The Child Health and Development Institute of Connecticut

Too Young to Count?

Promoting the Health and Development of Connecticut's Young Children and Their Families

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Prepared for

The Child Health and
Development Institute
of Connecticut

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How a society treats its youngest children and how it helps families ... are signposts to the future. Many of these signposts in the United States are troubling. Indeed, the Carnegie Corporation report, Starting Points, deemed the situation facing young children and their families a "quiet crisis." It called for concerted effort from all parts of this society to build a deeper commitment to its youngest children

Jane Knitzer &
Stephen Page, 1996

Map and Track:
State Initiatives for Young Children and Families

The Child Health and Development Institute of Connecticut is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. The Institute creates, supports, and facilitates innovative primary and preventive strategies for children, and works to maximize the effectiveness of the institutions, systems, and individual care givers that contribute to their well being. This report was supported as part of the Institute's agenda to promote more comprehensive service and support systems for young children and their families, based on knowledge of child development and best practices.

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Foreword and Acknowledgements

As the result of advances in the scientific and clinical study of the brain, body, and behavior, much is known about how to promote healthy physical and emotional development in young children. Healthy development from birth through infancy and early childhood requires a healthy body and a healthy mind. Safe and secure family relationships are essential, as are opportunities in the home and community to understand how to be physically healthy, how to learn, how to get along with people, and how to become a well-functioning person who can manage emotions while pursuing worthwhile goals.

The Child Health and Development Institute of Connecticut was interested in how to build on this knowledge to ensure the well being of each and every child in Connecticut. We enlisted two faculty members at the University of Connecticut Health Center, Julian Ford a clinical psychologist, and Marilyn Sanders a pediatrician, to address the following essential question: What are the resources, services, and supports that must be in place in order to enable all children to achieve their potential for healthy development and freedom from illness? This report is the result of their work and has been prepared in order to create a framework for constructive answers to this question for the State of Connecticut.

The authors received valuable consultation and interviewed a number of knowledgeable care givers, health care providers, program administrators, researchers, advocates, and policy makers in Connecticut. Their many contributions are gratefully acknowledged. We particularly want to acknowledge the contributions of a core group of primary consultants: Jane Bourns, L.C.S.W.; Eve Colson, M.D.; Paul Dworkin, M.D.; Walter Gilliam, Ph.D.; Mary Alice Lee, Ph.D.; and Carl Valentine. We also would like to express our gratitude for a generous grant from the Children's Fund of Connecticut that provided support for this effort.

We hope that the information and recommendations in this report will serve as a foundation for discussion about and action towards building a comprehensive support system—one that can both provide quality preventive services to all Connecticut's children and families and be responsive to the special needs of those who are most vulnerable.

Judith C. Meyers, Ph.D.

President and Executive Director
Child Health and Development Institute of Connecticut

Executive Summary

The years from birth to kindergarten are a time of both rich opportunity and significant vulnerability. Healthy development in early childhood provides the foundation for each person's wellbeing and their ability later in life to contribute to the community. During the first five years, children's bodies and brains grow faster than at any other time. Good health and development in early childhood depend upon primary health care such as well baby care and immunizations, on safe and stimulating family and social environments, and on a secure and caring attachment to primary care givers. It is also essential that problems be identified and interventions implemented early on in the home, the pediatric clinic, and the preschool or child care setting—both for children who are developmentally, behaviorally, or medically impaired, and for those who are "at risk" for health or developmental problems.

This report examines early child health care in Connecticut by addressing the following questions:

- What are the most pressing health problems for Connecticut's young children and their families?
- What are Connecticut's existing resources for early childhood health care?
- What are the limitations of Connecticut services for early childhood health and development?
- How can Connecticut achieve a system of care for early childhood health and development?

Next, you will find a brief overview of the key points and highlights of each chapter of the report.

Chapter 1

THE HEALTH NEEDS OF CONNECTICUT'S YOUNG CHILDREN AND THEIR FAMILIES

Key Physical Health Problems in Early Childhood

- **Infant mortality** among African American infants is more than double the rate found among White, non-Hispanic infants. Connecticut ranks 26th in the United States in infant mortality.
- **Preterm birth/low birth weight** are more than twice as likely among African American babies as among White babies. Connecticut ranks 21st in the United States in low birth weight births.
- **Dental problems** are seen in 67% of low-income preschoolers on their first dental visit. African American and Hispanic children are twice as likely as non-Hispanic Whites to have cavities.
- **Poor nutrition** causes anemia and obesity for many young children in Connecticut.
- **Asthma** affects more than 10% of all children who are insured by Health care for UninSured Kids and Youth (HUSKY). African American and Hispanic children are more likely to have asthma than White, non-Hispanic children.
- **Lead poisoning** is epidemic among low-income urban young children in Connecticut.
- **Unintentional injuries** are the fourth leading cause of death and the cause of 4% of all hospital admissions in Connecticut among infants, as well as a serious problem for all young children.

Key Combined Physical and Behavioral Health Problems in Early Childhood

- **Child abuse/neglect** and **domestic violence** cause severe physical harm and lasting problems with depression/anxiety each year for thousands of children from all walks of life in Connecticut.
- **Drug exposure** due to parental use of cigarettes, alcohol, cocaine, opiates or marijuana in pregnancy negatively affects the development of thousands of Connecticut children each year, with children in low-income families at highest risk.
- **Life threatening problems with sleep, feeding or coping with stress** occur in 2% of babies and infants.

Key Behavioral Health Problems in Early Childhood

- **Attention Deficit Hyperactivity Disorder (ADHD)** affects as many as one child in 17 by age 5. Providing appropriate medication for ADHD without overprescribing remains a dilemma.
- Other **disruptive behavior disorders** affect as many as one child in 20 by age 5. In 1999-2000, the State Department of Education reported 458 disciplinary actions involving *kindergarten children*.
- **Depression, anxiety** and **attachment disorders** affect as many as one child in 20 by age 5.
- **Autism** affects one young child in 200 and is more chronic and costly if treatment is delayed.

Chapter 2

EXISTING RESOURCES TO PROMOTE EARLY CHILDHOOD HEALTH AND DEVELOPMENT

Characteristics of a Comprehensive System for Early Child Health Care

Successfully promoting young children's health and development requires that federal and state legislation, regulations, and programmatic initiatives encourage the development of a cost effective and socially responsible system of health care. Such a system of care must possess the **capacity** and **coordination** necessary to ensure ready **access** to high **quality** services—including both those services needed by all families and children and those for families and children with special needs.

Promising Models for the Promotion of Young Children's Health and Development

A comprehensive system supporting the healthy development of young children must have programs and services designed to achieve several goals:

- To ensure **healthy births and babies**
- To provide a **medical home** for high quality pediatric health care from birth to 5 years
- To provide **family support and education** for parents and other care givers
- To ensure **early identification and treatment for** infants and young children with developmental or behavioral/mental health concerns
- To link **child care or preschool services** to the health care system

Young children and their families in Connecticut have a range of income and educational levels, ethnic origins, physical and behavioral health care problems and perceptions of service needs—all of which factor into determining the supports necessary for a child to thrive. Along with an infrastructure of universally available supports and services intended for all children and their families, there must also be services and interventions for those with special needs based

upon the physical or mental health of the child or parents, environmental challenges or other risk factors. With the guidance of our consultants, we selected a sample of programs in Connecticut with an established track record in meeting these goals, and we interviewed and obtained supporting documentation from representatives of each program.

Estimating the Public Sector Financial Resources for Early Childhood Health Services

Connecticut has many of the resources needed for an early childhood health care system with the capacity to provide accessible, well-coordinated, and high-quality services. While not the subject of this report, financial resources from the private sector should be considered in the development of an early childhood health care system, both from for-profit sources such as private health insurance and from nonprofit sources such as foundations or charitable organizations. In the focal area for this report, the public sector, the Connecticut Children's Budget for fiscal year 1999 describes an estimated total of $600 million that was allocated to state programs for services that directly or indirectly affect children from birth to 5 years old and their families. Because funding for most children's programs was not detailed by age cohort, we developed this estimate based on the proportion of services in each program that likely went to children 0-5 years old and their families.

Chapter 3

LIMITATIONS OF CONNECTICUT'S SERVICES FOR EARLY CHILDHOOD HEALTH AND DEVELOPMENT

Capacity is limited by fiscal (funding and reimbursement), work force, and program issues:

- State government funds for early childhood services are fragmented by categorical boundaries.
- Medicaid and private insurance reimbursement often is inadequate or entirely lacking for critical early childhood health care services, both for direct care and "indirect" consultation services.
- Model national programs have sites in only a minority of Connecticut communities.
- There are critical shortages of early childhood behavioral health care services and providers, and no overall system of behavioral health care exists for young children and their families.

Coordination of early childhood health care/developmental services is limited in several ways:

- Prevention services for high risk families and children are not well coordinated. For example:
  - (a) many women with high risk births or infants do not receive highly specialized neonatal or behavioral health care;
  - (b) many children who display behavioral or emotional problems in child care, preschool, or pediatric settings do not receive behavioral health services, and their care givers and families often do not receive support or counseling services.
- Many children fall through the cracks when no longer eligible for services. For example:
  - (a) children who are ineligible for the next program in a sequence due to different eligibility criteria (such as transitioning from Birth to Three into Pre-Kindergarten Special Education);

(b) children whose families are not informed of alternative eligiblity, such as from HUSKY A to HUSKY B.

- Despite notable positive exceptions, statewide partnerships among early childhood health care, child care, and school readiness programs are endorsed in principle but not achieved in practice.

