The First 1000 Days:
Getting it Right From the Start

Connecticut's Children: Off to a Healthy Start

Briefing Paper #3

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About the Child Health and Development Institute of Connecticut:

The Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund 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. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

Connecticut's Children: Off to a Healthy Start

BACKGROUND

In June 2012, Connecticut launched *The First 1000 Days: Getting it Right from the Star*t to focus attention on Connecticut's most vulnerable children from birth through their infancy and toddler years. The purpose was to begin the conversation about what needs to be done to create a continuum of care to improve the development and school readiness outcomes of young children in the State of Connecticut. ***The First 1000 Days*** **refers not only to the first three years of life, but what can be done in Connecticut over the next three years to improve the likelihood that all children will achieve optimal development leading to success in school and thriving in life.**

The First 1000 Days Initiative began with a June 18th event at the Legislature (Day 1 of 1000) with a keynote presentation by Matthew Melmed, President of *Zero to Three*. An accompanying briefing paper prepared by Janice Gruendel, Deputy Commissioner of the Department of Children and Families, summarized the research and information about vulnerable children and their families.[1] Ensuing discussion by state policymakers focused on what it will take to assure all children are fully ready to succeed in school and the challenges in Connecticut to achieving this goal. The speakers conveyed the research findings about early brain development, the effects of adversity on children's development, and the lifelong impact of toxic stress caused by domestic and community violence, extreme poverty, and parental difficulties. They also addressed the mitigating effects of such protective factors as responsive care giving, quality childcare programs, social connections, and concrete supports in times of need.

The June event focused broadly on the health, safety, and economic factors that contribute to the vulnerability of children and their families and the various programs across state agencies that have been designed to address these needs. A second briefing paper[2] outlined what a system of services in Connecticut should look like "to ensure optimal health, safety and learning for each child" as called for by Public Act 11-181, *An Act Concerning Early Childhood Education and the Establishment of a Coordinated System of Early Care and Education and Child Development*.

The First 1000 Days: Off to a Healthy Start, a second forum on October 19th along with this Briefing Paper #3 are the next steps in the 1000 days initiative (Day 124 of 1000…877 to go), providing the opportunity to delve deeper into one key aspect of child development and the early childhood system – that of children's health.

THE VISION FOR HEALTHY CHILDREN

Research has clearly documented the importance of health in the first three years of life as the grounding for lifelong well-being including academic success.

> Early childhood is a time of rapid development in body systems that are critical to health, including the brain, nervous, endocrine and immune systems. Under construction even before birth – and from the earliest moments of life, a child's experiences and environments exert powerful influences on his or her development and subsequent functioning.[3]

Health is defined broadly, encompassing physical, social, emotional and oral health. Health promotion, disease prevention and early identification and treatment during these earliest years lay the foundation for healthy development and decrease the need for costly and ineffective interventions later in life. The path to achieving healthy outcomes goes beyond the health of individual children to the health of their families, homes and communities in which they live.

To examine where we stand with regard to the health of young children in Connecticut and what needs to be done to address the gaps in our system, the well-known phrase from Steven Covey may serve us well: "*Begin with the end in mind."*[4] If our goal is to ensure the optimal health of all our children, it helps to have a picture of what that looks like and what conditions will lead us there. What are we aiming for during the first three years of life that will create the foundations for healthy early childhood development?

The following seven conditions emerge from the vast literature on what contributes to the optimal healthy development of a child. Perhaps we can consider these the *Seven Habits of Early Childhood Health*.

Seven Habits of Early Childhood Health

1. Mothers receive prenatal care beginning in the first trimester and do not expose their babies to toxic substances during or after their pregnancies.

2. Children are born at full term and at a healthy weight.

3. Once born, children have sufficient and good nutrition and grow within healthy weight guidelines.

4. Children form strong bonds with nurturing caregivers, including parents and childcare providers, who have the psychological resources to provide responsive caregiving.

