2ND ANNUAL

MOVING BEYOND IMPLICATIONS: RESEARCH INTO POLICY

Hosted by:

State Representative Jaime Foster, PhD, RD
Proudly serving East Windsor, Ellington, Vernon

State Representative Dominique Johnson, PhD
Proudly Serving Norwalk & Westport

Dr. Kerri Raissian
CT SSN Co-leader

THURSDAY, DECEMBER 12TH IN HARTFORD, CT

Legislative Office Building – 2nd Floor Atrium & 2nd Floor Hearing Rooms

Most policy makers aim to implement evidence-based policy. They want to create and pass bills that have the exact desired impact and are the state of the science given the best evidence of the time. Unfortunately, most academic research is behind a paywall and inaccessible to policy makers.

Most scientists and scholars have written a sentence in a peer reviewed publication that starts something along the lines of, "implications for policy include…." Unfortunately, the only people who often read those implications are other scholars. This conference is designed to build a bridge between these two ivory towers.

Thank you for being here today!

In Partnership with:

Scholars Strategy Network & The Institute for Collaboration on Health, Intervention, and Policy (InCHIP) at UConn

SCHOLARS STRATEGY NETWORK
CONNECTICUT

INCHIP

THANK YOU FOR JOINING US TODAY!

A HUGE THANK-YOU TO ALL OUR PARTNERS FOR MAKING THIS HAPPEN!

Thank you to all State Leaders, Legislators, Academics, and Scholars for participating today!

CTN

EPICUREANFEAST Cafés

LuAnn's

GATHERING PLACE J Rego's

AGENDA

Lunch.....**11:30am - 12:30pm** **(Hearing room)**

Please gather your lunch in the 2nd floor atrium and proceed to the hearing room

Welcome.....**12:30 - 1:30pm** **(Hearing room 2C)**

Rep. Foster, Rep. Johnson, Dr. Kerri Raissian, and other invited dignitaries

- Lieutenant Governor Susan Bysiewicz
- Speaker of the House Matt Ritter
- Majority Leader Jason Rojas
- Presentations by OPM Scott Gaul and Rachel Leventhal-Weiner

Presentation Tracks-Session 1.....**1:30 - 2:45pm**

Track A- Planning & Development (Room 2A)
Track B- Public Health (Room 2C)
Track C- Childrens (Room 2E)

Break for Coffee and Networking.....**2:45 – 3:15pm**
(2nd floor Atrium)

Presentation Tracks-Session 2.....**3:15 - 4:30pm**
(Hearing rooms)

Track D- Human Services (Room 2A)
Track E- Education (Room 2C)
Track F- Judiciary/Labor (Room 2E)

Happy Hour, Snacks, and Networking.....**4:30 – 6:00pm**
(1st floor Atrium)

Light refreshments and open bar!

COMMITTEE CHAIRS & VICE CHAIRS

Planning & Development

Chair – State Rep. Eleni Kavros DeGraw
Vice Chair – State Rep. Brandon Chafee

Public Health

Chair – State Rep. Cristin McCarthy Vahey
Vice Chair – State Rep. Kai Belton

Childrens

Chair – State Rep. Corey Paris
Vice Chair – State Rep. Mary Welander

Human Services

Chair – State Rep. Jillian Gilchrest
Vice Chair – State Rep. Robin Comey

Education

Chair – State Rep. Jennifer Leeper
Vice Chair – State Rep. Kevin Brown

Judiciary

Chair – State Rep. Steve Stafstrom
Vice Chair – State Rep. Jack Fazzino

SCHOLAR PRESENTATIONS
(TRACK A & B)

Track A - Planning and Development (Room 2A)

Leveraging Web GIS Mapping for Broadening Community Impacts

Peter Chen (UConn)
Rachel Hale (UConn)

Simplified Reports of Government Financial Information Increases the Public's Understanding, Interest, and Trust: Lab and Survey Experimental Evidence

Jinhai Yu (UConn)
Zhiwei Zhang (Kansas State University)
Josie Schafer (University of Nebraska)
Nicolai Petrovsky (City University of Hong Kong)
Shannon Cummins (University of Nebraska)

The Impact of Public Act 21-35 on the Children's Mental Health Continuum of Care

Tammy Freeberg (The Village for Families & Children)
James O'Dea (Hartford Healthcare)
Melissa Santos (Connecticut Children's Medical Center)
Howard Sovronsky (Connecticut Children's Medical Center)

Increase RAP Funding and Improve Waiting List Data to Reduce Rent Burdens

Crossan Cooper (Yale)

Track B – Public Health (Room 2C)

The Geography of Poverty and Medical Debt in CT

Emil Coman (UConn Health)
Samuel Bruder (Connecticut Judicial Branch)
Jason Byers (UConn)

Policies for Crisis Pregnancies in a Post-Dobbs Climate

Lori Bruce (Yale)

Early Introduction of Allergens for the Prevention of Food Allergy

Stephanie Leeds (Yale University School of Medicine)
Jason Linde (Food Allergy Research and Education)
Patricia Donovan, Helen Jaffe (Harvard Advanced Leadership Initiative)
James Dodington (Yale University School of Medicine)

Connecticut's Violent Deaths: Introducing a New Mapping Portal

Kerri M. Raissian (UConn)
Jennifer Dineen (UConn)

SCHOLAR PRESENTATIONS
(TRACK C & D)

Track C- Children (Room 2E)

Energy Drink Regulation: Protecting Youth from Dangerous Products
Frances Fleming-Milici (UConn)

Caring for Youth Behavioral Health: Preserving Connecticut's Crisis System
Jeffery J. Vanderploeg (Child Health and Development Institute)
Lisa Tepper-Bates (United Way of Connecticut)
Tamy Freeberg (The Village for Families & Children)
Gary Steck (Wellmore Behavioral Health)

Child Maltreatment Investigations and Family Well-being
David Simon (UConn)
Lindsey Lacey (Allegheny County)
Katherine Rittenhouse (University of Texas)

Track D- Human Services (Room 2A)

Raising Medicaid Rates Will Expand Access to Children's Behavioral Health Services
Aleece Kelly (Child Health and Development Institute)
Jason Lang (Child Health and Development Institute)

Experiences of Poverty Around the Time of a Birth
Christal Hamilton (UConn)
Jane Waldfogel (Columbia University)
Chris Wimer (Columbia University)
Laurel Sariscsany (University of Nebraska at Omaha)

Incorporating Eligible Participant Voices into the Connecticut Supplemental Nutrition Assistance Program
Emily Loveland (California State University San Bernardino)

Food as Medicine
Kathleen Duffany (Yale)
Rafael Pérez-Escamilla (Yale)
Katherine Lamonoca (Yale)
Jaime Foster (Yale)

SCHOLAR PRESENTATIONS
(TRACK E & F)

Track E – Education (Room 2C)

Two Connecticut State Interventions to Address Pandemic Effects on K-12 Students
Stephen Ross (UConn)
Eric Brunner (UConn)
Alexandra Lamb (UConn)

Supporting the Whole Child in Connecticut: Opportunities For Strengthening Educational policies
Kathleen M. Williamson (UConn)
Sandra M. Chafouleas (UConn)
Marlene B. Schwartz (UConn)
Jessica B. Koslouski (UConn)

Universal Free School Meals: Protecting Our Investment in Public Education
Marlene B. Schwartz (UConn)

Farm to School Programs Empower Connecticut Children to Thrive
Kate (Walder) Zahner (UConn)
Valerie Duffy (UConn)
Carolyn Pancarowicz (East Hartford Public Schools)

Track F – Judiciary/Labor (Room 2E)

Harms and Benefits Inventory: Findings from Wave 1 and 2
Jennifer Dineen (UConn)
Kerri M. Raissian (UConn)

Human Services Career Pipeline (HSCP)
Billy Huang (Office of Workforce Strategy)
Mary Pat DeCarlo (Department of Developmental Services)
Bernadette Park (Social Impact Partners)

How Much do Mandatory Minimums Matter?
Spencer Cooper (UConn)

Addressing the Needs of Formerly Incarcerated People: How Beneficiaries of Public Act 15-84 can Help Improve Prison Conditions
Sukhmani Singh (UConn)
Fernando Ricardo Valenzuela (UConn)
Josh Adler (UConn)
James Jetter (Full Citizens Coalition)
Rich Sparaco (Consultant)
Alex Tsarkov (UConn)

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Education - LOB Room 3100 | 860 - 240 - 0420 | ed@cga.ct.gov
Planning & Development - LOB Room 2100 | 860 - 240 - 0550 | pd@cga.ct.gov

Catering Restaurants

LuAnn's Bakery & Café
238 Somers Rd., Ellington CT
(860) 872-8073 | https://www.luannsbakery.com/

JRego's Gathering Place
175 West Rd, Ellington, CT 06029
(860) 454-4458 | https://www.jregosgatheringplace.com/

Data and Policy Analytics Unit

Mission:

The Data and Policy Analytics (DAPA) unit supports the collection, analysis, coordination and sharing of data to support CT state government capacity. DAPA is responsible for the state data plan, open data, P20 WIN and the GIS Office. Secure state and local data use supports Governor Lamont's vision for policy that is informed by data and evidence.