Access is limited for thousands of Connecticut's youngest children and families:

- Health care for UninSured Kids and Youth (HUSKY) does not enroll thousands of eligible children, and many parents of HUSKY children have no health insurance. Key special populations such as 18-25 year olds and documented and undocumented immigrants often cannot get health insurance.
- Although Infoline provides a single point of access for information and referrals, children and families often miss needed services because there is no single point of entry for early childhood health care.
- Disproportionate levels of early childhood health problems for African American and Hispanic children suggest a need to identify unique barriers to their access to early childhood health care.
- Managed care may compromise access to mental health services by failing to adequately cover medically necessary services such as parental support and home- or community-based mental health services for young children.
- Many programs restrict access with eligibility criteria that admit only severely impaired children or only certain children (such as firstborns), leading to particularly troubling barriers to developmental and health care services for children with emerging developmental or behavioral health concerns.

The quality of early childhood health care and developmental services has several limitations:

- Most young children are not assessed to determine whether they require specialized diagnostic or treatment services.
- The linkage to health care services by programs delivering child care and family support services is not closely monitored and is likely to be delivered with variable quality even under the best of circumstances.
- Racial and ethnic disparities in young children's health pose a special challenge for all early childhood service providers to develop and implement culturally competent approaches to meeting the needs of African American and Hispanic children and families.

Chapter 4

MAKING YOUNG CHILDREN COUNT: FUTURE DIRECTIONS FOR EARLY CHILDHOOD HEALTH AND DEVELOPMENT

Ensuring the healthy development of every young child in Connecticut is a key social responsibility and a sound economic investment. Existing resources require enhancement and expansion in carefully targeted areas in order to provide cost-effective remedies for the system's significant limitations. We conclude the report with recommendations designed to provide a framework for a comprehensive and innovative system of services and supports to protect and enhance the health and development of young children and their families. Our goal is to address the key priorities voiced by families, children's advocates, and early childhood service providers.

Provide support and education to all parents of young children

Most parents receive little training or guidance beyond the informal support they may get from their families and neighbors. Therefore, every expectant parent or parent of a child 0-5 years old should receive ongoing information, mentoring and peer support related to child development, family health and safety, effective parenting and early childhood services.

Make the medical home a basis for early childhood health care

Every child should have a medical home and receive thorough, regular pediatric checkups to identify and prevent or treat acute or chronic health problems. A medical home is a multidisciplinary pediatric care team, available to the child and family on a regular basis over the child's entire childhood, with a primary health care professional who knows the child and family well enough to provide personalized guidance. For many young children and families, having an ongoing dependable relationship with a primary health care professional is sufficient to address their health needs in a timely and effective manner. Young children and families who experience serious emerging or chronic health problems also need this primary provider to coordinate an individualized "wrap around" program of services provided by a team of specialists. In this case, the medical home extends beyond primary pediatric medical and dental health care to include the coordination of relevant socioemotional, developmental, educational, and family support services.

Expand access to and capacity of services for at-risk young children and families

Every parent and child at risk for developmental disability, behavioral health problems, or abuse or neglect should be identified and helped to develop an individualized family services plan including early intervention services by early childhood specialists. The type, duration and intensity of services, and the specific provider(s) and setting(s) should be determined on an individualized basis without a priori limitations on cost, providers, and duration.

Ensure culturally competent responses to racial/ethnic disparities in young children's health

All pediatric physical and behavioral health care, developmental, educational, and child care providers should be trained and have continuing education and consultation to ensure that their services are culturally competent in addressing the barriers to access and the disparities in young children's health affecting families from diverse racial and cultural backgrounds.

Chapter 1 The Health Needs of Connecticut's Young Children and Their Families

Exciting recent research demonstrates that the first five years of every child's life are a critical period of physical and behavioral development that lays a foundation for lifelong health and social adjustment. Small changes in a young child's health or environment can make an enormous and lasting difference. Therefore, it is essential—and highly cost-effective—to identify and address the health needs of young children, both to prevent major problems for the individual and to promote positive social contributions by an entire next generation. In this chapter we will offer a brief overview of the opportunities and challenges of early childhood development and identify several priority needs for the health of Connecticut's young children.

The Developing Young Child

Since brain and body development begin before birth, babies born to healthy mothers and healthy families have reduced risks of serious immediate health problems such as prematurity, low birth weight, and drug exposure. For babies born with compromised health, specialized newborn care is essential-- including both technical interventions and attention to the individual development of the infant and the emotional relationship and attachment between the infant and primary family care givers.

In the first year, babies' bodies and brains grow faster than at any other time. Even more important, infants are developing neurological connections that serve as the essential foundation for all future learning-- learning which happens primarily through positive interactions with primary care givers. The body and brain, character and personality, take shape in the first year. Healthy development in infancy depends upon:

- preventive pediatric health care such as well child care and immunizations;
- risk reduction to make the infant's immediate physical environment safe;
- establishment of secure attachments to primary care givers.

Establishing these positive conditions requires attention, effort, and resources such as transportation, money for house maintenance, and stress-free time for the care giver[s] to share with their child[ren]. Many families need support to give this attention and to have access to the necessary resources.

From the first to third year, body and brain development continue at a rapid pace. Toddlers grow by leaps and bounds, learning how to reach out and begin to shape the world around them. Continued healthy development depends upon having family, physical and oral health care and child care environments that promote good nutrition, healthy physical activity, active learning, self esteem, social skills and secure emotional attachments.

By the third birthday, children typically have developed a sense of identity and a style of interacting with other people and the environment—their core "self" for the rest of their lives. Continued well-child visits to the pediatric and oral health care providers are essential to the early identification of health or developmental problems. These health and developmental concerns include the most tragically obvious and severe conditions such as birth defects; the more common problems such as learning impairments; the effects of injuries or persistent illness; or behavioral and emotional problems that are more difficult for parents or child care providers to evaluate.

In the fourth and fifth years, the child's health and development increasingly are influenced by environments outside the home and family. Research demonstrates that, no matter how strong the foundation, 4 and 5 year olds who are not protected or helped to recover from persistent physical problems or significant social stressors are vulnerable to developing costly and debilitating personal and family problems that can last a lifetime.

Young Children in Poverty[1]

For young children and families living in poverty, access to preventive health and behavioral health care may be limited as a result of not having basic resources such as food, housing, and transportation. These children and families often face the additional stressor of living in environments that are not safe from physical harm and psychological trauma. Despite an unprecedented economic boom, one in five young children in the United States lives in poverty. In Connecticut, where the median income of families with children exceeds the national average by $16,000/yearly, one in seven children under age 5 lives in an impoverished family.

When children grow up in impoverished households, their health often suffers: only 69% of families with incomes under $10,000 yearly rate the health of their young children under 5 as "very good or excellent." By contrast, in families earning over $35,000 yearly, almost 90% rated their young child's health as "very good or excellent." Across the United States, infants from low-income families are more likely to be born low birth weight and more likely to die before their first birthday. Children from low-income families get sick more often from infectious diseases and are more likely to suffer serious chronic medical conditions such as diabetes and asthma. Indeed, asthma rates are increasing fastest among low-income, urban minority children.

Poor families clearly need resources to preserve and improve their young children's health. Health insurance is critical. Uninsured children are far more likely to lack a regular provider, to delay seeking health care and to use emergency room services than are children with health insurance. Thousands of Connecticut's young children still are uninsured. Because poor families moving off welfare are often uninformed regarding their continued eligibility for health insurance either through Medicaid or Child Health Insurance Program (CHIP) funds, poor children often lack health insurance.

The environmental and health problems facing young children in poverty have serious implications for their future. Longitudinal studies have followed cohorts of low-income children from infancy to young adulthood. Low-income children have lower global intelligence quotients and verbal test scores in the preschool period. Furthermore, the number of years of early childhood poverty exacerbates these income-related effects. Yet, only 50% of all eligible children are enrolled in Head Start programs.

Poor children also have lower reading and mathematics achievement test scores in elementary school and are twice as likely to repeat a grade in school or drop out of school prior to high school graduation. Thus, not only health but also educational (and ultimately, vocational and social) success is compromised by poverty from an early age. Although the focus of this report is the health of all young children in Connecticut, children and families living in poverty face particularly daunting obstacles to achieving and protecting good health.

KEY PHYSICAL HEALTH PROBLEMS IN EARLY CHILDHOOD

While young children from impoverished families are at increased risk for serious health problems, there are significant impediments to the optimal physical and emotional development of all our young children. Below, we have identified the key physical and behavioral health problems that clinical experience and research suggest are principal threats to the health and development of Connecticut's youngest children.

◆ Infant Mortality [2]

Connecticut ranks right in the middle of the 50 states (26th) in the United States in infant mortality (death in the first year)—a standing that is not in keeping with the state's high overall income and excellent network of services for prenatal and infant health care. Data comparing racial and ethnic groups show a major problem that may largely explain this deficiency. In Connecticut, African

American infants have more than double the rate of infant mortality of White, non-Hispanic infants (14.9 deaths/1000 live births vs. 6.4/1000). The increased risk for early death in African American infants can be attributed to two factors: increased rates of low birth weight infants and an increased risk for death due to sudden infant death syndrome (SIDS).

After the first month of life, SIDS is the primary cause of infant death. While the overall SIDS rate has fallen 38% nationally since the institution of the "Back to Sleep" campaign, African American infants continue to have a higher rate of SIDS compared to other groups. National and local experience suggest that African American infants are substantially less likely to be placed in the protective back sleeping position.

