since World War II, advertisers have spent trillions of dollars to develop media campaigns to influence America's purchasing decisions and shape our worldview. Companies and marketing agencies routinely develop products and manipulate audiences telling us what we need to be smart, affluent, or desirable. Consumptive marketing is pervasive in American culture and children are bombarded with marketing images of cultural ideals of beauty and success and relentless sales pitches for food and products no one needs.

This leads to a "me, me, and me" culture of acquisition and interpersonal competition. Relentless persuasive messages both in online media and television must be examined and regulated. The national commission may find it prudent to begin to develop critical viewing or media awareness messages to help inoculate children from shallow marketing and sales messages.

CRISIS OF YOUTH

Problems in Urban Settings

Every day, I become more certain that there is growing despair and hopelessness in the hearts and minds of today's urban, minority youth and it takes different forms in boys and girls. I have witnessed firsthand the hopelessness in children's eyes living in poor urban settings often taking the form of marijuana or alcohol abuse, teen pregnancy, gang violence and youth murder. I have thought to myself as I drove by a dusty playground or dilapidated soccer field that we all like to think that if children can do well in school they can somehow leave their family and neighborhoods, learn new social graces and make new friends, apply and get into college and rise to the working or middle social classes.

I am wholly unconvinced.

Doing well in urban schools is difficult, compounded by the enormous pressures experienced in living in female headed, single parent households. Good teachers often won't work in urban settings, and if they do they get easily burned out by the symptoms of despair—anger, illiteracy, and disruptive behavior in overcrowded

classrooms. Most children in urban centers, live in a female headed, single parent household, where mother is overwhelmed and depressed, lucky if she is working at a low-wage job. Without good parenting, high performing schools, access to extracurricular activities and social opportunities in safe neighborhoods the pathway out of poverty is forever blocked. I have personally seen again and again the hardship of single mothers raising sons, and daughters, without involvement of their fathers, living with little income, support or security; it would take *nothing less* than relentless political will, sustained and inspired leadership combined with coordinated public policy change to lift those children and their families out of poverty into the middle class.

Once and for all end teenage pregnancy, early parenthood, and out-of-wedlock births. This should be a commission priority in year one. If Madison Avenue can convince everyone, and I mean everyone, that luxury items are a necessity and that McDonalds is healthy, with a similarly robust and unrelenting campaign we can end this contagious and destructive social pattern promoting poverty and harming children, both teen parents and their babies.

In my childhood, I remember vividly the admonishments against littering ("Don't be a Litter Bug") and being taught the terrifying consequences of heroin use and addiction. There has not been a government-sponsored campaign to inoculate children from the stream of negative messages and images in recent memory and these protective and effective social marketing campaigns for young children need to be urgently resurrected.

Problems in the Suburbs

The recent gang rape of a young teenage girl by several young teenage boys in Madison, CT, an affluent suburb, represents another kind of crisis of youth. These heinous acts occurring under the influence of alcohol were captured on a cell phone and sent out to friends. These were children not living in financial poverty but living in a kind of moral poverty. Children of all ages and socioeconomic classes are exposed to a torrent of gratuitously sexual and aggressive messages and images in every media format. This desensitizing and dangerous exposure combined with the disinhibition associated with alcohol abuse leads to disaster, particularly for teenagers. Far too many parents continue to allow teenagers to have parties in their homes and tolerate drinking of alcohol by underage children. A national body on children can seize this opportunity in crisis to develop educational campaigns to better protect children against the flood of unhealthy messages and educate parents to be more aware of the importance of limit setting, parental supervision and legal responsibility.

ETHICS AND CHILDREN

A constant bombardment with messages urging consumption of marketed goods helps distort children's view of themselves, their families and their community. Before the recession, 70 percent of the GDP came from having Americans buy goods and services. This leads to a worldview concerned with acquisition of things and status symbols, leading to interpersonal competition rather than interpersonal cooperation.

The U.S. Commission on Children and America's Young People—or National Commission on Children and Youth in America—could initiate and sustain a public education campaign to educate youth, and the public at-large, to the virtues of an ethic of service to others. Championing the rewards of doing for others may help to make children' lives more meaningful, provide much-needed support to vulnerable populations and begin to mitigate the onslaught of negative influences of media and marketing.

SUMMARY

I thoroughly support Senator Dodd's proposal to initiate a U.S. Commission on Children and America's Young People. Establishing such a national body focused on the policy issues facing American children and youths will provide fundamental direction and positive change for American children historically not a domestic policy priority. In order for this new commission to work, it must have legal and financial authority in directing public policy affecting U.S. children. To ensure this, I suggest that the director of this body be designated as a cabinet member with direct access to the President.

The problems weighing on America's children have significant negative consequences for our Nation's potential and productivity. With political will and strong leadership, the national commission on children will be able to make life altering improvements by laying the groundwork to provide a vision for U.S. children by co-

ordinating, evaluating, and initiating effective public policy to dramatically improve their children's lives.

The U.S. Commission on Children and America's Young People once established, can set standards and follow indicators of well-being for American children, coordinate Federal policy affecting young people, and oversee program evaluation and funding.

Senator Dodd's vision of a national body on children is a far-reaching, life saving initiative, one that will forever raise the spirit of children in need and help lift all children out of harm's way.

I am deeply grateful for Senator Dodd's compassion, wisdom and courage on behalf of American children and would like to take this opportunity to thank him for his 35 years in the U.S. Senate positively impacting the lives of millions of children and families. We will miss him as our State champion and national hero but will continue to expect great things from this great leader and great man.