What we do: Data and Policy Analytics Programs

- State Data Plan
  - The CT State Data Plan connect the people and processes involved with data to promote communication between, and appropriate integration data, teams, and systems.
- Open Data
  - Launched in 2014, the CT Open Data Portal is the state's repository for open data.
  - Staff at state agencies publish their own data and data stories at data.ct.gov.
- Geographic Information Office
  - Coordinates the collection, compilation and dissemination of GIS data from state agencies, regional councils of governments, municipalities.
  - Manages a publicly accessible geospatial data clearinghouse.
  - Uses GIS to support economic development efforts in the state.
  - Provides training and outreach on the use of GIS.
  - Administers a statewide orthoimagery and lidar program.
  - Promotes geospatial data standards, guidelines, and procedures.
  - Performs technical data processing to aggregate and organize existing datasets and create new datasets.
  - Develops broadband data and mapping in accordance with Public Act 21-159.
- Preschool through 20 Workforce Information Network (P20 WIN)
  - P20 WIN (The Preschool through 20 Workforce Information Network) is Connecticut's state longitudinal data system and is the mechanism by which data from multiple agencies are matched to address critical policy questions.
  - P20 WIN informs sound policies and practice through secure sharing of longitudinal data across participating agencies to ensure that individuals successfully navigate supportive services and educational pathways into the workforce.
- Research & Evaluation
  - Supports the establishment of Learning Agendas and the generation of evidence in state agency work while expanding agency capacity to improve data storytelling
  - Expands agency capacity for evaluation to understand the impact of state-funded programs

Why work with Data and Policy Analytics?

We facilitate the use of administrative data. Administrative data are "…information collected, used, and stored primarily for administrative (i.e., operational), rather than research, purposes. Government departments and other organizations collect administrative data for the purposes of registration, transaction, and record keeping, usually during the delivery of a service." Examples of administrative data include: financial transactions, electronic medical records, insurance claims, educational records, arrest records, mortality records.

Where can I go to find data?

Public / aggregate data

- Open data portal: data.ct.gov
- Geodata portal: geodata.ct.gov

One agency's data

- Agency data officers

More than one agency's data linked together

- P20 WIN – state longitudinal data system

Something else / not sure?

- Just ask!

We're working to make data use easier through useful documentation:

Check out these resources:

Data sharing playbook

- Data inventory or catalog (2022 version)
- Catalog of your data If data is public or protected and whether data includes PII or PHI

Summaries of major state and federal legal and regulatory frameworks:

- Child Abuse Laws and Regulations
- Child Welfare Laws and Regulations
- Drug and Alcohol Use Disorders Laws and Regulations
- Health Laws and Regulations
- Mental Health Laws and Regulations
- Social Services Laws and Regulations

Data dictionary (P20 WIN)

Stay in touch:

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Rachel Leventhal-Weiner, Director of Research & Evaluation: rachel.leventhal-weiner@ct.gov
General Inquiries: dapa@ct.gov

Leveraging Web GIS Mapping for Broadening Community Impacts

Peter Chen[1], Rachel Hale[2]

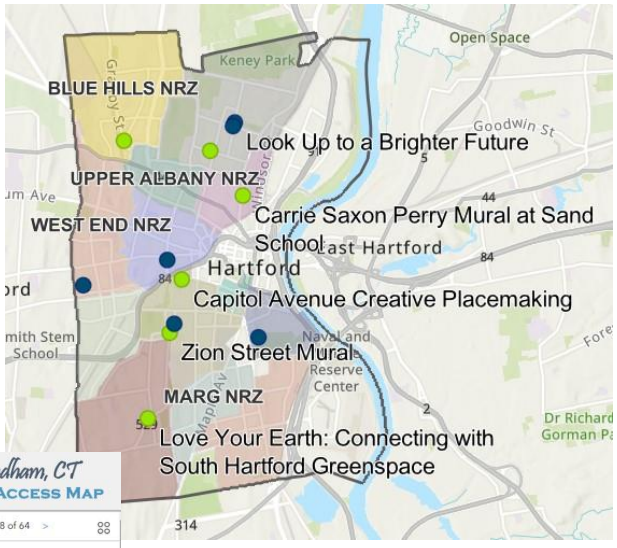
1. Associate Professor, Department of Geography, Sustainability, Community, and Urban Studies (GSCU), University of Connecticut, peter.chen@uconn.edu
2. Assistant Director, Research on Resilient Cities, Racism, & Equity (RRCRE), University of Connecticut, rachel.l.smith@uconn.edu

What is Web GIS?

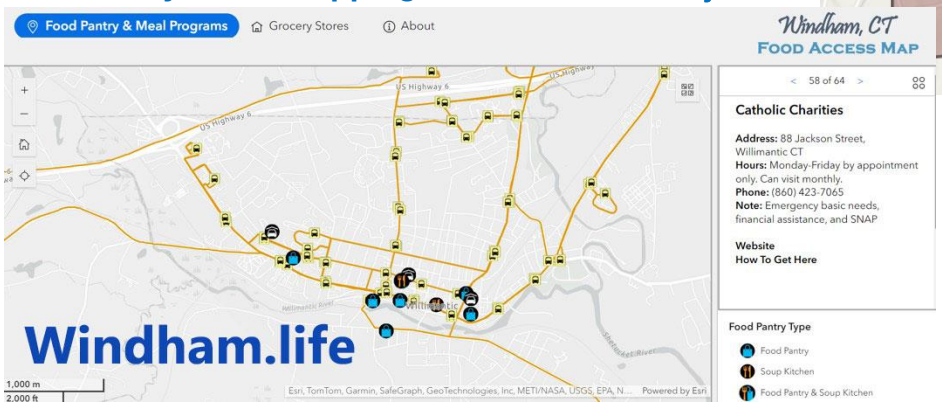
Web Geographic Information System (GIS) allows for scalable identification of community assets (e.g., transportation, facilities, and infrastructure) in real-time through web browsers or mobile devices, without requiring specialized knowledge. Web GIS has been employed in various policy contexts where decision-making relies on spatial data and patterns, such as the COVID-19 dashboard that tracks daily infections and casualties.

Story Mapping: Hartford Love Your Block (LYB) Program

Funded by the City of Hartford and the Hartford Foundation for Public Giving, the Hartford LYB program has provided dozens of mini grants to support urban beautification and renewal projects in Hartford over the past six years. These projects were all proposed and led by community members seeking to make their neighborhoods more livable and impactful. Web GIS-based story mapping has revolutionized how these projects are shared and narrated.



Community Asset Mapping: Windham Life Project



Windham Life is a USDA-funded project designed to enhance information sharing about community resources (e.g., food pantries and grocery stores) for residents of Windham County. The asset mapping platform (windham.life) and tools (e.g., SNAP eligibility checks) help residents make informed food choices.

Policy Recommendations

- **Increasing usage and visibility of GIS tools in public communication**: Focusing on data-driven maps to enhance communication between policymakers and the community.
- **Leveraging GIS tools for evidence-based decision making:** Collaborating with universities to leverage GIS in identifying patterns within socioeconomic, infrastructure, and environmental data.
- **Providing funding to GIS-based community projects:** Supporting organizations that actively use GIS to address community needs.

Enhancing Public Engagement through Simplified Financial Reporting

***Jinhai Yu (presenting author)**, PhD, University of Connecticut, jinhai.yu@uconn.edu | Zhiwei Zhang, PhD, Kansas State University, zhiwei@ksu.edu | Josie Schafer, PhD, University of Nebraska Omaha, jgschafer@unomaha.edu | Nicolai Petrovsky, PhD, City University of Hong Kong, npetrovs@cityu.edu.hk | Shannon Cummins, PhD, University of Nebraska Omaha, scummins@unomaha.edu*

Government transparency measures like publishing financial reports online are a critical means of promoting trust in institutions and providing citizens with an accessible foundation on which to build more active public engagement. Traditional financial reporting used by governments, such as Annual Comprehensive Financial Reports (ACFRs), is often inaccessible to the public due to its technical nature. Simplified formats like Popular Financial Reports (PFRs) offer a promising alternative, fostering greater public understanding, interest, and trust in government financial information. Our team's research findings from a survey and lab experiment highlight the benefits of simplified reporting for local governments, with implications for Connecticut's public financial communication strategies.

Survey and Lab Experiment Results Indicate PFRs are More Accessible, More Effective

1. **Survey Experiment (Amazon MTurk):**
    - Participants exposed to PFRs demonstrated significantly higher **understanding**, **interest**, and **trust** than those viewing traditional ACFRs.
    - Effects were most pronounced among:
        - Individuals with prior familiarity with government budgets.
        - Trump voters in the 2020 election.
        - Those with higher levels of education.

Implications: Simplified reporting addresses public transparency needs and fosters civic engagement, which is critical for local democracy.

2. **Lab Experiment (University Setting):**
    - Eye-tracking analysis revealed:
        - PFRs reduced cognitive effort and improved processing efficiency.
        - Subjects exhibited greater trust and engagement with simplified reports.

Implications: Presentation design plays a critical role in improving public comprehension and reducing information barriers.

Policy Implications for Connecticut

- **Adoption of Simplified Reports:**
  Despite the Government Finance Officers Association's (GFOA) longstanding Popular Annual Financial Reporting Awards Program, few Connecticut governments have embraced simplified formats. PFRs can bridge the gap between complex fiscal data and public accessibility.
- **Targeted Communication:**
  PFRs should be tailored to the diverse needs of citizens based on their education levels, political preferences, and familiarity with government finance. This ensures broad inclusivity and effectiveness in delivering key fiscal information.
- **Practical Considerations:**
  - Transitioning to simplified reporting may incur costs and require new skill sets among financial professionals.
  - Policymakers should weigh these costs against the long-term benefits of increased transparency, public trust, and civic participation.
- **Broader Applications:**
  Simplified reporting extends beyond financial literacy. It can enhance public understanding in areas such as:
  - Bond referenda.
  - Property tax assessments.
  - Broader fiscal accountability measures.