5. Children live in homes free of toxic stressors (environmental, physical and emotional).

6. Children live in safe communities with access to parks, recreation, and healthy foods.

7. Children have a medical and dental home (and the health insurance to pay for these services) resulting in:

    a. well-child visits according to the American Academy of Pediatrics schedule
    b. all recommended immunizations
    c. screening for developmental delays and linkage to needed services
    d. screening for lead toxicity, iron deficiency, and chronic disease such as asthma and allergies
    e. oral health promotion beginning at age one
    f. needed supports for families of children with special health care needs

If children experience these seven conditions from the time of conception through their earliest years, odds are highly in their favor that they will thrive in all domains: physical, social, emotional, and cognitive and be fully ready for success in school and in life.

HOW ARE CONNECTICUT'S CHILDREN DOING?

This section provides the highlights of available information, imperfect as it is, on health conditions and health risks for the approximately 108,650 children 3 years old and younger in Connecticut, with particular attention to those who are most vulnerable. What quickly becomes clear is an all too familiar but undeniable story; the majority of children fare relatively well, but the disparities, especially among racial and ethnic groups, are pronounced.

1. Prenatal Health

Although the majority of babies born in Connecticut are healthy, some enter this world already compromised because they are born to mothers who did not get adequate prenatal care, or they are exposed to toxic substances *in utero* including alcohol, tobacco, drugs, and environmental toxins. Some babies are born too early and/or too small. Perinatal interventions must be sensitive to the various and diverse backgrounds (age, race, ethnicity, geography) of pregnant women and the higher risk factors among various groups.

Table I below, from the Statewide Needs Assessment for Maternal, Infant and Early Childhood Home Visiting Programs (September 2010), quickly captures the points made above with regard to birth outcomes and the marked disparities among racial and ethnic groups.

Table I: Selected Maternal and Infant Indicators of Need by Race/Ethnicity: Connecticut 2008[5]

Indicator	White	Black	Hispanic
Population (% in CT)	74	10	12
Births (%)	58	12	21
Births paid by public insurance (%)	18	57	55
Late prenatal care (%)	8	20	20
Singleton low birth rate (per 100)	4.3	10.7	6.3
Feto-infant mortality rate (per 1,000)	5.2	13.1	8.1
Teen birth rate (per 1,000)	8.5	41.8	78.0

Relevant facts:

- ✓ Of the 38,846 births in Connecticut in 2008, 12% of all mothers (4,947 women) reported receiving late (after first trimester) or no prenatal care.
- ✓ 2% (631 women) received very late (third trimester) or no prenatal care. 2009 shows a marked improvement, with only 1% receiving very late or no prenatal care (541 women).[6]
- ✓ As Table I indicates, the rates for late prenatal care among African American and Hispanic women were markedly higher than for White women.[7]

- ✓ As few as 5% of women smoke during pregnancy but the rates are higher in some communities and among lower income women.[8] In 2008 rates were as high as 14-18% in some, mostly rural, communities including five in Windham County (Brooklyn, Killingly, Plainfield, Putnam, Thompson), Torrington, and Winchester.[9] The 2009 Pregnancy Nutrition Survey of over 12,000 women in the Women, Infants and Children (WIC) program, low income for the most part, found that 10% reported smoking during pregnancy, though more than half quit by their first prenatal visit.[10]
- ✓ In 2008, one in every 13 teenage Hispanic women between 15 and 19 years of age (78 per 1,000) gave birth to a baby, a figure over nine times higher than that among non-Hispanic White teens (8.5 per 1,000). The teen birth rate among non-Hispanic Black women was over four times higher (41.8 per 1,000) than that of White women.[11]
- ✓ Nearly one-third of all births to Connecticut residents in calendar year 2009 (30%) were to mothers who were born in countries other than the United States.[12] Of births to foreign-born mothers, the largest percentage was to women born in Puerto Rico (14%). Other countries frequently reported included Mexico, India, Jamaica, Brazil, Ecuador, and Poland.