◆ Preterm Birth/Low Birth Weight [3]

Rates of preterm birth (less than 37 completed weeks of gestation) and low birth weight (under 5 lbs. 8 oz) and very low birth weight (less than 3 lbs. 5 oz) are important measures of infant health. Connecticut ranks near the middle (21st) among all states in the United States in the percentage of low birth weight babies. In 1998, 10.1% of all Connecticut births were preterm; 7.8% were low birth weight, and 1.7% were very low birth weight.

Here too, as with infant mortality, significant disparities exist among Connecticut's racial and ethnic groups. While only 6.5% of births to White, non-Hispanic women were preterm, 13.2% of births to African Americans, and 9.7% of births to Hispanic women were preterm. African American women had more than triple the rates of White women for very low birth weight infants (3.9% African American vs. 1.2% White women). These racial discrepancies are particularly stark for teen pregnancies. Seventy-three percent (73%) of all low birth weight infants with mothers under 18 years old were born to African American and Hispanic mothers.

Despite improvements in survival of preterm and low birth weight infants, these children continue to have increased risks of delays in language, poor development of social/behavioral skills, poor motor skills, hearing and vision problems and poor school performance. Very low birth weight infants are at particular risk for long-term developmental problems, and recent research suggests that on average their brains are physically smaller than those of infants born at term.

◆ Dental Problems [4]

The incidence of tooth and gum decay increases in relationship with decreasing socioeconomic status. African American and Hispanic children have twice the rates of dental cavities as White children. A 1991 Connecticut study of children under 5 years old who presented to an inner city community health center revealed that 67% of these preschoolers had cavities on their first dental visit.

◆ Nutrition Problems [5]

The prevalence of obesity among low-income children in the United States from 0-6 years old increased from 8.5% in 1983 to 10.2% in 1995. These increases were most significant among urban children, boys and Hispanic children. In Connecticut, the Women Infants and Children Program (WIC) data for 2000 revealed that as many as one in 20 (5.4%) of all infants 0-12 months and as many as one in 6.5 (15.2%) children 1-5 years were obese.

A recent review of 264 patient charts from three primary care centers in Hartford, Connecticut serving predominately low-income children revealed 43.9% of 18-36 month old children were anemic using WIC criteria. Two-thirds of the mothers were Hispanic, and 27% of mothers were under 19 years old. These rates are dramatically higher than in the general Connecticut WIC population in which 9.2% of children 1 to 5 years old were anemic.

◆ Asthma [6]

According to the Centers for Disease Control, asthma is the most common chronic illness affecting children. In 1998-1999, the Children's Health Council studied the prevalence of asthma in children who were enrolled in Medicaid Managed Care. Rates were highest among children under 5 years old. According to Children's Health Council data for children under 1 year old, 19.7% of Hispanic,

14.8% of African American and 11.3% of White infants received a diagnosis of asthma. For all children under 15 years old, asthma rates were highest for children living in the predominantly poor and African American or Hispanic populations in Bridgeport and Hartford.

◆ Lead Poisoning [7]

Lead poisoning is a major public health problem in the United States, particularly affecting children living in older, poorly maintained houses. Evidence suggests than even modestly elevated lead levels result in learning and behavioral problems that interfere with education. In 1999, 3.4% of all Connecticut children under 6 years old who were screened had elevated blood lead levels. The ill effects of poverty and racial disparities again are clear: children living in poor urban settings are as much as four times more likely than other children in Connecticut to experience lead poisoning (5.3% in Hartford, 9.7% in New Haven and 11.6% in Bridgeport).

◆ Unintentional Injuries [8]

For Connecticut infants under 1 year old, unintentional injuries, which excludes injuries due to child abuse, are the fourth leading cause of death and the cause of 4% of all hospital admissions. The Connecticut Injury Prevention Center reports that from 1990-1997, hot object scaldings, falls and poisonings accounted for about 70% of the unintentional injuries requiring hospitalization in 0-4 year old children.

KEY COMBINED PHYSICAL AND BEHAVIORAL HEALTH PROBLEMS IN EARLY CHILDHOOD

◆ Child Abuse / Neglect and Domestic Violence [9]

Neglected and abused children are at risk for central nervous system or head / face injuries, malnutrition, failure to thrive, sexually transmitted diseases, fractures, burns, immunodeficiency and exposure to environmental toxins. In addition to the physical effects, abused children are at risk for a range of neurologically-based problems: poor impulse control, aggression, diminished attention, and language acquisition delays; attachment and self-regulatory disorders in infancy; chronic medical illness; and profound socioemotional problems. The impact of abuse is felt into adolescence, with depression, suicidality, delinquency, and substance abuse. More than 50% of all children experience violent victimization at least once, and by the most conservative estimate (child abuse reports confirmed by official child protective services agencies) one million children are known to experience child abuse in the United States each year. In 1998, our youngest children (0 to 3 years old) had a significantly increased victimization rate, 14.8 / 1000, compared, to the overall childhood victimization rate of 12.9 / 1000. Infants and young children are at dramatically increased risk for child fatality due to abuse and neglect. **Over three quarters (77.5%) of all fatal injuries due to abuse and neglect were in children under 5 years old. Children less than 1 year old accounted for 37.9% of all fatalities due to abuse or neglect.**

Child neglect is more prevalent than child abuse. Nationally almost 2 in 3 cases of documented maltreatment are primarily due to neglect, and in Connecticut as many as 4 in 5 cases confirmed by the Department of Children and Families are primarily due to severe neglect that causes harm or serious endangerment. From July 1, 1999 to June 30, 2000, the Connecticut Department of Children and Families investigated 28,387 reports of abuse or neglect and confirmed the abuse or neglect of 14,003 children. According to the National Child Abuse and Neglect Data System Reports for 1998, almost 40% of all confirmed cases of abuse / neglect in Connecticut were younger than 5 years old. These confirmed reports in young children are more than twice the expected rate compared to the overall proportion of young children among all Connecticut's children. This may be only the tip of the iceberg because abuse often goes unreported, and neglect is often invisible even to others close to a child.

Nationally, 10-15% of all women of childbearing age and their children are exposed to domestic violence--between 2-4 million women and 3-10 million children each year. As many as one in three children exposed to either domestic violence or child abuse experiences both adversities. Children exposed to either domestic violence or physical/sexual abuse are at high risk for immediate or delayed physical and behavioral health problems that require costly treatment and can lead to long-lasting disruption and failure in school, work, and relationships.

◆ **Infant and Family Exposure to Addictive Substances such as Cigarettes, Alcohol, Cocaine and Opiates** [10]

One in ten (9.7%) 1997 Connecticut births were to mothers who smoked during pregnancy. Although there is probably substantial underreporting of alcohol use during pregnancy, 1.1% of all children in 1997 were born to mothers who acknowledged drinking during their pregnancies. At Yale-New Haven Hospital, a 1994 survey revealed that 25% of pregnant women utilizing the clinic smoked during pregnancy, and 15% used alcohol. A Hartford Hospital anonymous drug screening survey showed that 1% of women with private physicians, and 12% of women using the hospital clinic had positive toxicology screens for cocaine or marijuana at delivery.

◆ **Regulatory Disorders** [11]

Babies, infants, and toddlers may develop severe or persistent problems with feeding, sleeping or other regulatory functions that can lead to lasting frailty or severe physical or behavioral health problems. Recent research indicates that as many as 2% of infants have such serious, potentially life-threatening, difficulties in the development of self-regulatory capacities. The result can be both persistent health problems as the child grows into a toddler and severe difficulties for the child and care giver in establishing the secure attachment that is essential for child health and growth.

KEY BEHAVIORAL HEALTH PROBLEMS IN EARLY CHILDHOOD

On average, 10% of 2-5 year old children from general community samples have a clinically significant behavioral disorder—only slightly less than among older children or teens (13-15%). Serious behavioral health problems in young children may differ substantially from those of older youths and adults because the rapid developmental changes in infancy and early childhood often result in a particularly close connection among physical, behavioral, and social/relational problems. For this reason, the *Zero to Three* project of the National Center for Clinical Infant Programs has developed a classification system for "mental health and developmental disorders of infancy and early childhood" which mirrors the concerns voiced by many of the child care, preschool, and pediatric health providers with whom we spoke in compiling this report[11].

◆ **Attention Deficit Hyperactivity Disorder (ADHD)** [12]

Attention deficit hyperactivity disorder (ADHD) is the most commonly diagnosed and treated child behavioral health problem. ADHD is very difficult to diagnose accurately before school age because young children's behavior is in flux. It is often not clear if their problems of excess excitability and distractibility are truly lasting and severe. ADHD is likely to be at least partly genetic in origin. When properly diagnosed, ADHD often is found to follow from the mother's or child's exposure to unhealthy environmental conditions such as lead exposure and cigarette smoking. Unlike other disruptive behavior disorders, ADHD is not linked to violence, abuse, or neglect experienced by the child. ADHD is considered present only if a child has persistent problems with hyperactivity, impulse control, and distractibility in two or more life settings (e.g., home, child care, playground) which cause clinically significant impairment in social, academic, or other activities. Parents, physicians, teachers and other providers want to detect and treat ADHD appropriately because it can be the beginning of problems that can grow into aggression and delinquency or depression and

anxiety. However, since the long term physical and psychological effects of the stimulant medications used to treat ADHD are unknown, parents and providers are understandably concerned that the diagnosis "ADHD" may be overused and overtreated.