Call to Action

Connecticut policymakers are uniquely positioned to lead by example in enhancing financial transparency.

Implementing PFRs at state and local levels can transform public engagement and establish Connecticut as a model for innovative, accessible governance.

Disclaimer

- The survey experiment (Amazon MTurk) is currently under revision for publication in a peer-reviewed journal.
- The lab experiment (University Setting) has preliminary findings presented at a professional conference.

The Impact of Public Act 21-35 on the Children's Mental Health Continuum of Care

Melissa Santos, PhD | Division Head, Pediatric Psychology| Connecticut Children's

The Covid pandemic brought about a renewed focus on the mental health of children. The volume of headlines focused on problems accessing care at the height of the pandemic was staggering. Children waiting for days in emergency room hallways for care. Families unsure of where to turn to access help for their children. Teens isolating at home having lost their connection to the things that supported their mental health. *Families were suffering and unsure of how to support their children*. While many feel relief that this acute Covid era has ended, we must not confuse the increased attention brought to issues like children's mental health with the idea that the acute problems we observed were only a function of that era, and therefore do not require our sustained attention.

The state of Connecticut has made a much-needed significant investment in children's mental health allowing for a variety of measures to strengthen the mental health continuum of care. These include the creation of Urgent Care Centers throughout Connecticut, expansion of inpatient beds, the creation of a Med-Psych inpatient unit, and more. These efforts have significantly improved the throughput and ability for children to get the right care, at the right time, at the right intensity level. However, without continued investment in this system—and specific actions like improving reimbursement rates and fixing broken billing practices—these efforts are not sustainable, and we will return to the headlines seen during Covid.

Past Problems, Future Trends, and Inequalities All Highlighted by Covid

Prevalence studies (which look at what proportion of a population exhibited a given characteristic during a snapshot in time) clearly documented the increased rates of mood and behavioral problems seen during the Covid pandemic, leading many to refer to a concurrent "mental health pandemic" that has become emblematic of this era. However, research is clear: The mental health pandemic experienced by children and adolescents started long before Covid. Pre-Covid, suicide was the second leading cause of death for children starting at the age of 10. In the years leading up to Covid, research showed a steady increase in the rates of suicide attempts, suicidal ideation, depression and hopelessness in younger and younger children. *Children and adolescents were suffering and in need of help long before Covid arrived.*

Perhaps what Covid did do was highlight longstanding problems within our mental health system infrastructure. Pre-Covid, rates of emergency department visits for mental health services and families reporting being unable to access mental health care were steadily increasing. Significant ongoing issues with workforce development, poor reimbursement, lack of resources and the continued stigma attached to those who need help with their mental health can only cause system disfunction. *The mental health system, like the children and adolescents it served, was suffering and in need of help long before Covid arrived.*

From the underlying idea that youth in need of help have been inadequately served by a system that needed support long before Covid, it is easy to understand how not all children's and adolescents' mental health has been equally affected by various stressors or equally served by the resources and interventions (or lack thereof) that have been in place. As detailed in the Surgeon General's Advisory on Protecting Youth Mental Health, higher rates of mental health concerns are seen in youth with varying ability statuses, racial and ethnic minorities, those from lower socioeconomic statuses, those in rural areas and sexual and gender minority youth. *The youth mental health pandemic didn't start in Covid, won't end with Covid and didn't impact all of our kids equally—meaning we can't solve this with a one-size-fits-all approach to care.*

Connecticut Takes Youth Mental Health Seriously

Policymakers in Connecticut rose to the challenge of addressing youth mental health with a series of bills passed starting in 2021. These bills supported the creation of new clinical programming, workforce development and more. *And in the years since those bills passed, there have been improvements.*

Here is some of the ways this legislation has been helpful:

- DSS bed expansion resulting in increased child and adolescent psychiatric beds reducing delays in access to care in the last 24 months.
- Funding for the specialized med/psych unit at Connecticut Children's.
- Funding for both Urgent Care Centers (UCCs) and sub-acute residential services allowing youth and families access to care options without going to the Emergency Department (ED) or inpatient care. Across the three-community based UCCs, 1,470 children have been served. This valuable resource, with an average length of stay of 3.8 hours, has prevented unnecessary emergency department (ED) visits with nearly 50% of those served having to go to an ED if a UCC was not available.

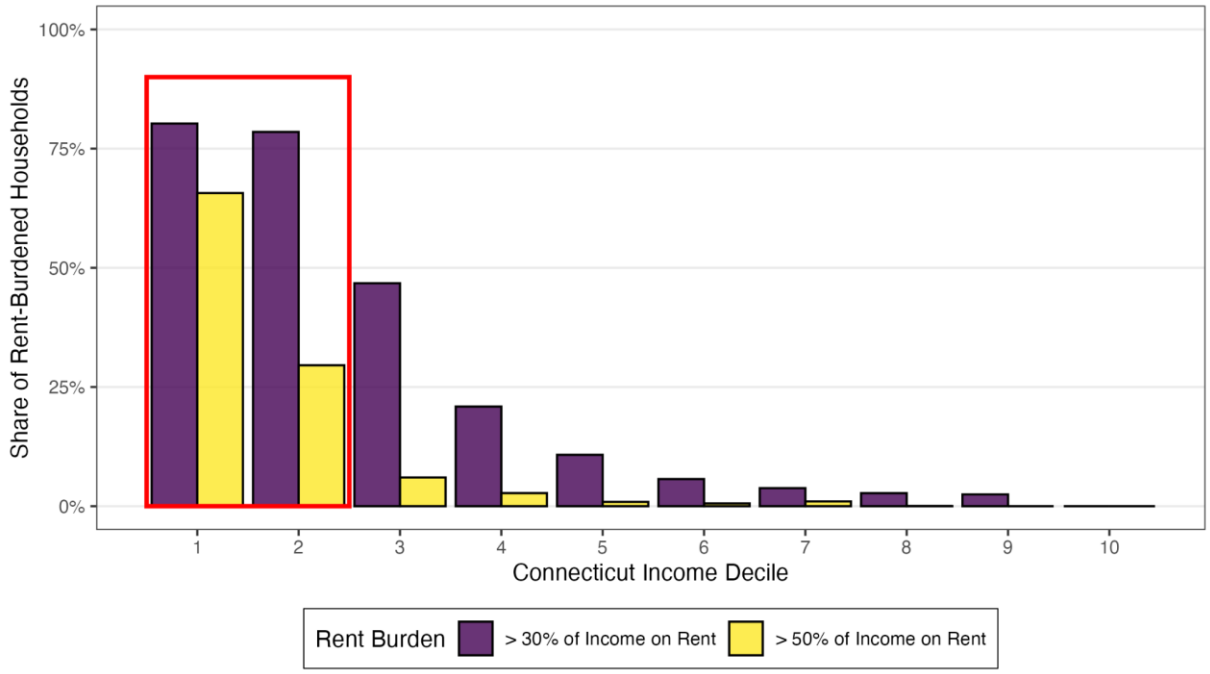
Too often, legislators and practitioners work together to bring about changes like these, and then move on to the next challenge without sufficient pause to celebrate the impact of their efforts. Our work shows how theses investments in the children's mental system can, and has, improved lives. However, without continued investment, including in workforce development and reimbursement practices, these efforts are not sustainable, and these important gains can disappear.

Recommendations to Maintain Connecticut's Commitment and Realize Further Success

1. Continued advocacy for improving reimbursement rates for mental health services to ensure sustainability.
2. The fulfillment of initiatives not completed under previous legislation, like removing billing barriers so that legislative efforts granting temporary licenses for psychology postdoctoral fellows can expand the mental health workforce as intended.

Crossan Cooper, PhD Candidate
Yale University Department of Economics

Increase RAP Funding and Improve Waiting List Data to Reduce Rent Burdens



Note: author's calculation using ACS 5-year estimate from 2018-2022. Rent is defined as gross rent (i.e. rent inclusive of utilities). Income decile calculated across all (renter and non-renter) Connecticut households. The y-axis is the share of Connecticut renter households within each income decile that spend more than 30% or 50% of their monthly household income on gross rent. Data accessed through IPUMS

A Crisis of Rental Housing Affordability in Connecticut

Connecticut's poorest renter households face large cost-burdens. From 2018-2022, **49.7%** of Connecticut renters spent more than 30% of their income on rent and utilities. This situation worsens for Connecticut's poorest households: **51.4%** of renter households in the bottom fifth of the income distribution – outlined in red – spent over half their income on rent and utilities.

While supply-side policies to address housing policy are (with good reason) promoted by advocates and legislators, zoning reform and incentives for affordable housing development have proven politically intractable in recent legislative sessions. In light of this, our analysis suggests two practical demand-side solutions to the problem of elevated rent burdens for Connecticut's poorest households:

1. $20 million increase in funding for the Department of Housing's Rental Assistance Program to expand access to housing assistance for Connecticut's poorest households.
2. Development of a state-wide housing assistance voucher waitlist to provide real-time visibility into the housing assistance needs of Connecticut's poorest households.

Crossan Cooper, PhD Candidate
Yale University Department of Economics

Existing Programs Fail to Satisfy Connecticut's Need for Housing Assistance

Connecticut offers state-funded rental assistance to income-eligible households through its Rental Assistance Program (RAP). RAP was created by the Connecticut legislature through Connecticut General Statute § 8-345 in 1985. Funding for RAP is limited, and the Department of Housing (DOH) uses a waiting list to ration access to the benefit program. Because the waiting list has been closed since 2007, it is hard to accurately measure current demand for rental assistance. DOH states that around 6.7k households currently receive assistance through RAP. This implies that no more than **2.7%** of income-eligible Connecticut renter households participate in the program. Federally-funded housing vouchers accommodate another 39.6k households across the state, but this raises the share of income-eligible renter households receiving assistance to only **18.7%**.