PREPARED STATEMENT OF WILLIAM B. WICKWIRE, ATTORNEY

This statement is being presented by me, Attorney William B. Wickwire, who was the Prosecutor for Juvenile Matters in New London County, State of Connecticut, for 30 years. I retired on July 1, 2009, and I am currently a sole practitioner primarily in New Haven County, State of Connecticut. My practice of law is focused on defending juveniles in the Connecticut Juvenile Justice System.

I will now take a child, charged with one or more delinquency offenses through Connecticut's Juvenile Justice System, with comments along the way, as to how the Juvenile System works today, and how it could work better on behalf of our juvenile children. Before I do this, it is incumbent that I mention a recent change in Connecticut's Jurisdictional Age for Juveniles. Connecticut increased the age to 17 years of age for the prosecution of all juveniles. Adulthood now begins at 18 years of age, instead of at 16 years of age, for two main reasons:

1. Connecticut, as with 47 other States, now allows prosecution of juveniles beyond their 16th birthdays.
2. Connecticut agrees with the scientific literature that a child's brain is not fully mature at 16 years of age.

Once a child is charged with a delinquency offense, the child is presented in juvenile court and given his/her rights and the nature of the charge(s) against the child. However, one key difference in Juvenile Court, as opposed to Adult Court, is that once a child enters the courthouse, the child is assigned a probation officer. The probation officer works with the child and parent(s) or guardian throughout the process. Therefore, a child can receive treatment and services early in the processing of the child's case. This must be with the agreement of the child, the child's parent(s) or guardian and the child's attorney (if the child is so represented). In Adult Court, a probation officer is not assigned to a defendant until after his/her conviction.

Juvenile Court is very treatment-oriented, with the best interest of the child as paramount. However, Connecticut does not have enough diagnostic and treatment facilities for juveniles. Connecticut has only one facility that provides a comprehensive report, after a 45-day in-patient commitment for drug issue(s). The report indicates potential treatment options for a child's drug and/or alcohol problem(s). Connecticut has only one residential psychiatric hospital for the diagnosis of a child's potential mental health issue(s). Unfortunately, many children languish in detention (lock-up) centers, because there are insufficient beds at the two in-state facilities. Especially as to children with mental health issue(s), the choice becomes the child's remainder at the diagnostic hospital or return to detention (lock-up). A child's remainder at the diagnostic hospital after the report has been completed is not in the best interest of the child. The child is not receiving therapeutic treatment. Furthermore, the hospital does not have a bed available for another child.

After the child's initial presentment in Juvenile Court, the case goes to a pre-trial. Most juvenile cases are settled at the pre-trial level. The case then goes to a probation officer for a thorough report with recommendations as to the best interest of the child. The settlement of a juvenile case could result in a recommendation of community service with no adjudication of delinquency. More serious offenses, usually sexual assault offenses, are tried in Juvenile Court. As to the most serious crimes, the children are transferred to the Adult Court for handling as adult criminals. If a child is adjudicated a delinquent after a trial, the probation officer prepares a thorough report with recommendations.

If the recommendation(s) is probation, the terms and conditions are entered by the Court. Problems in Juvenile Court stem from a probation officer's recommendation that the child be placed out of the home by DCF (The Department of Children

and Families). DCF does not have enough funding to place, in a timely manner, all of the children that require alternative placements. Therefore, the child languishes in detention (lock-up), until the funding is available for the child's placement.

Certain male juvenile delinquents are placed at the Connecticut Juvenile Training School in Middletown, CT. The cost of a year's placement is prohibitive. Not only that, but the Training School was built and designed by the Roland Administration and was effectively an inappropriate placement facility for children. As stated in the *New York Times* article of June 25, 2004, page B5, "One of the biggest complaints about the facility is the cell-like rooms, which consist of a plastic bed and a shelf." The cells are quite small and would be more appropriate for convicted adult defendants. As of today, July 29, 2010, the rooms are still small and cell-like. Governor Rell tried to create three (3) regional centers for adjudicated delinquents and hoped to close the Training School. Her efforts failed for financial reasons, and Connecticut male juveniles are still placed at the Training School. Improvements have been made at the Training School, as to the treatment of the children placed there. However, it is still an inappropriate placement for Connecticut's children. Maybe the funding can be appropriated to open the three regional treatment centers. Connecticut still does not have an appropriate facility to place adjudicated delinquent girls that need secure long-term placements.

With the influx of the 16-year-old children, and eventually, the 17-year-old children into Connecticut's Juvenile Justice System, I can only hope that the appropriate funds can be made available to service, effectively, all of Connecticut's juvenile delinquent children. A delinquent child in Connecticut should have a good chance to become a happy and productive member of society. Hopefully, this occurs.

At Senator Christopher Dodd's Connecticut Hearing on Monday, July 26, 2010 as to the State of the Child, various preventative programs that aim to nurture and to protect Connecticut's children, all indicated a lack of appropriate funding. Not only do we need sufficient funding of preventative programs for children, but we also need sufficient funding as to intervention programs, such as Connecticut's Juvenile Justice System.

Speaking as a resident of the State of Connecticut and as a retired Juvenile Court prosecutor, I want the best for our children.

At this time, I commend and thank Senator Christopher Dodd for his untiring and successful efforts on behalf of America's children, who will benefit from his leadership and dedication.

Respectfully submitted.

[Whereupon, at 11:46 a.m., the hearing was adjourned.]

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