◆ Disruptive Behavior Disorders [13]

There is a serious and growing concern about toddlers and preschool children who exhibit persistent and severe problems with impulsive, aggressive, and oppositional-defiant behavior. The Surgeon General's 1999 report on the state of mental health in the United States notes that the prevalence of clinically-significant disruptive behavior in young children may be as high as 6%. These children are at high risk for developing subsequent severe and lasting conduct disorders leading to legal problems, incarceration and violence. In preschool children, boys are more likely than girls to exhibit severe aggression, defiance, or impulsivity. Young children with disruptive behavior may be subject to disciplinary actions as early as in kindergarten. The State Department of Education reported 458 formal disciplinary actions involving kindergartners in the 1999-2000 school year. Many early childhood programs simply will not enroll, or will quickly dis-enroll, children whom they consider unmanageable, creating ongoing difficulties for both the child and family.

◆ Depression, Anxiety, and Attachment Disorders [14]

Each year, as many as 5% of young children will become severely depressed, overwhelmed by fear and anxiety, or unable to bond with their parent(s). Young children suffering from intense fears or depression tend to exhibit very different symptoms than adolescents or adults. For example, young children may complain of physical aches and pains, seem withdrawn or extremely angry, or have specific phobias, rather than voicing the classic adult symptoms of worry, panic, or hopelessness. The symptoms of anxiety or depression in young children instead often take the form of persistent problems with irritability, fussiness, withdrawal, confusion, or unexplained bodily aches and pains.

In some cases, the result is a "Reactive Attachment Disorder" in which the child cannot seem to form a loving and trusting relationship with parents or care givers. Severe attachment problems take the form of debilitating apathy, dependency, ambivalence, or confusion in relation to primary care givers. These problems interfere significantly not only with the primary bond to a care giver but also with a child's ability to play and work well with peers and adults outside the home.

Children younger than 5 rarely commit suicide, but those with severe and persistent anxiety, depression, or attachment problems often think of or even wish for death. Untreated early anxiety, depression or attachment disorders place a child at risk for more severe depression, anxiety, fears, disruptive behavior, and suicidality later in childhood, as a teenager, and into adulthood.

◆ Autism [15]

A small but nevertheless substantial number of young children--about 1 in 200—experience profound problems with mental disorganization which severely impair their ability to develop mentally, emotionally, socially, or educationally. Autism is perhaps the best known severe behaviorally-based developmental impairment of childhood. While each autistic child is different, they all have a profound detachment from other people that leads them to seem to be completely in another world and responsive only to the most basic rewards and directions. Intensive behavior management programs at home and school, initiated by 3 years of age, may enable some autistic children to become at least partially self-sufficient as teens and adults.

Chapter 2 Existing Resources to Promote Early Childhood Health and Development

Successfully promoting young children's health and development requires that federal and state legislation, regulations, and programmatic initiatives encourage the development of a cost effective and socially responsible system of health care that links families, child care providers, and preschool or school readiness providers with pediatric, mental health, family support, and child development services. Such a system of care must possess the **capacity** and **coordination** necessary to ensure ready **access** to high **quality** services[1] —including both those services needed by all families and children and those for families and children with special needs.

To ensure system **capacity,** there must be an adequate funding base and an effective model for allocation of funding; an infrastructure of high-quality programs and services; and a pool of well-trained, well-compensated, and available providers with special expertise in delivering and evaluating services for early childhood and family health and development.

System **coordination** requires providers and services to work together to ensure that age-specific care addressing physical, behavioral, and developmental needs is provided to each child and family in all relevant settings. All children need a consistent primary care provider to deliver and coordinate services and supports. However, in addition to the primary care provider, children with complex medical, behavioral or developmental needs may benefit from a multidisciplinary team that provides personal support as well as assistance in coordinating the many necessary community-based services and programs.

Access to supports and services requires program or provider eligibility requirements that cast a sufficiently wide net to make services actually available to children and families. Access also depends upon locating supports and services in places that are acceptable to and practical for children and families (e.g., in the natural environment as well as in clinics or hospitals; near public transportation lines). Even when supports and services are available nearby, the manner in which clients are treated by providers, staff, and peers can radically diminish or enhance the child's or family's willingness and ability to participate.

Additionally, young children and families who have or are at risk for serious health and development problems often face particular difficulty accessing critical specialized services. Low-income, non-English speaking, and other socially disadvantaged children and families face particularly daunting barriers to accessing health care and related services and supports. For such disenfranchised groups, services must be carefully designed and delivered to ensure that they are culturally competent.

Health insurance is a major factor which can enhance or limit access to crucial physical and mental health supports and services for all young children and their families—and especially for children with severe medical, behavioral, or developmental problems who may need particularly costly or scarce services in order to avert or mitigate crises.

Determinants of **quality** include whether services address the needs expressed by families and service providers in a manner that is timely, knowledgeable, culturally competent, gender sensitive, and effective. Ideally, services are provided in and integrated with the ongoing activities of the multiple settings in which children and families conduct their lives—including the home, community, child care settings and/or structured alternative settings. Finally, health services and supports must ensure families and children are fully engaged as active and trusting participants by providing continuous care and "helping alliances" in the context of personal relationships with peers and with service providers.

In the rest of Chapter 2 we highlight key resources in Connecticut that are particularly relevant to building and enhancing a comprehensive system of services and supports for healthy early childhood development. The following survey is not meant to be an exhaustive cataloguing of all potentially available supports and programs. Our goal is to provide a picture of Connecticut's capacity to provide

young children and their families with accessible and high quality services with good coordination. In Chapter 3, we will discuss the problems that need to be addressed in order to overcome shortfalls in service capacity, barriers to access, and gaps in the quality and coordination of services for young children and their families.

PROMISING MODELS TO SUPPORT YOUNG CHILDREN'S HEALTH AND DEVELOPMENT

A comprehensive system supporting the healthy development of young children must have programs and services designed to achieve several goals:

- To ensure **healthy births and babies**
- To provide a **medical home** for high quality pediatric health care from birth to kindergarten
- To provide **family support and education** for parents and other care givers
- To ensure the **early identification and treatment** of infants and young children with developmental or behavioral/mental health concerns
- To link **child care or preschool services** to the health care system

Young children and their families in Connecticut have a range of income and educational levels, ethnic origins, physical and behavioral health care problems, and perceptions of service needs—all of which factor into determining the level of supports necessary for a child to thrive. Along with an infrastructure of universally available supports and services intended for all children and their families, there must also be services and interventions for those with special needs, based upon the physical or mental health of the child or parents, environmental challenges or other risk factors. With the guidance of our consultants, we selected a sample of programs in Connecticut with an established track record in meeting these goals, and we interviewed and obtained supporting documentation from representatives of each program.

Ensuring healthy births and babies

Women of childbearing age need to be healthy and to have resources to help them ensure a healthy start in life for any children they may have or for whom they care. In Connecticut, as in most states, there is no systematic approach to assuring that all women of child-bearing age receive either health care services per se or information that will enable them to be healthy and seek health care. In particular, women who are very young, have cultural or language barriers, lack health insurance or have serious behavioral health risk factors may require special supports, services and programs to support healthy births. Listed below are examples of Connecticut programs that address the needs of women at risk for poor pregnancy outcomes or infants requiring specialized services at the time of the birth.

Connecticut's **Healthy Start** program, administered by the Department of Social Services (DSS), has been available in 23 sites where low-income pregnant women and their families are offered access to transportation, care coordination, home visits, and specialized group services. In the fall of 2000, the Department of Social Services began a transformation of Healthy Start into the **Connecticut Community Health Care Initiative**. Each site is now required to offer a set of key services that focus on insurance enrollment, prenatal support and outreach to eligible parents and young children through health care providers, schools, employers, and community groups and organizations.

The development of modern newborn intensive care units (NICUs) has resulted in dramatic decreases in infant mortality in the past 40 years. While survival has improved with advanced technology, preterm and low birth weight infants continue to have increased risks for major developmental problems including cerebral palsy, mental retardation, blindness and deafness, as well as learning disabilities and attentional problems. There are a number of newborn intensive care units throughout Connecticut where specialized personnel and state-of-the-art technology are available to support the sickest newborn infants. In addition, the **Newborn Individualized**

Developmental Care and Assessment Program (NIDCAP) at the University of Connecticut Health Center is an evidence-based model for structuring the physical and social environment of the NICU to support and nurture both the individual infant's and family's needs. Trained observers gather and use information in collaboration with the care giving team to modify the environment to meet the needs of each high-risk infant and family.

Connecticut also has several promising local initiatives designed to provide prenatal care and intensive psychosocial assistance for impoverished women in urban areas. For example, the **Maternal and Infant Outreach Program (MIOP)** of the City of Hartford and the **Maternal and Newborn Outreach Support Services (MANOS)** of New Haven provide community-based outreach workers who bring women into prenatal care, make extensive home visits in pregnancy, and provide assistance in coordinating health care and in accessing the transportation, housing, food or other basic services that every woman needs in order to be healthy.

Providing a medical home for high quality pediatric health care

Good pediatric care for young children involves regular well-child physical and oral health checkups to identify and prevent potential problems in health or development, and timely care for children experiencing illness or mental health or developmental difficulties. Ideally, this care is provided via a "medical home." A medical home is a primary pediatric health care provider or a multidisciplinary health care team that the child and family come to know and trust. For children whose families have private health insurance, the medical home usually is provided by a pediatrician, family practitioner, nurse practitioner or physician's assistant in a private practice.