Is this low rate of assistance driven by weak demand for housing assistance among Connecticut residents? Evidence from New Haven proves that the answer is **no**. The Housing Choice Voucher waiting list for the Housing Authority of New Haven opened indefinitely in March 2021, and there are currently over 30k households on the waiting list. At existing funding levels and program departure rates, the waiting list for this program will not clear for at least **50 years**.

What Can Legislators Do to Help Cost-Burdened Renters?

Our team identifies two straightforward demand-side policies to reduce rent burdens for low-income households in Connecticut:

Policy Proposal	***Impact***
Expand access to housing assistance subsidies by ***increasing funding for the state-wide Rental Assistance Program by $20 million***	***Meet projected 4% rise in rental costs and provide long-term rental assistance to over 1000 additional low-income households***
Follow Massachusetts by creating a centralized waiting list managed by DOH *to accurately measure real-time demand for rental assistance among low-income renter households in Connecticut*	***Reduction in administrative costs of housing assistance program administration. Improvement in visibility into demand for rental assistance programs***

Crisis Pregnancy Policies in a Post-Dobbs Climate: Infant Abandonment Devices & Confidential Birth

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Associate Director, Interdisciplinary Center for Bioethics,
Yale University
Key Researcher, Oxford-NUS Centre for Neuroethics and Society
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Impact to Connecticut: In at least 13 states, birth rates are rising. Reproductive and maternity care for these populations has already spilled into several other states, including Connecticut. In 2024, there was a sharp increase in people coming to Connecticut for contraception and other reproductive care. People also visit Connecticut for crisis-pregnancy care. A small number of Massachusetts parents already visit Connecticut each year to surrender their infant under Safe Haven laws because Connecticut's law permits surrender 30 days post-birth; MA's limit is 7 days. If national access to birth control is curbed under the new federal administration, it would likely contribute to higher rates of unintended births and crisis pregnancies. Connecticut is not immune to national reproductive policy changes and is therefore likely to see rising numbers of births from crisis pregnancies, sometimes from out-of-state residents.

Overview: Policies most effective in addressing crisis pregnancies & infant abandonment include affordable & accessible options for contraception, prenatal care, and childcare, yet these are limited in many US states. We should therefore examine three other policies: abandonment boxes, face-to-face surrender, & confidential birth.

Abandonment Boxes/Devices: Policymakers across the US are concerned about perceived or anticipated increases in crisis pregnancies and infant abandonment. While rates of abandonment are hard to track, some cities report 500% increases from 2022 to 2024. In response, new state laws allow the rental of costly, unregulated infant abandonment devices. Also called "baby boxes," they are a high-tech version of the ancient foundling wheel, and a fast-track option to existing Safe Haven laws. They allow parents to deposit their infant into the device, often installed in fire stations or medical centers, and walk away. As articulated in a recent open letter to US Dept Health & Human Services by 100 clinicians & scholars, the devices pose serious legal and medical risks, including a lack of informed consent, risks of malfunction (as they are unregulated), and co-opting roles of Child & Family Services. Two deaths have been associated with these devices over the last 9 months. The devices are not labeled, "You have choices." Instead, training from the device manufacturer *discourages* providers from discussing options with at-risk parents.

Do Abandonment Devices Decrease Unsafe Abandonment?

- *No evidence* supports their efficacy. Analysis from countries with a longer history of abandonment devices finds they do not reduce the rates of unsafe abandonments or infanticides.[i] While the devices may be used, those parents would have otherwise participated in a face-to-face surrender. The devices therefore likely *redirect parents from options that would otherwise safeguard their health & promote informed consent*.

Face-to-face surrender, through CT's existing Safe Haven law, *potentially* supports crisis counseling & informed consent. When parents learn about other options (e.g., temporary placement, kinship care, adoption, & assistance for family preservation), some choose one of these other options. The main reason for parental relinquishment (including to adoption) is due to financial difficulties, and "even just enough for a car seat" would have been enough to keep many families together. Relinquishment causes unabated grief in parents. Face-to-face surrender & boxes have *a major flaw*: only providing *a location* to receive the infant, not *the means* to safely deliver the child. This is despite common knowledge that these parents usually give birth alone, outside a hospital.

Confidential Birth safeguards the health of the parent & infant by permitting a parent to give birth in a hospital without providing their name. It provides crisis counseling & informed consent. No US hospitals are known to have an official confidential birth policy, but it is similar to existing policies (e.g., policies for survivors of violence & sexual assault).

	Confidential Birth	Abandonment Devices ("Baby Boxes")	In-Person Surrender (existing Safe Haven law)
Reduces infant abandonment?	Yes	Possibly, but unlikely	Yes
Ethical approach to a birth in crisis?	Yes	No	No
Safeguards health of the birthing person?	Yes	No	No
Safeguards infant health?	Yes	Only in part	Only in part
Promotes informed consent?	Yes	No	Partially

Key Policy Takeaways: Infant abandonment devices are unregulated, costly, and likely ineffective in reducing infant abandonment. They increase medical and legal risks and likely increase family separation. Confidential birth is a tested, effective, and empathic policy response to crisis pregnancies and infant abandonment. *Connecticut should sponsor a bill in support of confidential birth*. Any policy is dependent on public awareness campaigns so that at-risk populations are aware of their choices.

[i] There will always be a certain number of infanticides; parents who commit infanticide are exceedingly unlikely to have the psychological ability to use an abandonment box (Rohde 2008). In rare circumstances, boxes may be better for parents (e.g., Safe Haven laws in states like Virginia don't provide legal immunity to parents; these parents may prefer anonymity of a box to reduce legal risks & costs, despite increased medical risks).

Connecticut Can Reduce the Rise of Food Allergies, Save Lives, and Save Money

Delaware's New Early Introduction Law Fuses Science and Policy to Reduce Food Allergy Epidemic

Stephanie Leeds, MD, MHS (Assistant Professor of Pediatrics, Yale School of Medicine); Jason Linde MA (Senior Vice President, Advocacy, FARE); Tricia Donovan; Helen Jaffe. Legislative Lead: Robin Comey, State Representative, 102nd Assembly District.

The Problem

According to 2023 census data and research published in 2018 and 2019, more than 367,000 Connecticut residents have potentially life-threatening food allergies—making the state's food allergy population larger than the combined sizes of Bridgeport, Waterbury, and Danbury. Furthermore, the state's food allergy population for children 18 and under is nearly 55,000, a size larger than Stratford.

Life-threatening food allergies are on the rise as the Centers for Disease Control and Prevention (CDC) found that over the past 20 years, the rates of children with food allergies has grown by 50%; for children with a peanut or tree nut allergy, it has tripled. Life-threatening food allergies and the risk of fatal anaphylaxis are growing at an even faster rate among African-American, Latino, and Asian-American children. The CDC has also found that food allergies impact nearly 8% of all children. Worse yet, a 2021 Northwestern study revealed that the adult onset of food allergies is a very real phenomenon as there are now more adults allergic to peanuts than children.

While food allergies are on the rise nationally, a 2020 study found that children on Medicaid were less than one-tenth as likely as children on private health insurance to be diagnosed with a food allergy. This is especially troubling in Connecticut as the Kaiser Family Foundation found in 2023 that approximately 37.7% of the state's children are on Medicaid/CHIP.

Food allergies have a profound economic impact—costing the 2013 American economy more than $25 billion per year, equal to $33 billion in CPI-adjusted dollars today—and often harm those who can least afford it. For those with a peanut allergy, which is generally a lifetime disease, a 2022 study found that the average cost is about $7,261 per individual per year from ages 1 to 18.

Finally, there is also a tremendous healthcare cost: Every ten seconds in America, a food allergic individual visits the emergency department and, sadly, food allergy fatalities (especially to peanut) are all too common striking down promising lives—whether it was an Alvin Ailey trained dancer or, most recently, a young college student.

The Rise of Early Introduction to Prevent Future Food Allergies

But it doesn't have to be this way. For years, the American Academy of Pediatrics recommended against feeding allergenic foods like peanuts to children until they were three years old. Yet, that guidance was overturned and reversed following the historic 2015 Learning Early About Peanut Allergy (LEAP), which found that the early consumption of safe-to-consume peanut products by infants reduced the risk of developing a peanut allergy by 87%. Similar findings were replicated with egg by the 2019 Enquiring About Tolerance (EAT).

It was clear from these findings that the early introduction of known allergens provokes a response in the microbiome and builds resistance. It is why, for example, Israel has almost no peanut allergies because infants there are often fed Bamba snacks, which are easy-to-consume puffed peanut treats.

Since those studies were published, the American Academy of Pediatrics along with numerous organizations and government bodies including the National Institutes of Health, the American College of Allergy, Asthma, and Immunology and the American Academy of Allergy, Asthma and Immunology (AAAAI) have embraced early introduction as an evidence-based method of reducing food allergy.

In December of 2020, the United States Department of Agriculture (USDA) and the United States Department of Health and Human Services (HHS) for the first time ever in its Dietary Guidelines for Americans, 2020-2025 called specifically for the introduction of "potentially allergenic foods", and emphasized that peanut-containing foods should be introduced between four to six months of age for infants at a high risk for developing a peanut allergy.