2. Healthy Births

Most children are born full term and at a weight that does not increase their risk of developmental problems. But the numbers of those who are born too small hovers in the 3,000-4,000 range and they and their families will require supports and services from the start. Underlying many of the risk factors associated with pre-term and/or low birth weight are infants born into poverty, inadequate or late prenatal care, tobacco use during pregnancy, and perinatal depression.[13]

Relevant Facts:

- ✓ Infant mortality – From 2006-2008, Connecticut experienced a rate of 6.2 deaths per 1,000 live births and fetal deaths (753) to infants before one year of age.[14] More recent data indicates the number for 2009 decreased to a rate of 5.5 deaths per 1,000 live births.
- ✓ Pre-term births – 10.2% of all births in Connecticut in 2009 were born pre-term (before 37 full weeks of gestation). The rate for Hispanics was 11.2%, for Blacks it was 13.3% and 9.2% for Whites.[15]
- ✓ Low birth weight - 8% of all live births in 2009 (3,127 infants) weighed less than 5 lbs. 8 ounces.[16] 1.4% were born at a very low birth weight (less than 3.4 lbs).
- ✓ Pronounced racial and ethnic disparities prevailed with rates of infant mortality among Black women three times higher than among White women (11.9 per 1,000 vs. 3.8 in 2009) and rates of low birth weight 60% higher (11.7 per 1,000 vs. 7.0).

3. Nutrition and Healthy Weight

We know that good nutrition is essential for healthy child growth and development and that insufficient food (hunger) is a problem. We also cannot ignore the increasing extent of obesity and its long-term health consequences. Healthy eating habits and healthy weight begin in the earliest years. There are not much data available on the extent of the problem among infants and toddlers in Connecticut but the data we do have are concerning.

Relevant Facts:

- ✓ Almost 10% of infants and toddlers in the US are overweight and the rates increase in the ensuing years. [17]
- ✓ 31.4% of low-income children in Connecticut age 2-5 enrolled in WIC in 2009 were overweight or obese.[18]
- ✓ 26% of children and teens ages 10-17 in Connecticut were overweight or obese in 2007 and half of obese children are obese by age 2.[19]
- ✓ There are estimates that nearly 12% of children in Connecticut lack food security[20] but there are also many programs in Connecticut that assure very young children have access to adequate food including WIC, child care food programs and Supplemental Nutrition Assistance Programs (SNAP), such that no child should suffer from hunger. According to the Pediatric Nutrition Surveillance report, in 2009 WIC and SNAP served 64,745 children under the age of 5 (about a third of children in this age group).[21]

4. Nurturing Caregivers

Warm and positive relationships in the very earliest years translate into better health, creating the foundation for self-regulation, attention and social and emotional functioning. The first briefing paper and the June Forum explored the effects of toxic stress, stemming from extreme poverty, abuse, parental mental illness and/or substance abuse and domestic violence.

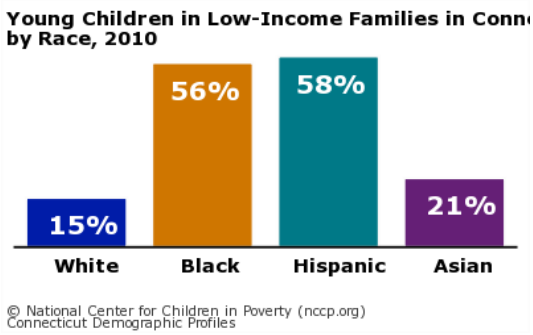
The majority of children who are healthy on day one will go home to families and communities with the capacities to provide for their healthy growth and development. But a significant subset of babies will not go home to healthy environments because their mothers or fathers do not have the sufficient abilities or resources to provide for their care and nurturance. It is difficult to find data about how many children in Connecticut are at risk of, or experience, lack of nurturing and responsive caregiving. Nevertheless, we know the risk and resiliency factors for disrupted emotional development are closely tied to the capacity of parents to provide the kind of care that supports bonding and attachment in these early years.