All children and families benefit from having a medical home. However, a medical home is particularly important for children with complex acute or chronic health or developmental concerns. Young children or families with special needs depend upon having access to health care that is high quality and well-coordinated across a variety of services that often are complicated, time-consuming, challenging, and expensive. When these services are developed on an individualized basis with careful coordination by the primary provider and the multidisciplinary team of specialists, they can provide a timely, sensitive, and cost-effective support net for the child and family – in effect, they "wrap around" the child and family like a protective shield. For example, children who are insured by HUSKY A or HUSKY B are often seen by multiple providers whom they do not have the opportunity to know and come to trust, or in emergency rooms for acute illness when no other health care is accessible. These families need help in finding, affording, and keeping a medical home. There is no program in Connecticut that systematically links young children who are **at risk** for physical, oral health, developmental or behavioral health difficulties to an appropriate medical home.

For infants whose families struggle with behavioral health problems such as addiction, alternative intensive strategies may be required. These families need support for getting their infant to see the pediatric clinician and for providing healthy parenting for their child while managing the stress of their own lives and working toward their own recovery. Specialized programs exist in local sites to provide a medical home for both the parent(s) and child, such as the Connecticut Children's Medical Center's **P**rimary care, **R**esilience enhancement, **O**ptimal development **(PROKidsPlus)** program and the Yale Child Study Center's **Coordinated Intervention for Women and Infants (CIWI)** program. Both programs provide intensive outreach services to mothers and families in order to keep them connected with a pediatric clinician. In addition, PROKidsPlus actually provides the medical home by providing pediatric care at its main site for every enrolled child from birth through the rest of childhood.

All health care professionals and families may benefit from guidance about what pediatric services are most beneficial, and how to know if additional or alternative services or supports are needed. The **Healthy**

Steps and **Bright Futures** programs are national models for guiding child health care professionals in providing thorough, timely, and culturally- and developmentally-competent well-child care. Both programs provide evidence-based guidelines and education materials for distribution to families. The Healthy Steps curriculum is available in Spanish as well as in English.

Providing family support and education for parents and other care givers

Babies, infants, and young children spend most of their time in home and child care or preschool settings. All parents can benefit from information about child development and about the practical steps they can take to foster their young child's healthy development in the first five years of life. Providers of child care and preschool services may have specialized education or training (although many do not), but they often ask for assistance to help them deal with the highly individualized needs of each child for whom they care.

Connecticut offers many family support programs. **Parents as Teachers (PAT),** a local affiliate of a prominent national program, offers parents a multimedia curriculum, *Born to Learn*™, which describes brain development and early childhood behavior. The curriculum is adaptable to the needs of diverse families and is widely used in Head Start and Early Head Start programs. PAT provides other education and support services at convenient sites (such as community centers, family resource centers, and schools) in many Connecticut communities. PAT also supports healthy births by providing a prenatal curriculum for families desiring additional information about normal pregnancy, fetal development and childbearing. **Bright Beginnings** is available at Yale-New Haven Hospital to provide peer support for young mothers having their first or second child. The **First Steps** and **Nurturing programs** are also available in identified sites throughout the state to provide peer mentoring for first time parents (First Steps) or community-based group sessions to facilitate parenting skills (Nurturing).

Family Resource Centers (FRC) have been established in 60 Connecticut schools with State Department of Education funding. Several FRCs partner with School Readiness sites. FRCs provide parent training classes and support groups, adult learning and literacy classes, and child care provider education classes and materials. Connecticut and Kentucky are the only two states to mandate and fund a statewide networks of FRCs, based on the *Schools for the 21st Century*[2] (21C) model for continuous comprehensive services for child and family health from birth to age 12. Connecticut also drew upon the model for comprehensive universal early childhood services developed in France, as the result of a 1997 colloquium co-sponsored by the Connecticut Commission on Children, the Children's Health Council, and the French-American Foundation[3].

Socially isolated, young, impoverished or mentally ill or retarded parents need a safety net of accessible services. Several Connecticut programs offer model services to parents and families needing intensive, individualized family support and education. **Healthy Families Connecticut,** with its 16 Connecticut-based sites, is part of the national Healthy Families America network which targets families at high risk for child abuse and/or neglect. Healthy Families is a voluntary home visitation program delivered by trained paraprofessionals for mothers having their first child who experience psychosocial stressors (such as single parenting, unemployment, poor education, or social isolation). Home visitors provide ongoing practical and emotional support, case management, linkage to services, and education about parenting, family relationships, and child development.

Teen parents are another at risk group for whom specialized services and supports can make the difference between a healthy or troubled child. Teen pregnancy prevention programs are offered in many Connecticut sites, but few also provide health care, parenting education and supportive services for teens who become pregnant or are new parents. The **Polly T. McCabe Center** and the **Elizabeth Celotto Child**

Care Center of Wilbur Cross High School, both located in the New Haven Public Schools, stress the opportunity for prevention of early repeat childbearing through interventions shortly before and after a teen mother delivers a baby. By providing on-site child care for infants and toddlers of these teen parents, the Celotto Center offers the opportunity for mentoring and modeling of parenting skills, developmental support and disciplinary alternatives appropriate for young children.

Ensuring early identification and treatment for infants and young children with developmental or behavioral/mental health concerns

Early identification in the first years of life is a well-demonstrated strategy for optimizing healthy physical and emotional development and preventing tragic and costly physical, behavioral, and developmental crises. The recent increase in young children in child care and educational settings who show signs of severe disruptive behavior has heightened awareness of the importance of early identification of young children with serious behavioral problems. Identifying these problems may help avert a cycle of child care expulsions, school-based disciplinary actions, and serious problems with aggression, delinquency and school failure in adolescence—problems which can lead to a lifelong pattern of failure, depression, illness, violence, unemployment, crime, or addiction. Connecticut has several promising early identification programs or services.

The **Birth to Three program,** funded and administered by Connecticut's Department of Mental Retardation, is charged with strengthening "the capacity of Connecticut's families to meet the developmental and health-related needs of their infants and toddlers who have delays or disabilities." This federally subsidized extension of educational services to children under 3 years old calls for the creation of early intervention services on a statewide, coordinated, multidisciplinary, interagency basis for developmentally disabled infants and children. About 6000 Connecticut children under 3 years old are served annually by the 38 program sites. Families or health care providers can request that any child under 3 years old receive an evaluation to determine if s/he is eligible for Birth to Three services, by contacting the "211" Birth to Three Infoline of the United Way of Connecticut. Only children with severe developmental delays or disabilities are eligible for Birth to Three.

Pre-Kindergarten Special Education in every Connecticut school district serves children ages 3 to 5 years old who have been evaluated by an educational specialist and found to be in need of an Individualized Education Plan (IEP). Currently, 7000 Connecticut children, many of whom had been enrolled in the Birth to Three Program, receive Pre-Kindergarten Special Education services. Part-day child care and classroom activities are provided, as well as referrals to and funds to pay for the costs of occupational therapy, physical therapy, mental health treatment and individual classroom aides.

Connecticut's 26 **Child Guidance Clinics** provide outpatient mental health services for young children who have a diagnosable "serious emotional disturbance" that interferes with or limits the child's function in family, school, or community activities. Child Guidance Clinics provide mental health assessment and treatment for several thousand Connecticut children and families each year. Note however, that although one child in six in Connecticut is under 5 years old, fewer than one in twenty child guidance clinic visits are from children 0 to 5 years old. Very few child guidance clinics have any professional staff with specialized expertise in the treatment of behavioral problems in children under the age of 5. This capacity limitation (see Chapter 3) is paralleled by an acute shortage of such specialists in almost all community agencies or private practice groups that offer child mental health services.

The **ChildServ program**, of the City of Hartford, is a resource accessed by the primary health care provider for young children with developmental or behavioral/mental health concerns who are not eligible for Birth to Three. ChildServ's trained staff, based at the United Way Children's Health Infoline

(CHIL), work with families to address each identified need of the child. The most common requests are for parenting education and/or support programs, management of behavioral issues in very young children, and enrollment in appropriate pre-school programs. If child or family needs are unclear, ChildServ contacts the **Child Development Program** of the Hartford Health Department for a home-based assessment of the child's and family's individualized needs.

Child FIRST (Family Interagency Resource Support and Training) is a recent and developing initiative of the Greater Bridgeport community. This multidisciplinary, interagency team develops family-focused integrative services with a focus on the multi-risk family whose needs require collaborative problem solving by professionals from health care, behavioral health care, family support and child care programs. In addition to taking referrals from health care providers, Child FIRST has had many requests from child care providers for consultation in working with children who have significant behavioral problems.

Linking child care or preschool services to health care

Most young children spend time in child care settings including both formal and informal child care or preschool programs. Young children's health is best promoted if child care and preschool providers are organized to support healthy and safe development and if providers are aware of resources relevant to children in their care.

At present in Connecticut there are no systematic links between child care or preschool programs and pediatric physical or behavioral health services except those provided by two programs for low-income children or children living in low-income school districts. These programs serve children who have special needs as a result of living in families and communities challenged by poverty, low educational levels, language barriers, chronic physical or mental health problems, or other stressors. As noted in Chapter 1, children and families living in poverty face many obstacles to getting access to high quality child care or preschool programs, and these programs often provide linkage for the child and family to other health care and developmental services.