While the science was clear—that the early introduction of safe-to-consume peanut and egg products to infants starting at four to six months of age reduced the rise of food allergies—the implementation of that guidance was incredibly difficult.

Early Introduction Challenges for Pediatricians and Parents Alike

A 2020 study demonstrated the challenge of implementing widespread adherence to the new early introduction recommendations: 93% of pediatricians were aware of the importance of sharing this information with parents and caretakers but only 29% were doing so. The whopping drop-off was due to a variety of factors, with "not enough time for the pediatrician to share this information with parents" as the leading cause of non-compliance.

Parents, especially first-timers, faced similar challenges to doing it on their own. They were overwhelmed and there was no clear product to use or simple process to follow to ensure their child would not develop a peanut or egg allergy later in life.

Delaware's New Law Solves the Early Introduction Riddle

For two years, FARE, the nation's largest food allergy patient advocacy organization, worked closely with Delaware State Representative Kim Williams (D-19) as her historic early introduction bill, HB 274, was introduced, voted on, and ultimately signed into law by Governor Tom Carney on August 29, 2024.

This new law fuses together established science and provides a policy path forward for Delaware to help free its infants and children, regardless of economic background, and their parents and caretakers from the challenges, costs, and pain of managing life-threatening food allergies.

Starting in 2026, the State of Delaware will require Medicaid, State, and private health insurance plans to cover the cost of a safe-to-consume "early peanut introduction supplement" and an "early introduction egg supplement" to every family with no copay. Because food cannot be covered by insurance, adherence to insurer guidelines was ensured by creating early-introduction categories similar to those used by non-food consumables like prenatal vitamins.

The coverage timeframe is only from four months of age to one year as per early introduction guidelines, and will cost $80 per child—but the law will save the state $94.30 in year one, and $210 every year thereafter. The cost savings is one of the reasons why Delaware's private insurers were not opposed to HB 274.

Now, we would like to work with the Connecticut legislature and introduce a similar bill to change the future for thousands of unborn children while saving the state and insurers millions of dollars.

Policy Brief

Energy Drink Regulation

Protecting Youth from Dangerous Products

By: Fran Fleming-Milici, PhD, UConn Rudd Center for Food Policy and Health

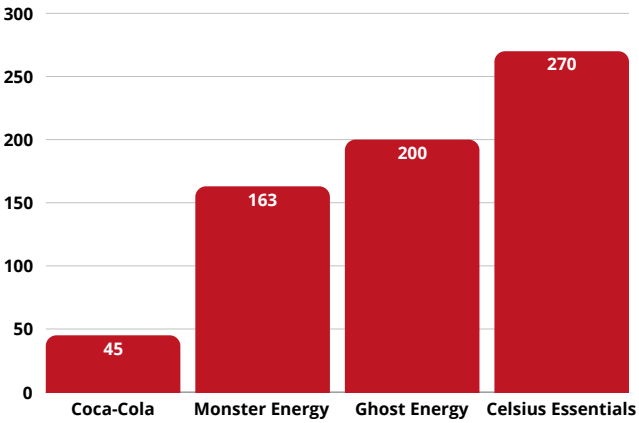
Background

The American Academy of Pediatrics (AAP) concluded that "caffeine and other stimulant substances contained in energy drinks have no place in the diet of children and adolescents." [1] Aggressive marketing drives consumption and sales among young people, and a growing body of literature supports the need for energy drink regulations to protect children and teens.

ENERGY DRINK SALES AND CONSUMPTION

- Energy drinks are readily accessible to children. They account for approximately one-third of all packaged drinks sold at US convenience stores, where they are stocked alongside sports drinks and sodas. [2]
- Energy drink brands and sales are growing rapidly. In the US, the market size of energy drinks grew 13.5% per year on average from 2018 to 2023, and continued growth is expected. [3]
- Children and young adults (13-24 years) have the highest prevalence of energy drink consumption. Almost one-third of adolescents (12-17 years) drink them regularly. [4,5]
- More than three-quarters of parents support limiting youth access to energy drinks with age restrictions for purchase.[6] Yet, a child of any age can purchase energy drinks in Connecticut.

HEALTH RISKS OF ENERGY DRINKS



Milligrams of caffeine in a 16-ounce can of popular drinks.

- Children under age 12 should have no caffeine. For teens, a single energy drink **provides up to three times the maximum daily limit of caffeine** experts recommend (100 mg). [7]
- Unlike coffee and other caffeinated drinks, energy drinks also contain ingredients that act as stimulants, such as taurine. These interact with caffeine and can exacerbate negative effects. [8]
- Most energy drinks contain high levels of added sugar.
- Consumption can lead to anxiety, suicidal ideation, low academic performance, alcohol/tobacco/marijuana use, and **dangerous health outcomes**, including heart attacks, seizures, and diabetes. [8]
- Children face **increased risk for caffeine toxicity** due to their small body size and lack of tolerance to caffeine. [8]

ENERGY DRINK MARKETING TO YOUTH

Companies continue to aggressively market these products to teens. Recent marketing campaigns target children and portray products as healthy and important for success in sports, including:

- **Promotion via social media** with marketing disguised as entertaining content or advice from trusted influencers and athletes they admire.[9]
- Collaborations with popular **children's food and candy brands** that appeal to pre-adolescent children. For example, candy brands such as Swedish Fish, Sour Patch Kids, Warheads, and Skittles appear on the front-of-package and in-store displays of energy drink brands.[9]
- Sales of **pre-workout products** with promises to boost athletic performance. Of note, a number of deaths have occurred among young people who consumed energy drinks before and/or after exercising. [10]

Candy | Energy drink

Soda and candy | Energy drink

POLICY RECOMMENDATION

Legislation should prohibit the sale of energy drinks to children under the age of 16 in Connecticut. This would signal the state's commitment to protecting the health and well-being of children. This policy is:

- Necessary. It would reduce youth access to products that pose a danger to developing brains and bodies.
- Widely supported by parents and US public health and medical organizations.
- Feasible. Retail outlets are already legally required to verify the age of customers purchasing tobacco and alcohol. Specialty retailer GNC has already set an 18+ age restriction to purchase energy drinks.

Conclusion

Evidence of potential toxicity and a wide range of other negative consequences associated with consuming energy drinks, coupled with aggressive youth-targeted marketing, justify the need for measures to reduce consumption among children and teens. While people with underlying health conditions may be more susceptible to the adverse effects of energy drink consumption, these products can also cause cardiac arrest in young, healthy people.[8] Further, as **the vast majority of energy drink brands state on the product label that the drink is intended for healthy adults 18 years of age or older**, such a policy would support energy drink makers' efforts to ensure products are not consumed by children.

Learn more about the Rudd Center's research on food marketing:

uconnruddcenter.org/foodmarketing

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UCONN RUDD CENTER FOR FOOD POLICY AND HEALTH

Caring for Youth Behavioral Health

Preserving Connecticut's Crisis System

As rates of youth suicide and mental health needs rise in Connecticut, community-based youth crisis services **provide lifesaving support** and are **essential for a well-functioning behavioral health system**. Connecticut has four best-in-class crisis services for youth that operate as a comprehensive system to improve behavioral health.

Investing in crisis services saves $$ and improves care:

- ✓ prevents escalation of mental health and substance use concerns
- ✓ helps youth avoid more costly and unnecessary care
- ✓ links families to services and supports statewide
- ✓ improves long-term outcomes

CT MOBILE CRISIS USERS are up to **25% LESS LIKELY** to use **EMERGENCY DEPARTMENTS**

A school-based program using **CT MOBILE CRISIS** demonstrates a **25% REDUCTION IN COURT REFERRALS**

Connecticut's Nationally-Recognized Youth Crisis System

Someone to Talk To ---> Someone to Respond ---> A Safe Place to Be

988/211 Crisis Line

186,000+ calls per year

Resources Needed:

$1.3m/year in new money ($2.4m total) in upcoming biennium

Mobile Crisis Intervention Services

11,346 episodes per year

Resources Needed:

$8m/year in new funds to replace ARPA ($23m/year total)

Increase Medicaid + commercial insurance rates

Urgent Crisis Centers

1,119 episodes per year

Resources Needed:

$13.6m/year to replace ARPA

Finalized Medicaid payment model + rate

Subacute Crisis Stabilization Centers

new in 2024

Resources Needed:

$5.8m/year in new money to replace ARPA

Additional $5.8m/year (per original plan)

Part or all of these services are currently supported with American Rescue Plan Act (ARPA) funds that are set to expire before the next state biennium.

View data and recommendations for action in the full Policy Brief at www.chdi.org

Without sustained state support, Connecticut's youth crisis services will be significantly compromised or could close altogether, reversing years of progress. Consequences of inaction could include:

ACTION IS NEEDED TO SUSTAIN LIFESAVING SERVICES

- **Access to youth behavioral health services will be greatly reduced**, despite high need
- Mobile Crisis services may be **unable to maintain 24/7/365** capacity
- Youth with behavioral health needs and **at risk of suicide** will be at higher clinical risk
- **More youth will present to hospital emergency departments**, leading to overcrowding, negative care experiences, and poor outcomes
- Connecticut will be **out of compliance** with federal guidance and national best practices

Recommendations

1. **Identify sustainable funding** that supports best practice implementation of 988, Mobile Crisis, Urgent Crisis Centers, and Sub-Acute Crisis Stabilization Centers
2. **Invest annually in marketing and advertising with an equity lens** and focus on promoting 988/211 as a central access point to reduce confusion *($300k/year)*
3. **Invest in training, data collection, reporting, and quality improvement activities** to ensure crisis services are working as intended to improve outcomes. *($1 million in each year of the upcoming biennium)*

View our full Policy Brief for more data, funding details, and recommendations for action:

www.chdi.org/CTcrisis

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Child Health and Development Institute · 2-1-1 Connecticut · United Way of Connecticut · The Village Where real change happens · Wellmore Behavioral Health Wellness for a lifetime

Improving Connecticut Child Care Providers' Fractured Technology Landscape

The Connecticut Office of Early Childhood surveyed Connecticut child care providers to gauge their use of and comfort with technology in their business. Findings suggest that many child care providers lack adequate access to properly functioning business devices and require more technology training/support.