The Center for the Developing Child at Harvard has described family capacities as: financial, time investments, psychological resources and human capital.[22] As they note, these are concerns across all social classes, particularly in light of changing family and work

structures, but the burden is greatest on those who are impoverished or whose children have special needs.[23] I have listed some Connecticut data relevant to each.

a. Financial resources. Poverty is linked to poor health outcomes stemming from fewer resources for health care, housing, childcare and food.

- 14.4% of children in Connecticut younger than 18 lived in families with incomes under the federal poverty level in 2011 (close to 119,000 children). Hartford, with 36% of children living in poverty, had the highest rate of any city in Connecticut.[24]
- Statewide, 32% (36,450) of young children, under age 3, live in low-income families (below 200% of the poverty level).[25]
- Black and Hispanic children younger than 6 are much more likely to live in poverty. (See Figure 1).[26]
- 6% of children under the age of 6 live in extreme poverty (50% of the poverty level)[27]



b. Time investments. Single parenting, a demanding workload and other care-giving responsibilities may interfere with the time to devote to nurturing and child rearing.

- 61% (43,336) of young children in low-income families in Connecticut live with a single parent, while this is the case with only 15% (24,740) of young children in families with higher incomes.

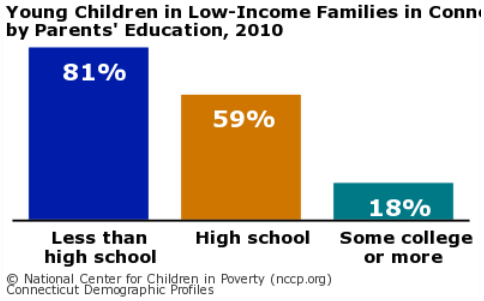
c. Psychological resources. Parental mental health including maternal depression, and impaired emotional and cognitive skills may impede the ability to address parenting demands.

- Nationally, an estimated 9% of mothers experience major depression in the year after delivering a child, with rates much higher among lower income women.[28] Estimates of the prevalence of maternal depression in Connecticut were not available but based on national rates, there may as many as 3,500 women.

- DCF received 3,215 alleged cases of abuse in 2011 for children under the age of one year old, which is an extreme indicator of what can happen when families do not have the psychological resources to cope.

d. Human capital. The skills and knowledge to obtain, process and understand health information needed to make basic health-related decisions are important for parents and caregivers to be able to provide the best care for their children.

- 81% (17,391) of young children (under 6) in Connecticut whose parents do not have a high school degree live in low-income families.[29]



5. Safe Homes

A safe physical environment that promotes good health and keeps children free from illness and injury is an environment that is free from toxic substances such as lead. Exposure to lead, with its long-term neurodevelopmental consequences, is a leading environmental health concern for young children in Connecticut.

Relevant Facts: [30]

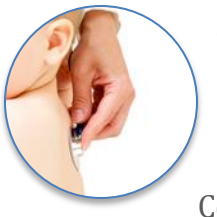
- ✓ In 2010, 66% of 3,000 children 1 and 2 years of age (53,000 children 12-35 months) were screened for elevated lead levels in their blood, two-thirds of all children in this age group. There has been more than a 20% increase in the numbers of children screened since 2003, though the law requires that all children be screened.
- ✓ Of the children in 2010, 0.9% (484) had elevated blood levels (> 10 ug/dL). There has been a steady decrease since 2002 when 982 children were identified.
- ✓ Once again there is a link with race and ethnicity. Among children under 6 years of age who had a confirmed blood lead test in 2010, Blacks had the highest rates of elevated blood lead levels (1.6%) followed by Hispanics (1.5%). The level for Whites was the lowest (0.8%).
- ✓ Hartford, Bridgeport, New Haven, and Waterbury, cities with the highest numbers of households living below the poverty level, have the highest rates of elevated blood lead levels.