Head Start enrolls 7000 children in Connecticut at 25 sites serving 3-5 year olds and 7 sites serving 0-3 year olds. Home visitation for parent and family support and education is provided as needed in all Head Start programs and is a focus of the Early Head Start sites serving infants and toddlers. Head Start provides preschool, health and nutrition, and social services for children as well as educational and support services for parents in classroom settings and in some instances by home visits. Head Start programs are required to provide services to promote child and family health (such as health education classes). They also are required to have a medical and a mental health consultant who can evaluate children and families to assist them in addressing health problems and link them to health care services.

School Readiness programs have been established in 16 "priority" (low-income) school districts and at one or more "priority" schools in 30 other school districts. This "school-community partnership" was implemented to ensure that economically impoverished children receive the health, social, and learning resources needed for kindergarten preparation. In 1999-2000, 6900 children were enrolled in School Readiness sites funded by State Department of Education and administered by the mayor or school superintendent in the local municipality. Each program's curriculum and services include classroom-based child care, parent involvement activities, and education and information for parents about child learning, development, health and health care services. Good nutrition has been a particular focus of program development and performance monitoring in the School Readiness state system during the past year, and mental health is planned as a priority focus in the next year.

CONNECTICUT'S PUBLIC SECTOR FINANCIAL RESOURCES

Connecticut has many of the resources needed for an early childhood health care system with the capacity to provide accessible, well-coordinated, and high-quality services. While not the subject of this report, financial resources from the private sector should be considered in the development of an early childhood health care system, both from for-profit sources such as private health insurance and from nonprofit sources such as foundations or charitable organizations. In the focal area for this report, the public sector, the Connecticut Children's Budget for fiscal years 1996-1999 provides a snapshot of potential fiscal resources for early childhood services and programs. In the public sector, in fiscal year 1999, an estimated total of $600 million was allocated to state programs for services to 0 to 5 year old children or their families. Because funding for most children's programs is not detailed by age cohort, we developed estimates of the proportion of services in each program that likely went to children 0-5 years old and their families. (See Appendix for detail of estimates)

Two-thirds ($434 million) of the annual public sector funds for early childhood programs are allocated to the Department of Social Services to support safety-net services such as HUSKY A and B insurance, Temporary Assistance to Needy Families (TANF) and child care subsidies. The Department of Children and Families receives approximately $102 million annually to support child protective, foster care, adoption, residential, and mental health services. The Departments of Education, Mental Retardation and Public Health receive smaller but still substantial amounts of funding to support early childhood education, early intervention and infrastructure support/immunization-related services, respectively.

Chapter 3 Limitations of Connecticut's Services for Early Childhood Health and Development

Public policy concerning the health of young children and their families is a mirror that reflects two key features of a society. On the one hand, the "better angels of our nature" move us toward the commitment to provide every child a healthy start in the crucial first years of life. On the other hand, there are financial and political pressures that tempt us to compromise or even renounce those values. Most of the tens of millions of dollars in federal and state funds spent on programs relevant to young children's health are allocated to safety net services that, while extremely important, can not address the full range of children's needs. Connecticut (like most states) allocates **less than $50 per child per year for comprehensive** early childhood programs[1]. This may seem at odds with the estimated $600 million allocated yearly by the State for services to young children or their families, and indeed the sharp contrast poses an important question: Where are funds going for young children and their families, if not to comprehensive programs? The answer is that most of the funds go to programs other than comprehensive initiatives like Birth to Three, Head Start, or School Readiness. These other programs often provide substantial benefits for young children and their families, but they are limited in their impact precisely because they are not part of a well-coordinated comprehensive program that addresses more than a limited set of health and development goals.

Strong commitments to promoting child and family health and development have been made over the past several decades. Federal legislation has authorized innovative initiatives such as Head Start, Healthy Start, Child Abuse Prevention, the Children's Health Insurance Program, and the Individuals with Disabilities Education Act (IDEA). Some states mandate comprehensive early childhood health and development programs — but Connecticut is **not** among this group. Nationally and in Connecticut, early childhood programs have been only partially funded, leaving large gaps in services and thousands of young children in poor health and many others developmentally unready to enter kindergarten[2].

As a result, nationally as well as in Connecticut, there is no true system of care for the health and development of young children and support of their families[2]. Many constituencies, including families, advocates, and providers, vie to set the agenda for early childhood health care services. Nearly every level of government and sector of society has a stake in improving early childhood health and development, but the responsibilities and resources are so fragmented that no single entity can bring everyone together to get it all done. Further, although most would agree that a partnership among all the players is required to create and sustain a system that works, there is no consensus on an approach to providing early childhood health and development services[2].

The fragmentation of early childhood services is a major problem for our nation and our state:

> *… Early childhood services … lack a shared vision or sustained public commitment. … Several factors have caused this, [including] crisis-oriented public policy … and sporadic government intervention … Without a cohesive public policy for children, a large number of federally funded and uncoordinated categorical programs (72 by last count) arose to address children's needs. … The result has been unconnected programs with few controls, few mechanisms for organization, and little coordination. … Dedicated practitioners are forced to compete with their colleagues for resources, causing a continual struggle not only for new programs but among them.*
>
> Kagan, Goffin, Golub and Pritchard (1995)
> *Toward Systemic Reform: Service Integration for Young Children and Their Families*

Next, we describe Connecticut's current limitations in the **capacity, coordination, accessibility, and quality** of services and programs to promote the health and development of young children and their families. See Table 3.1 for a summary of Connecticut's current limitations.

THE CAPACITY TO PROVIDE EARLY CHILDHOOD HEALTH CARE SERVICES AND SUPPORTS IS LIMITED BY FUNDING, REIMBURSEMENT, WORK FORCE, AND PROGRAM ISSUES:

Categorical funding requirements

State government funds for early childhood services are fragmented by categorical boundaries. The estimated $600 million in government funding allocated in the state budget for programs relevant to early childhood health and development is distributed across almost 50 categorical programs in five state agencies (Department of Social Services, Department of Children and Families, Department of Education, Department of Mental Retardation and Department of Public Health).

Inadequate insurance reimbursement

Medicaid and private insurance reimbursement often is inadequate or entirely lacking for early childhood direct patient care and consultation services. Pediatric professionals, the primary providers of early childhood health care, receive reimbursement sufficient only to cover the direct costs of providing very brief well child visits. Reimbursements do not begin to cover the costs of more intensive developmental "surveillance" or care coordination mandated by the federal Medicaid standards for Early and Periodic Screening, Diagnosis, and Treatment of children's health (EPSDT) or recommended by Bright Futures and Healthy Steps[3].

The reimbursement gap is even more striking for children with behavioral issues[4]. Behavioral health services for children aged 0 to 5 years old require a qualitatively different approach from care for adults, adolescents, or even older children. In most cases, parents or primary care givers are integrally involved, with a focus on developing safe, intellectually stimulating, and emotionally secure environments. Yet, reimbursement is at best minimal and usually nonexistent for family participation or for services to be delivered in home or child care settings with appropriate coordination and consultation to the "natural care givers." As noted below, this lack of reimbursement is particularly acute for children on Medicaid Managed Care whose parents often cannot access non-emergency mental health services because so few mental health providers accept Medicaid Managed Care insurance[5].

Lack of broad availability of promising programs

Even model national programs such as Head Start, School Readiness, Family Resource Centers, Parents as Teachers, or Healthy Families have sites in very few Connecticut communities[6]. Only 20-33% of Connecticut's 169 cities and towns have any one of these programs. Very few have more than one of them. Only a handful of communities have a collaborative infrastructure that combines several programs within the framework of a multidisciplinary team serving the full spectrum of young children.

Critical shortages of early childhood mental health care services

Despite extensive evidence of the benefits of specialized behavioral health prevention and treatment services for young children, specialized early childhood mental health services are almost nonexistent in Connecticut[2].

The Department of Children and Families, in collaboration with the Department of Social Services is undertaking a major overhaul of the publicly-funded behavioral health care services for children and families. The program, based on the national model of local systems of care[4], is called Connecticut Community KidCare. The initiative seeks to make behavioral health services available in the local community to all children with behavioral health disorders who either are insured by the HUSKY program or are eligible through the Department of Children and Families' voluntary services program. However, the services being developed are designed largely for school age children and adolescents. A complementary system of care for toddlers and preschool children will be necessary because of the highly specialized nature of behavioral health care for these younger children and their families[4].

Moreover, services for parents' behavioral health needs are not provided in most programs or settings except by referral, with some positive exceptions in which staff are trained to assist parents and children in a seamless fashion. For example, local programs such as PROkids and CIWI, and statewide initiatives such as the joint DCF-DMHAS (Department of Mental Health and Addiction Services) enhancement of Project SAFE (Substance Abusing Families Engagement) train their professional and peer staff to help parents in recovering from their own behavioral health problems while providing them with parenting and child development education and support. The need for services that assist the parent in dealing with behavioral health problems within the trusted framework of child-centered services is illustrated by a finding from the most recent Healthy Families Connecticut program evaluation. They found that children of chemically dependent parents did more poorly than other children despite receiving excellent home visitation, family support, and substance abuse referral services[6].

Shortage of early childhood mental health care specialists

In Connecticut, a number of accredited psychiatry and pediatrics residency programs, psychology, social work, counseling internship programs, and nursing advanced practice programs and associated postdoctoral fellowships provide training in early childhood development and physical and mental health. However, very few professionals, not only in Connecticut but also nationally, are trained as specialists in early childhood mental health. There is a significant need for these specialists in Connecticut.