The Study

- The Connecticut Office of Early Childhood (OEC) wanted to hear from child care providers about their access to and comfort with technology.
- In Spring 2023, in partnership with 211 Child Care, the Women's Business Development Council, and the Staffed Family Child Care Networks, the OEC disseminated a survey to child care providers in Connecticut.
- 1,142 child care providers (62% family child care business owners, 36% child care center or group home providers) responded.
- Notable study limitations include the nature of its marketing and administration, which was done online—meaning child care providers with lower levels of access to/comfort with technology may be underrepresented in our data.

Key Findings

- Child care providers in Connecticut need properly functioning technological devices for business use.
  - **39% of providers reported not having enough functioning computers**
  - **46% of providers had at least one issue with the condition of their technology**
- Family child care business owners in particular need technological devices dedicated to business use.
- Child care providers in Connecticut could also benefit from access to technology training and support.

Call to Action

- CT child care providers need free and accessible technical support services (e.g., support available in multiple languages and outside of "traditional" working hours).
- Further research is warranted to better understand child care providers' technology needs and preferences, and to understand what policy action steps would be most impactful (e.g., grants for new devices).

CONNECTICUT Early Childhood

Research conducted by the OEC-UConn Partnership.
Contact: Samantha.Lawrence@uconn.edu

UCONN SCHOOL OF SOCIAL WORK

Child Health and Development Institute

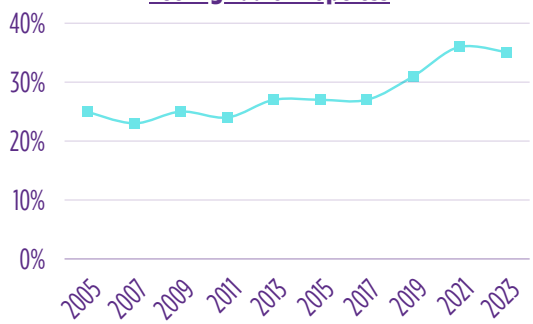
Saving Children's Behavioral Health Services: The Essential Role of Medicaid Rates in Safeguarding the System

Behavioral health needs among youth in Connecticut are rising. Families seeking care regularly encounter long wait lists and delays in accessing services due to staffing shortages.

Connecticut's behavioral health system has been nationally recognized for its continuum of care and highly trained staff. However, high burnout, low salaries, and the resulting workforce challenges are eroding the system's infrastructure and reducing service access, especially for the most vulnerable.

The state's own analyses conducted per legislative mandate have found that Connecticut's Medicaid reimbursement rates for behavioral health are dramatically lower than both comparable states and rates of commercial insurers within Connecticut.

Connecticut High School Students Reporting Feeling Sad or Hopeless



Increasing Medicaid rates will help address workforce shortages and increase access to care.

Research on the Children's Behavioral Health Workforce in Connecticut

In 2024 the Child Health and Development Institute (CHDI) surveyed licensed behavioral health professionals in Connecticut (psychologists, professional counselors, social workers, marriage and family therapists, addiction counselors, and psychiatrists). Over 2,800 currently licensed professionals responded (of the 23,639 invited). The survey was designed to increase the state's understanding of providers' experiences working in Connecticut. Relevant to Medicaid reimbursement, the following questions were addressed in the analysis:

(1) Does acceptance of public insurance (i.e., Medicaid) vary by setting?
(2) How do children's needs differ as reported by providers accepting Medicaid compared to those only serving children with commercial insurance or paying out-of-pocket?
(3) Are there differences in salaries or job satisfaction among the workforce serving children with Medicaid compared to the workforce serving children with commercial insurance or paying out-of-pocket?

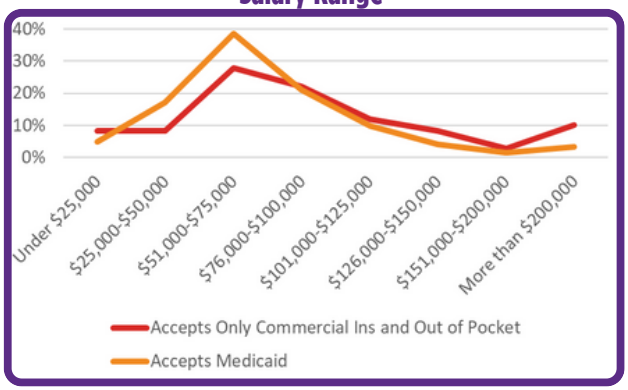
The analysis compared responses from the workforce accepting Medicaid with the workforce accepting only commercial insurance or out-of-pocket payment. The findings highlighted the strong role that providers who accept Medicaid insurance offer in serving children and in particular children with high needs (professionals accepting Medicaid were more likely to serve children, more likely to work in a nonprofit clinic or hospital setting, and more likely to serve children who had more significant needs related to social and economic conditions and exposure to trauma). The findings also raised concerns regarding the impact of reimbursement rates on salaries, and in turn, recruitment and retention of providers in settings that accept Medicaid. Professionals accepting Medicaid were more likely to make less than $75,000 than their those who did not, and scored higher on average on a measure of staff intention to leave their employer (Turnover Intention Scale).

Findings

Providers who accept Medicaid payments are more likely than those who don't to..

- ✓ Serve children
- ✓ Work in nonprofit clinics or hospital settings
- ✓ Serve populations with higher needs, including social and economic challenges and trauma exposure.
- ⚠ Work for lower salaries
- ⚠ Dream of a new job

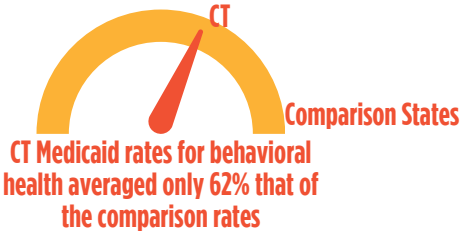
Salary Range



Child Health and Development Institute

The Role of Reimbursement Rates in Access to Care

The state legislature previously mandated review of Medicaid rates and their parity with commercial insurance as well as parity between rates for behavioral and medical services. **The results were clear that Connecticut's Medicaid reimbursement rates are lower than comparable states' rates, and behavioral health rates are the lowest.**



- Department of Social Services' Phase 1 Medicaid rate study found that nearly all of Connecticut's behavioral health billing codes had rates lower than those of the other states, and an estimated annual shortfall of $42 million to meet the 5 state comparison rates (considerably more than the $7 million allocated following the release of the study).
- The Office of Health Strategy's report on parity found that Medicaid payments for behavioral health services were significantly lower than commercial insurance and Medicare, with some services covered at only half the rate of commercial insurers.
- The report further indicated challenges with access to care for Medicaid enrollees, with up to four times as many providers available for those with commercial insurance.
- The State Comptroller Healthcare Cabinet Children's Subcommittee recommended increasing reimbursement rates to both meet parity with rates for medical services, and as a strategy to address unmet behavioral health needs among children.

The findings from CHDI's survey of Connecticut's behavioral health professionals indicate that these low reimbursement rates are placing downward pressure on salaries and in turn increasing burnout and turnover in the settings serving the most vulnerable populations with highest needs.

Nonprofits relying on insufficient reimbursement rates are not able to cover costs and raise salaries to be competitive with other settings which offer more flexibility, smaller caseloads, and less acuity. Prior reports from providers demonstrated significant challenges with recruitment and retention of behavioral health staff among nonprofits in Connecticut (e.g., an average of one third of staff positions were vacant in intermediate level of care settings and nonprofits overall reported an 18% vacancy rate in a recent report by The Alliance). **These staffing challenges in turn result in reduced access to care. The Alliance report found 59% of nonprofits reporting waitlists overall, with waits varying from a few weeks to a few months depending on the level of care**.

This connection between reimbursement rates and access to care mirror the findings from the broader literature and experiences in other states. In an evaluation of factors impacting the behavioral health workforce in Oregon, low reimbursement rates were identified as having increased turnover in the behavioral health field broadly, and in particularly within publicly funded services. Research indicates that higher reimbursement rates have the potential to lead to greater access to services by improving recruitment and retention for settings serving those with Medicaid and by incentivizing additional providers (e.g., those in private practice, etc.) to accept Medicaid insurance.

Recommendation

Connecticut's Medicaid rates for behavioral health services are documented as consistently significantly lower than all available benchmarks (other states, Medicare rates, and commercial insurers). Research has demonstrated that professionals working in settings that are more reliant on Medicaid reimbursement are receiving lower salaries for what is often more challenging work, and are getting burnt out and leaving for less stressful and higher paying opportunities. Children covered by Medicaid are among the states most vulnerable populations with the highest needs.

Connecticut has the opportunity to stabilize the workforce, increase access to critical services, and address the rising behavioral health needs among children in Connecticut. In the upcoming session, the state legislature should increase Medicaid reimbursement rates for children's behavioral health services.