6. Safe Communities

Communities that offer a safe environment help promote physical activity, social interaction and play, all of which are important to early physical and emotional development. This includes the built environment (parks, roads, buildings, restaurants, stores) as well as safe childcare facilities, where a majority of children spend a portion of their days. Children who live in communities that lack recreational facilities and have high crime rates are at higher risk for injury and do not have the same access to experiences that are important to their healthy development.

Relevant Facts:

- ✓ 1,261 children in Connecticut younger than the age of 5 were hospitalized for unintentional injuries between 2000-2004.[31]
- ✓ The overall crime rate in Connecticut in 2008 was 2,805 per 100,000 people but much higher in the largest cities and surrounding towns (ranging from 2,000 – 7,000 more cases than the expected rate based on population). New Haven, Hartford, Bridgeport and Waterbury had the highest rates.
- ✓ Nationally, 50-66% of early care and education centers fail to meet the minimum safety requirements, placing children at increased risk for injuries because of unsafe conditions.[32]
- ✓ A 2009 Child Care licensing study in Connecticut reported concerns about noncompliance with health and safety standards, particularly with regard to outdoor playground safety and medication administration. 48% of centers were noncompliant in outdoor playground safety. 1 in 5 centers did not have a provider trained in medication administration; 40% of the centers administering medications were doing so without an approved written medication order, 30% had medications not in their original labeled container, and 10% had medications accessible to children.[33]



7. A Strong Child Health System

CHDI developed a framework for a comprehensive health system for young children, from primary care to highly specialized services in Connecticut. ***The Framework for Child Health Services*** was included in Connecticut's Race to the Top Early Learning Challenge Grant and adopted by the prior Early Childhood Cabinet's Infant/Toddler workgroup.[34]

The framework describes a three-tiered system that includes:

- Universal preventive and primary health services provided to all children and families with an emphasis on early identification of health and developmental concerns, ideally through a medical home;
- Selected services, including developmental, medical and mental health, available to all children and families for early intervention and referral;
- Intensive services provided to those children with more complex needs.

Coordination of care is central to addressing children's needs within the health system and across service sectors, including early care and education and family support, at all three levels of the *Framework*. The resulting system, when fully integrated, should ensure optimal healthy child development.

The *Framework* recognizes the person-centered medical home model as the most effective way to promote early childhood health. A medical home provides comprehensive, coordinated, culturally competent and community-based care. Through a medical home, a child should have all the recommended well-child visits (6, 12, 18, 24 or 30 months), receive all recommended immunizations, be screened for all potential developmental concerns, and families should receive educational materials providing guidance about good health practices in the home. Medical homes should identify children with risks as early as possible and link their families to services and supports. We know that early identification and early intervention go a long way to preventing more serious and costly outcomes in later years. The goal should be that no child will arrive at school with an unidentified and untreated health or developmental problem.

Relevant Facts:

- ✓ 6% of children ages 0-5 (15,000) were without health insurance at any point during the year in 2010,[35] thereby limiting their access to preventive care and increasing their reliance on emergency departments for treatment.
- ✓ 60% of children have a medical home.[36]
- ✓ 82.2% of 2-year olds had all recommended immunizations in 2010.
- ✓ About half of the 0-3 year olds participating in the state Medicaid Program (HUSKY - Health Insurance for Uninsured Kids and Youth) received a developmental screening in 2011.[37]
- ✓ According to parent report on the National Child Health Survey, only 16.6% of children 10 months–5 years in Connecticut received standardized developmental screening during child health visits in 2007.[38]

An important role for primary care services is to provide screening to identify conditions for which early intervention and treatment can prevent serious consequences later on. Connecticut's children experience the following health problems, which are amenable to early detection and intervention.