COORDINATION OF CONNECTICUT'S EARLY CHILDHOOD HEALTH CARE SERVICES IS LIMITED IN SEVERAL WAYS, INCLUDING:

Lack of cross programmatic coordination

Identification and service coordination for high risk families and children is often haphazard or totally lacking. Women with high risk pregnancies and births needing specialized medical or behavioral health care often do not receive any formal screening, evaluation, information and referrals or ongoing care coordination to ensure that they actually receive the appropriate services[7]. Even the most promising programs to support parenting and child health do not have formal mechanisms for coordination with the many other programs from which their clients receive related services. Even when a program such as ChildServ is a basis for cross-program coordination, providers of early intervention or family support services often are unaware of this resource.

Lack of continuity due to cross-program differences in eligibility criteria

Many children fall through the cracks when no longer eligible because of cross-program differences in eligibility requirements. Even when programs are set up in a sequence to help children transition smoothly into the next set of services, differing eligibility criteria leave many parents and children with no next step. The seamless transition from Early Head Start into Head Start is a positive exception. The provisions for linking children aging out of Birth to Three to Pre-Kindergarten Special Education services is an example of an excellent approach to coordination that nevertheless is limited by capacity and access problems. Specifically, one child in three who ages out of Birth to Three is not eligible for Pre-Kindergarten Special Education because the developmental disabilities that established his/her eligibility for Birth to Three are assessed as insufficient impediments to learning to permit entry into Pre-Kindergarten Special Education. While all programs attempt to help

parents find appropriate resources, there is no guaranteed alternative to ensure that the child's and family's needs continue to be met.

In addition, parents may not be informed of eligibility for critical programs such as insurance through the HUSKY programs. For example, many children who are ineligible for HUSKY A automatically qualify for HUSKY B, but enrollment of these children into HUSKY B often does not occur[8].

Lack of statewide and local partnerships among early childhood programs

Despite notable positive exceptions, statewide and local partnerships among early childhood programs typically are endorsed in principle but not achieved in practice. For example, while Birth to Three and Pre-Kindergarten Special Education are a positive example of relatively seamless coordination of services for children with severe learning and developmental disabilities, there is no systematic statewide coordination of these programs with other vital programs and resources such as the Healthy Families, School Readiness, Family Resource Centers, or Head Start programs.

In 1996, the Governor's Collaboration for Young Children brought together dozens of programs and hundreds of parents and providers[6]. However, the resultant recommendations for statewide and local partnerships of early childhood services in eight priority areas related to health have not been realized. Partnerships have been attempted, but often they have not been actively sustained. For example, Healthy Families and Healthy Start created a network linking many of their programs in co-located sites, but these links continue only in a few local sites and are uncertain in the future as a result of substantial reorganization of Healthy Start. While the positive efforts of these specific programs and by the larger group of concerned citizens, parents, and providers involved in the Governor's Collaboration are to be commended-- even the best efforts to promote coordination face severe funding and staffing limitations.

Table 3.1

Summary of Major Limitations in Connecticut's Services and Supports for Early Childhood Health

Capacity Limitations

- Categorical funding streams
- Inadequate insurance coverage
- Limited availability of promising programs
- Critical shortages of early childhood behavioral health specialists and no overall system of behavioral health care for young children and their families

Coordination Limitations

- Prevention services for high risk families and children are not well coordinated.
- Eligibility differences across programs
- Statewide cross-program partnerships are endorsed but not achieved

Access Limitations

- Uninsured children and families
- No single point of entry
- Racial/cultural barriers to access
- Restrictive eligibility criteria
- Insurance limitations restrict access to mental health services.

Quality Limitations

- Most young children are never assessed to determine if they need specialized services.
- Child care and family support programs do not link children to health care.
- Early childhood services are challenged by the need to develop and implement culturally competent approaches to care.

ACCESS TO HEALTH CARE PROVIDERS AND SERVICES IS LIMITED FOR THOUSANDS OF CONNECTICUT'S YOUNGEST CHILDREN AND FAMILIES:

Uninsured children and families

Although net enrollment in HUSKY has increased by more than 15,000 children since July 1998, there were still 90,000 uninsured children in Connecticut, many of whom are qualified for HUSKY. Many parents of HUSKY children also have no health insurance. Key special populations often cannot get health insurance, such as 18-25 year old parents (or potential parents), and documented and undocumented immigrants.

Lack of a single point of entry for early childhood programs and services

Although Infoline provides a single point of access for information and referrals, children often miss needed services because there is no single point of entry for early childhood health care. A notable exception is the Hartford metropolitan area's ChildServ program, which provides a point of entry to services for children who are experiencing developmental, behavioral, family stress, or school readiness problems and are ineligible for early intervention or other categorical programs.

Racial and ethnic disparities in early childhood health

African American and Hispanic children in Connecticut experience a disproportionately high risk of early childhood health problems. Scientific and clinical evidence is needed to determine the causes of these heightened risks, including the degree to which they result from difficulties with access to or quality of programs and services.

Access to mental health services

Mental health services for many young children nationally and in Connecticut are delivered with payment provided by insurance that involves managed care organizations (MCOs)[4]. Managed care is designed to reduce costs and provide the most appropriate type and level of care to each patient. This can be particularly problematic for children's mental health care, as described by experts from the Yale Child Study Center:

> *Mental health coverage has been the type of health care that is least well provided by MCOs. Young children's mental health care is particularly vulnerable to overcutting because it is relatively expensive (additional parental support and special education are often crucial for success), but the patients are not yet old enough either to vote themselves or by their behaviors to upset large numbers of others who do vote.*
>
> John Schowalter and Albert J. Solnit (1995)
> *Managed Care and Children's Psychiatric Services*

Primary care physicians may fail to refer young children who are in need of specialized mental health services because they have not received the training or do not have the time required to appropriately screen and identify children with behavioral health concerns. In addition, they may not know of or be able to access early childhood mental health specialists to whom they can turn for guidance and information, and to whom they can make referrals. Thus, access to mental health services may be limited because primary care physicians themselves do not have access to needed knowledge and resources. Even when they do identify and wish to refer a young child for mental health services, these services may not be accessible because insurance coverage may be insufficient to enable the family to pay for the care. Even when young children are insured, the limitations imposed by insurers or managed care fiduciaries on coverage for mental health services often are so severe as to rule out necessary mental health care.

Restrictive eligibility criteria

Many programs have had to limit access to their services by setting eligibility criteria that restrict entry to severely impaired children (Birth to Three) or at-risk parents (MIOP, MANOS, PROkids, or CIWI), or to first-time parents (Healthy Families). Young children and families with behavioral health problems face particularly troubling barriers to accessing specialized services. Many programs and insurers exclude or severely restrict early childhood behavioral health problems in their eligibility criteria. Moreover, even when eligible, Connecticut families with behaviorally troubled young children often cannot get an appointment with—or even find—a specialist in early childhood behavioral care. While eligibility restrictions are understandable in light of funding limitations, they prevent many children and families from accessing needed medical, behavioral, and developmental services.

THE QUALITY OF EARLY CHILDHOOD HEALTH CARE AND DEVELOPMENTAL SERVICES HAS SEVERAL LIMITATIONS:

Failure to use specialized screening, diagnostic, or treatment services.

In 1996, only 37% of all eligible children nationally received EPSDT medical screening; 21% dental screening; 15% vision screening, and 13% hearing screening. Rates for children with private insurance are comparably low[8].

Health care providers rarely identify young children with behavioral health problems, despite improvements over the past 20 years with older children[8]. Connecticut's EPSDT protocol simply does not address behavioral health problems.

Lack of comprehensive monitoring and support for early childhood programs

Even in programs with performance standards (such as Head Start, School Readiness, Healthy Families, or EPSDT), the linkages of child development and family support services to health care are not closely monitored or fully supported, and are delivered with variable quality[9]. Basic health education, safety precautions, good nutrition, and a stimulating social and learning environment are achieved in many but not all school readiness, child care, and family support programs.

Racial and ethnic disparities

Racial and ethnic disparities in young children's health pose a special challenge for all early childhood service providers to develop and implement culturally competent approaches to meeting the needs of African American and Hispanic children and families.

Chapter 4 Making Young Children Count: Future Directions for Early Childhood Health and Development

Ensuring the healthy development of every young child in Connecticut is a social responsibility and a sound economic investment. Existing resources require enhancement in carefully targeted areas that will provide cost-effective remedies for the system's significant limitations. The goals for system development should be to move the state toward a comprehensive and innovative system of early childhood health care services by addressing the following key priorities voiced by child and family advocates and early childhood service providers. While we will not recommend specific policy or regulatory changes, we note that the programmatic changes necessary to achieve an early childhood system of health care will require careful planning of modifications in existing eligibility, funding, and reimbursement criteria and mechanisms.

PROVIDE UNIVERSAL PARENTING SUPPORT AND EDUCATION

Every adolescent and adult of childbearing age and every parent in a birthing hospital or with a child aged 0-5 years should receive ongoing information, mentoring, and peer support related to child development, family health and safety, effective parenting and health-related early childhood services. This goal can be achieved if existing programs and services are enhanced to create a system that provides four types of essential services or supports for families with young children.

1. **Hospital-based outreach for prospective and new parents** providing peer mentoring, support, education, information and referrals.
2. **Parent education** in all medical office/clinics based on materials and curricula such as provided by Healthy Steps or Bright Futures.
3. A **network of Parent Child Centers** in every community which would:
   - **a. Link existing family development services** such as Family Resource Centers, schools, and community libraries.
   - **b. Provide a consistent parent education curriculum** based on materials and curricula from such programs as PAT, Healthy Families, or the Nurturing Program.
   - **c. Provide home visitation** to support child and family behavioral and physical health.
4. **A school- and community-based public education and coalition-building campaign** based on national initiatives such as I Am Your Child, The National Safe Kids Campaign, or Prevent Child Abuse America[1].