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About CHDI:
The Child Health and Development Institute is a non-profit organization providing a bridge to better and more equitable behavioral health and well-being for children, youth, and families. We collaborate with policymakers, providers, and partners to transform child-serving systems, disseminate evidence-based and best practices, and advance policy solutions that result in better outcomes for children in Connecticut and beyond.

Read the full Strategic Plan for the Children's Behavioral Health Workforce in Connecticut here.

Experiences of Poverty Around the Time of a Birth

Christal Hamilton, Laurel Sariscsany, Jane Waldfogel, and Christopher Wimer

The arrival of a newborn can have significant financial implications for families. While mothers need to take time off from work before and after a birth, only 23% of workers in the United States have access to paid family leave. The costs associated with childbirth, therefore, place increased demand on families' resources at the same time that their incomes decline.

The financial burdens experienced around childbirth can be particularly acute for certain women. Black and Hispanic women have lower incomes pre-birth, are more likely to lose their jobs around a birth, and often lack savings to buffer financial shortfalls. First-time mothers may lack the employment flexibility needed for child-rearing, be more likely to be unfamiliar with public program eligibility criteria, and lack resources from previous births.

Increased financial strain around the time of childbirth can result in many mothers falling into poverty, which can increase the risks of low birthweight, pregnancy and birth complications, and maternal mortality.[1] Poverty around childbirth also has negative consequences for children since infants living in poverty have, on average, lower cognitive development[2], lower school readiness and educational outcomes[3], poorer health[4], and are more likely to have behavioral problems[5]. This situation should be of concern to Connecticut because in 2021, 15% of infants in the state lived in poor households, with 25% and 30% of Black and Hispanic infants living in poverty respectively.

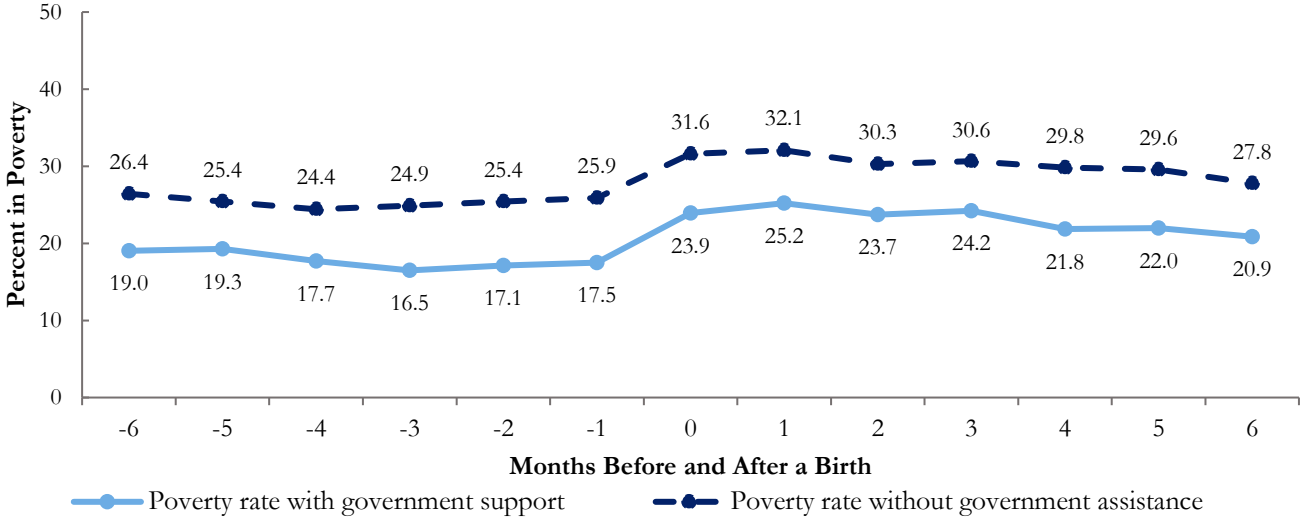
How We Examine Poverty Rates Around the Time of a Birth

We use reference data for 2013–2019 from a large nationally representative survey to examine the poverty status of mothers of newborns in the six months before and after childbirth. We examine poverty rates for mothers overall and for women disaggregated by race and ethnicity. We also assess the extent to which current social supports ease economic losses surrounding the birth of a child.

Key Findings

- Mothers experience substantial increase in poverty after childbirth, the extent of which varies by race and ethnicity.
- Current public programs play a key role in reducing poverty among mothers of newborns, but do not protect mothers—particularly first-time and Black and Hispanic mothers—from falling into poverty around childbirth.
- For first-time mothers, the poverty rate in the birth month increases by 79% and remains well above pre-childbirth levels by the sixth month after childbirth even after accounting for government support.
- Black and Hispanic mothers have consistently higher poverty rates than non-Hispanic White mothers around the time of a birth.
- Approximately 40% of Black and Hispanic mothers experience poverty around a birth.

Figure 1: Poverty rates significantly increase after childbirth



Notes: Graph shows the poverty rate among all mothers of newborns when including and excluding income from government support

Policy Recommendations

- While Connecticut has a paid family leave policy, other programs can be amended to ensure mothers with recent births have enough income to meet basic needs in the first few months post-birth. For example, WIC benefit amounts could be increased.
- Barriers limiting access to and participation in social programs, including administrative burden, for low-income and minority groups should be removed.
- Connecticut can implement a birth grant—a one-time payment around childbirth to assist with the costs of having a child—which is provided to mothers in several developed countries to reduce the financial strain of childbirth.
- Implementing a state monthly fully refundable Child Tax Credit that provides support to low-income families, can provide needed funds to Connecticut mothers within the first few months after childbirth and thereafter. This policy will also provide needed benefits to children from low-income and minority backgrounds, who are the most likely to be excluded from the current annual federal Child Tax Credit because of their parents' low income.

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Incorporating Eligible Participant Voices into the Connecticut Supplemental Nutrition Assistance Program

Emily Loveland, PhD MSW – California State University, San Bernardino

Food insecurity is on the rise in the United States, and the Supplemental Nutrition Assistance Program (SNAP) is a critical federal anti-hunger program that protects against this social issue. In Connecticut, it is estimated that 87% of individuals eligible for SNAP participate in the program.

As part of a 2023 research study examining the Connecticut Supplemental Nutrition Assistance Program, researchers conducted in-depth semi-structured interviews with individuals who were eligible for but not using CT SNAP benefits, in order to identify barriers to participation. Barriers these interviews uncovered included excessive verification requirements, the phone and computer system, and interactions with eligibility staff members.

Connecticut legislators can help address gaps to SNAP participation by implementing two key recommendations:

Develop a hunger-free/SNAP client community advisory board consisting of individuals who experience food insecurity and/or participate in SNAP as well as policymakers, administrative officials and representatives from local and state organizations

States like California, Oregon, Washington, and Maryland have developed hunger-free advisory boards that include representatives from the community to help shape policy solutions. Oregon and Washington have specific SNAP Client Advisory Councils which recruit and pay individuals with lived experience of SNAP participation to participate and inform policy and programmatic changes to improve SNAP in their state. This is like the Connecticut 2Gen Advisory Board which aims to incorporate parent perspectives into state government in improving economic policies. Connecticut recently passed legislation that appointed a Food and Nutrition Policy Analyst to the Council on Women, Children, Seniors and Equitable Access for All who could lead the charge on a SNAP Client/Hunger-Free Council with the collaboration of the Connecticut Food Policy Council. It is recommended that CT develop a SNAP Client Advisory Board and recruit people with lived experience of SNAP participation who are paid for their time and participation in council meetings.

"The SNAP benefits could help because then I don't have to go to the soup kitchens… The last time that I spoke to them [DSS] was this morning. They told me they need a letter from the last place that I worked… which was over a month and a half ago. The company has sent them the paperwork they need, and they're still not trying to help." - *Bobby*

Expand Special Act 24-4 (AN ACT CONCERNING THE EFFICIENCY OF THE DEPARTMENT OF SOCIAL SERVICES IN DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE AND RESPONDING TO REQUESTS FOR INFORMATION OR ASSISTANCE) to include efficiency regarding SNAP

Special Act 24-4 was approved May 30, 2024 to study the efficiency of the Connecticut Department of Social Services (DSS) in determining eligibility for Medical Assistance and responding to requests for information or assistance. This is a valuable effort to examine standards of promptness for medical assistance and telephone wait times for the DSS Benefit Center and provide recommendations on improving DSS efficiency in processing work related to medical assistance. This improvement is particularly critical as telephone wait times have been a documented issue with DSS for over a decade, rising and falling as administrators have implemented varying solutions.

This research should intentionally incorporate SNAP eligibility in its study design. In 2012, Connecticut was sued for their untimely processing of SNAP benefits. DSS spent nearly a decade tracking this data for the CT legislature, working to improve timeframes. However, the current qualitative research indicates that eligible non-participants are still struggling to obtain benefits even though processing times have improved. It is possible that SNAP applications are being denied more hastily to comply with SNAP processing standards. As DSS processes multiple programs and many people who contact DSS are multi-program recipients, it would benefit the legislature to examine the Department holistically rather than siloing the examination by program. Additionally, the research study should critically examine both qualitative and quantitative indicators for success rather than simply relying on processing timelines and call wait times. By robustly examining both Medical Assistance and SNAP in this study using multiple indicators for success, recommendations can address efficiency across all programs DSS offers and highlight holistic and effective ways to improve participant experiences with the Connecticut Department of Social Services so that it may meet the program objective: serving the people of Connecticut.