- Anemia –Low-income children are more likely to be anemic. Nearly one in ten (9.2%) Connecticut children from 1 to 5 years old who participated in the WIC program were found to be anemic.
- Dental Caries - By kindergarten, 27% of children have had tooth decay. For low income children (those in Head Start) 31% have experienced dental decay by 3 years of age.
- Asthma -
  - In the 2008-09 school year, 14.4% of public school students in prekindergarten and kindergarten were reported to have asthma, higher than any other grade-level.[39]
  - 2008-2009 data on school age children indicate the highest rates among Hispanic students (16.9%) followed by Black students (14.8%) with 10.6% for White students. Rates were highest in the poorest communities (Bridgeport, Hartford, New Haven and Waterbury) ranging from 7.4% in students in District Reference Group A - highest socio-economic status (SES) to 19.2% in District Reference Group I (lowest SES).
  - In 2005, the asthma rate among children younger than 5 enrolled in HUSKY A (state Medicaid program) was 23%, which was significantly higher than among any other age group.[40]
  - Children younger than 5 years of age are more likely to be hospitalized (32.1 per 10,000) or have gone to an emergency department (ED) because of their asthma, with higher rates of ED and hospitalization among Black children than White children.[41]
  - An astounding 53% of all deaths to children in CT in 2001-2005 were either directly or indirectly related to asthma. [42]

WHAT IS CONNECTICUT DOING TO ASSURE ALL CHILDREN ARE OFF TO A HEALTHY START?

Clearly Connecticut has its challenges in meeting the goal that all children should attain their optimal healthy development during the first three years of life. But we are a state that expends a large amount of resources in programs at the state and community level that contribute to ensuring the seven conditions described above. We have not been sitting idly by and have some successes to show for it.

Connecticut has had a concerted response to the dangers of lead poisoning that provides the best example of what can be accomplished when there is the will to fix a problem. The result has been the alignment of policies and programs at the state and local levels that require health providers to screen all children 9-35 months of age (mandated by law as of 2009) and intervention by local health departments, as well as targeted prevention programs aimed at the environmental causes of lead poisoning (most often old homes with lead based paint surfaces). These initiatives have provided clear benefits for children with measurable decreases in the number of children with lead poisoning.[43]

The second Briefing Paper, *Building an Early Childhood System*, presented a table of all the programs by state agencies that provide services and supports statewide to young children. The chart below lists the subset of those programs that have a direct health component.

State Dept of Education • Early Head Start • Head Start State Collaboration Center • Child Care Food Programs • Family Resource Centers • Even Start (family literacy and developmental screenings for children)	**Department of Social Services** • HUSKY Children's Health Program • Supplemental Nutrition Assistance Program (SNAP) • Healthy Start • Nurturing Families Home Visiting Network • Support for HELP ME GROW • Positive Parenting Program	**Department of Public Health** • Child Day Care Licensing • Women, Infants and Children • SNAP Education • MIECHV (Home Visiting) • Putting on Airs • Lead Poisoning Prevention and Control Programs • Asthma Action Plan • Title V – Maternal and Child Health Grant
Department of Mental Health and Addiction Services • Community and residential programs for adults (and sometimes their young children) who are "substance users"	**Department of Children & Families** • Early Childhood Consultation Partnership • Parents in Partnership • Child Protective Services/Foster Care • Adolescent Development/Teen Pregnancy Prevention • Family Enrichment Services • Family-Based Recovery	**Department of Developmental Services** • CT Birth to Three Program

In addition to these state sponsored programs, there are other statewide programs that benefit the health of young children and their families. Examples include:

- United Way 211 Child Development Infoline. A state-funded centralized point of access to many services including Birth to Three, Help Me Grow with Ages and Stages monitoring, and Children and Youth with Special Health Care Needs.
- Discovery Communities. With public and private funding from the William Caspar Graustein Memorial Fund, the State Department of Education, the Children's Fund of Connecticut, the Annie E. Casey Foundation and local funders, 39 communities are developing and implementing comprehensive plans for young children birth to eight, with the goal that health be fully integrated into their work.
- The Connecticut Association for Infant and Mental Health Competency Guidelines for Culturally Sensitive, Relationship-focused Practice to Promote Infant Mental Health® is being disseminated to a wide range of professionals who work with young children.
- Educating Practices in the Community (EPIC). A program operated by the Child Health and Development Institute (CHDI) delivers information and training to child health providers throughout the state on a range of topics important to early childhood screening, referral and treatment.
- Child FIRST. An evidence-based home visiting model for the most vulnerable young children (prenatal through age five) and families decreases serious emotional disturbance, developmental and learning problems, and abuse and neglect, with funding from national, state and local philanthropy, DCF and Medicaid.