PROVIDE EVERY CHILD WITH A MEDICAL HOME FOR EARLY CHILDHOOD HEALTH CARE

Every child should have a medical home and receive thorough, regular checkups to identify and prevent or treat acute or chronic health problems. A medical home is a multidisciplinary pediatric care team, regularly available to the child and parents over the child's entire childhood, with a primary health care professional who knows the child and family well enough to provide personalized guidance.

This goal can be achieved if the following resources are developed and coordinated:

1. **Every birthing hospital** should assure the **linkage** of every newborn to a primary health care provider and the **enrollment** of every eligible family in HUSKY or private health insurance. Peer support and mentoring (see above) by well trained and supervised parent aides or educators is a low-cost but potentially high-yield approach to ensuring this linkage while providing timely family support and assistance with parenting and child development.
2. **Reimbursement rates** for physical, developmental and behavioral/mental health services through both private insurance and HUSKY should be set at a **level sufficient to permit and encourage** health care providers to fulfill the surveillance, diagnosis, and treatment standards established by EPSDT, Bright Futures, or Healthy Steps.

3. Health care providers for young children should have a **reliable and efficient mechanism** for ensuring their patients receive **timely and affordable access** to other services needed for truly comprehensive, continuous, and coordinated care.

ENHANCE THE CAPACITY TO PROVIDE ACCESS TO COORDINATED HIGH QUALITY SERVICES FOR AT-RISK YOUNG CHILDREN AND FAMILIES

Every child at risk for developmental disability, behavioral health problems, or abuse or neglect should be identified and a family service plan should be developed. The specific types and intensity of services, and the specific provider(s) and setting(s) should be individualized.

This can be done for all disabled or at-risk young children if existing programs are extended by:

1. **Developing eligibility criteria** for early intervention services that include all high-risk young children with a clinically-significant developmental or behavioral condition.
2. **Developing a statewide network** of local child development evaluators to assess and offer transitional case management for families concerned about their young child's physical, learning, behavioral, or family risk factors. These evaluators should work closely with the above noted hospital-based linkage and support programs, pediatric health care providers, information and referral systems, and community-based multidisciplinary parent-child centers.
3. **Developing a complementary statewide network** of behavioral health services combining community- and milieu-based services using the Systems of Care model, which would address both prevention and treatment of emotional disturbance for children 0-5 years old.
4. **Expanding** HUSKY **and private insurer reimbursement criteria** and rates to achieve adequate coverage for specialized **behavioral and physical health consultation** services as indicated to primary health care providers, child care, preschool, and early intervention providers and agencies, as well as to parents and other care givers in home and community settings.

ENSURE CULTURALLY COMPETENT RESPONSES TO RACIAL AND ETHNIC DISPARITIES IN YOUNG CHILDREN'S HEALTH

All physical and behavioral health care, developmental, educational, and child care providers should be **trained** and have **ongoing consultation** to ensure that they are **culturally competent** in promoting child and family health and in addressing barriers to access and disparities in health faced by young children and families of diverse racial and cultural backgrounds.

Careful scientific study and ongoing dialogue with families is needed in order to understand the sources of racial or cultural disparities in young children's health, and to refine services accordingly.

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I am Your Child: http://www.iamyourchild.org/

The National Safe Kids Campaign: http://www.safekids.org/

Prevent Child Abuse America: http://www.preventchildabuse.org/programs/hfa.html

Appendices

Programming for Young Children by Chronological/Developmental Period

Program Goal	Prenatal	Perinatal/Newborn	Infant (1-17 months)	Toddler (1.5-2.9 yrs)	Preschool (3.0-4.9 yrs)
Ensuring healthy births and babies	**Low income women** Community Health Care Initiative **Impoverished urban women** MIOP/MANOS	**Low income women** Community Health Care Initiative **Critically ill newborns** NIDCAP **Impoverished urban women** MIOP/MANOS	**Low income women** Community Health Care Initiative **Critically ill newborns** NIDCAP **Impoverished urban women** MIOP/MANOS		
Providing a medical home		**Curricular guidelines** Healthy Steps/ Bright Futures **Chemically dependent women and their infants** PROKids/CIWI	**Curricular guidelines** Healthy Steps/ Bright Futures **Chemically dependent women and their infants** PROKids/CIWI	**Curricular guidelines** Healthy Steps/ Bright Futures **Chemically dependent women and their children** PROKids/CIWI	**Curricular guidelines** Bright Futures **Chemically dependent women and their children** PROKids/CIWI
Providing family support and education	**Prenatal curriculum** Parents as Teachers (PAT) **Teens** Polly McCabe	**General parenting education and support** PAT, Bright Beginnings, First Steps, Nurturing, Family Resource Center (FRC) **Women at risk for abuse and neglect** Healthy Families **Teens** Polly McCabe/Wilbur Cross	**General parenting education and support** PAT, Bright Beginnings, First Steps, Nurturing, Family Resource Center (FRC) **Women at risk for abuse and neglect** Healthy Families **Teens** Polly McCabe/Wilbur Cross	**General parenting education and support** PAT, Nurturing, FRC **Women at risk for abuse and neglect** Healthy Families **Teens** Wilbur Cross	**General parenting education and support** PAT, Nurturing, FRC **Women at risk for abuse and neglect** Healthy Families
Ensuring early identification and treatment of children at-risk for developmental and behavioral problems		**Significant risk for severe disabilities** Birth to Three **Chemically dependent women and their infants** PROKids	**Significant developmental delays** Birth to Three **Serious emotional disturbance** Child Guidance **Infants at risk for developmental or behavioral problems** ChildServ/Child FIRST **Chemically dependent women and their infants** PROKids	**Significant developmental delays** Birth to Three **Serious emotional disturbance** Child Guidance **Children at risk for developmental or behavioral problems** ChildServ/Child FIRST **Chemically dependent women and their children** PROKids	**Significant developmental delays affecting learning** PreK Special Ed **Serious emotional disturbance** Child Guidance **Children at risk for developmental or behavioral problems** ChildServ/Child FIRST **Chemically dependent women and their children** PROKids
Linking child care and preschool to health care			**Child care** Early Head Start	**Child care** Early Head Start	**Pre School** Head Start School Readiness

Estimates of Public Sector Funds Allocated for Health-Related Services for Children Aged 0-5 Years Old, based on the Revised Appropriations in 1998-1999 by the State of Connecticut

Source: Connecticut Children's Budget Fiscal Years 1996-1999.
Office of Fiscal Analysis, Connecticut General Assembly, February 1999, pp. 8-15

Department of Social Services

State Children's Health Initiative**	$813,000
Day Care Projects	$496,000
HUSKY Program**	$4,814,000
Medicaid**	$198,310,000
Temporary Assistance to Families**	$ 5,256,000
Temporary Assistance to Families –TANF**	$42,584,000
Maternal and Infant Health Services	$2,865,000
School Readiness	$7,597,000
Connecticut Children's Medical Center***	$2,000,000
Child Care Services	$169,742,000
DSS Total:	**$434,477,000**

Department of Children & Families

Personal Expenses (Staffing)**	$50,365,000
Children's Trust Fund	$2,870,000
Substance Abuse Screening**	$537,000
Grants for Psychiatric Clinics for Children****	$1,070,000
Day Treatment Centers for Children****	$556,000
Treatment and Prevention of Child Abuse****	$520,000
Community Emergency Services**	$259,000
Community Preventive Services*	$1,279,000
Family Violence Services**	$119,000
Health and Community Services*	$576,000
No Nexus Special Education***	$819,000
Substance Abuse Treatment**	$781,000
Family Preservation Services**	$1,999,000
Child Welfare Support Services**	$844,000
Board and Care (Adoption, Foster, Residential)***	$39,145,000
DCF Total:	**$101,739,000**

Department of Education

Early Childhood Program	$19,780,000
Head Start	$5,100,000
Family Resource Centers	$6,033,000
Young Parents Program	$259,000
Extended School Hours and Support Program***	$750,000
Early Reading Success	$19,800,000
SDE Total:	**$51,722,000**

Department of Public Health

Young Parents Program	$201,000
Pregnancy Healthline	$112,000
Children's Health Initiatives**	$354,000
Services for Children Affected by AIDS*	$138,000
Community Health Centers**	$689,000
Immunization Services	$3,897,000
Childhood Lead Poisoning	$336,000
Genetic Diseases Programs	$691,000
Infant Mortality Action Plan	$254,000
Newborn Screening/Laboratory Testing	$847,000
Day Care Licensing	$1,210,000
DPH Total:	**$8,729,000**

Department of Mental Retardation

Personal Services****	$756,000
Early Intervention	$12,390,000
Family Support*	$478,000
DMR Total:	**$13,624,000**

Unless otherwise stated, all estimations assume 100% of allocation provides for services for children 0-5 years old or their families. Categories followed by asterisk(s) include funds for children older than 5 years old, and the proportion of these funds that are allocated for services to children 0-5 years old has been estimated based upon agency or program descriptions of services, as follows:

* Estimate for children 0-5 years old or their families represents 50% of total state allocation
** Estimate for children 0-5 years old or their families represents 33% of total state allocation
*** Estimate for children 0-5 years old or their families represents 25% of total state allocation
**** Estimate for children 0-5 years old or their families represents 10% of total state allocation

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