In addition to a wealth of programs, Connecticut has some significant policies in place that are working to promote children's health. Key examples include:

- Medicaid coverage for pregnant women up to 250% of the federally poverty level with presumptive eligibility for pregnant women and children.
- The restructuring of Medicaid to be centered around a Person Centered Medical Home (PCMH) model with incentives to primary care providers to gain recognition as medical homes. Developmental screening, connection of children to dental services, and meeting the standards for scheduled well-child visits will be included as performance measures.
- Mandated screening and intervention for lead poisoning.

WHERE DO WE GO FROM HERE: THE NEXT 877 DAYS

The clock began ticking on June 16th, 2012 with *The First 1000 Days: Getting it Right from the Start* forum. As of the second forum, October 19th, we have 877 days remaining if we are serious about taking on this challenge of ensuring that Connecticut's children are off to a healthy start in life and arrive at school healthy and ready to learn.

The problem is not insurmountable. In Connecticut, we have approximately 105,000 children younger than 3 years of age, and the majority of them are doing rather well. These children often have the benefit of the seven habits of early childhood health, from pre-birth through their earliest years. The fact that Connecticut ranks 6th among states on health indicators in the 2012 Kids Count Report is not so surprising.

At the same time, a portion of young children experience very few of the seven habits crucial to early childhood health, placing them at risk for poor health, with 10-15% especially vulnerable. The children who are at greatest risk for poor health outcomes are those who live in the poorest families, usually in the poorest communities and more often are members of racial and ethnic minority groups.

I don't have the answers for eradicating poverty but **whatever we do must be framed by a commitment and concerted effort to reduce health disparities across the board.** Drawing from the seven habits for early childhood health as a guide we need to:

- ✓ **improve the health status of women, including prenatal care, smoking cessation, and screening and treatment for post-partum depression**
- ✓ **enhance early identification of developmental delays**
- ✓ **enhance child health data systems**
- ✓ **improve access to mental/behavioral health services for young children and their families**
- ✓ **enhance the provision of oral health services to prevent tooth decay**
- ✓ **promote good nutrition and prevent and reduce obesity**
- ✓ **prevent and reduce the effects of asthma**
- ✓ **improve linkages to services and access to care**

These priorities are not new. Many of them are already included in DPH's most recent needs assessment (fulfilled as a requirement of the Maternal and Child Health Block Grant (Title V) in 2010). In every one of these areas Connecticut has or has had task forces, programs, plans, recommended policies and advocacy efforts that lay out the problems in Connecticut and the recommended solutions. Now, we need a focused and concerted effort that brings these disparate initiatives together breaks down the silos that exist among our state agencies and overcomes the bureaucratic impediments making it difficult for families, providers and communities to work together. The effort currently underway to design a comprehensive early childhood system, as mandated by P.L. 11-181, provides us the opportunity to do just that.

The problems outlined in this brief are complex and they require going beyond incremental problem-solving to transformational change. As written in a recently published book, *The Power of Habit*, "Once you understand that habits can change, you have the freedom and the responsibility to remake them…Once you understand that habits can be rebuilt, the power of habit becomes easier to grasp and the only option left is to get to work."[44] If the seven conditions outlined at the beginning of this paper really do become habits, the outcomes for Connecticut's children will change. The work isn't easy, quick or simple, but it is possible, and what makes it possible is that we know what has to be done. Now we just have to get to work and make it happen.

Endnotes

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