> "There is no option after you press "1" that says push this to go speak to someone. You got to play a guessing game to try and figure out how to get to these people… And then they say, oh, there's a five hour wait. These people need to eat now!" - *Virgina*

As rates of food insecurity rise and DSS' workload along with it, administrators and caseworkers may feel pressured to comply with processing timeline. Yet it is critical that the Department adheres to both quality and quantity standards. This is not an easy task to achieve, but incorporating the voices of individuals with the lived experience of food insecurity and SNAP use can help bring light to some aspects of the program that legislators and administrators may not necessarily be aware of. By developing a SNAP Client Advisory Board and including SNAP in the Medicaid monitoring efficiency study, DSS can better meet their mission to provide person-centered programs and services to enhance the well-being of individuals, families and communities.

Contact Me: Emily Loveland, PhD MSW; emily.loveland@csusb.edu

Food As Medicine
as a CT Policy Priority

PREVENTION RESEARCH CENTERS

At a Glance

Produce prescription programs are an effective and cost-saving method to improve health and food security for Connecticut residents. Local studies show feasibility and client satisfaction. Policy changes such as a Medicaid 1115 waiver would significantly support scale-up, positively impact population health, allow long-term sustainability, and save taxpayer dollars.

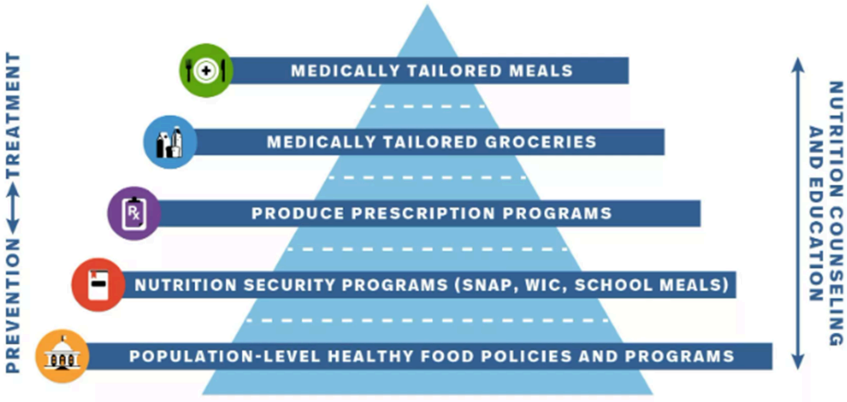
Chronic Disease & Food Insecurity

Nutrition-related chronic diseases are leading causes of death and disability in Connecticut. Nearly 11% of adults have been diagnosed with diabetes, with 17,000 new cases reported annually. In 2021, heart disease accounted for 20% of deaths and stroke accounted for an additional 4%.

At the same time, food insecurity has worsened since the COVID-19 pandemic and the elimination of federal relief programs. Currently, 18% of residents are food insecure, reporting they could not afford enough food to feed themselves or their families.

Food As Medicine

> Food As Medicine can be defined as food-based nutritional interventions integrated within health systems to treat or prevent disease and advance health equity.
>
> Dariush Mozaffarian, MD, DrPH



Tufts Food Is Medicine Institute (2024)

Produce prescription programs (PRx) allow healthcare providers to prescribe produce to patients who meet specific criteria like food insecurity and nutrition-related diseases.

Produce prescription programs (PRx) have been shown to

- Increase access to healthy foods, health care, and nutrition knowledge
- Improve diet quality, especially fruit and vegetable consumption
- Improve health outcomes like diabetes control and cardiovascular disease
- Save on healthcare costs (like Medicaid spending)

American Diabetes Association (2024), Connecticut Department of Public Health (2023), Data Haven (2024), Hager et al. Circulation (2023), Muleta et al. Ped Res (2023), Wang et al. JAHA (2023),

Produce Prescriptions in Connecticut

The Yale-Griffin Prevention Research Center partners with community and healthcare organizations on produce prescription programs in CT.

Program Name	Population	PRx type	Location	Partners
Produce4Life	Medicaid-eligible, type 2 diabetes, Hispanic	Fresh Connect card, nutrition education, community health worker - $40/mo for 6 months	Greater Hartford region	Hispanic Health Council, Hartford Hospital, Wholesome Wave, Emory University
Food4Moms	Low income, pregnant Latinas	Fresh Connect card or delivery, nutrition education - $100/mo for 10 months	Greater Hartford Region	Wholesome Wave, Hispanic Health Council, About Fresh
Griffin Hospital PRx	Medicaid eligible, pre-diabetes or diabetes	Fresh Connect card, nutrition education - $40/mo for 1 person and $5 per additional person for 6 month	Lower Naugatuck Valley	Griffin Faculty Practices, Griffin Hospital, About Fresh

Recommendations from Community Co-Design

- Provide flexibility in purchase options (stores, delivery, electronic benefit)
- Link nutrition education to PRx (e.g., SNAP-ED, EFNEP)
- Engage Community Health Workers in a central role
- Increase benefits for larger households
- Support use of all federally funded nutrition programs (SNAP, WIC, School Meals etc.)

Equitable and participatory community input is key to designing an effective Medicaid 1115 Waiver and corresponding state program.

Policy Implications

- Supporting the application and implementation of a Medicaid 1115 waiver to support Produce Prescriptions for Medicaid beneficiaries with nutrition-related chronic disease
- Addressing barriers to participation in the WIC Farmers Market Nutrition Program

Funding Acknowledgement. This work was supported in part by the American Heart Association Grant # 24FIM1264456/Yale School of Public Health/2024 and the Gus Schumacher Nutrition Incentive Program USDA # 2022, 7042438552

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To learn more, visit:
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Two Connecticut State Interventions to Address Pandemic Effects on K-12 Students

Eric J. Brunner
Alexandra J. Lamb
Stephen L. Ross
University of Connecticut

K-12 students in Connecticut experienced large learning losses leading up to and during the 2020-21 school year following the onset of the Covid-19 pandemic. Further, like other states, schools in Connecticut experienced a dramatic increase in chronic absenteeism that has persisted into the present. Among many other efforts, the Connecticut State Department of Education (CSDE) launched two initiatives to support students, families, and schools in pandemic recovery: the Learner Engagement and Attendance (LEAP) program and the High Dosage Tutoring (HDT) program. This policy brief describes the evaluation of these two programs. Both evaluations were funded by the Center for Connecticut Education Research Collaboration (CCERC), a partnership between CSDE, The University of Connecticut, and other institutions of higher education across the state.

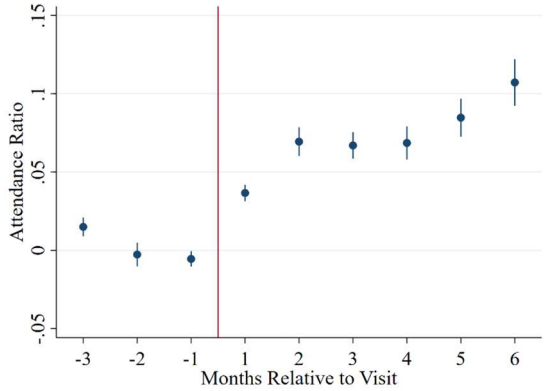
During the pandemic, the federal government provided an unprecedented amount of funds to states and districts to support both pandemic era schooling and pandemic recovery. These funding sources included the Elementary and Secondary School Emergency Relief (ESSER) program and the American Rescue Plan Act (ARPA). Together, such COVID relief funds provided the funding for the two programs described here, LEAP and HDT.

Learner Engagement and Attendance Program

To address the concerning rates of chronic absenteeism, the State of Connecticut launched the LEAP program. This program was designed to support school districts in conducting home visits with students identified as chronically absent in a targeted sample of 15 large and mostly urban school districts. LEAP began in the summer of 2021 and continued into the 2021-22 school year. For the 2022-23 school year and beyond, the State of Connecticut expanded the LEAP program to reach more students in the 15 districts. In 2022-23, an additional 12,000 students received home visits and school follow-up in addition to the approximately 8,500 students who received home visits in 2021-22.

To evaluate the LEAP program, we estimated event studies that compared student attendance rates prior to receiving a LEAP home visit to their attendance rates after receiving the home visit, where students who had not yet been treated provide a control group. Figure 1 below presents effects of the LEAP program on attendance for the 2022-23 school year.

Figure 1. Impact of LEAP Program on Attendance

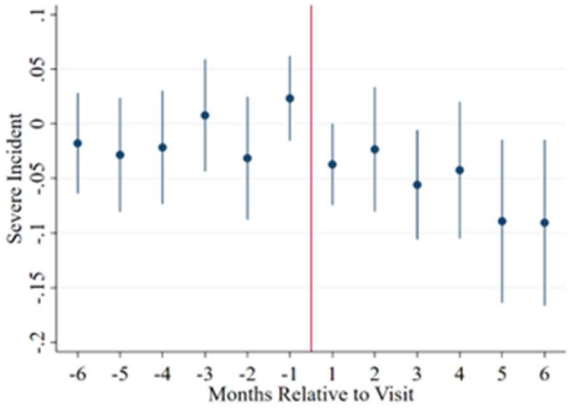


Attendance rates are relatively stable leading up to treatment (home visit) but jump up shortly after a visit. Six months after treatment attendance rates rise by 10 percentage points relative to attendance rates among students not yet treated by LEAP. These attendance improvements were observed at all grade levels but are largest for students in grades 9-12 with attendance rates rising by nearly 15 percentage points 6 months after the first LEAP visit.

Finally, while we did not find effects of LEAP on Smarter Balanced test scores, we do find substantial reductions in the frequency of disciplinary incidents among treated students. Figure 2 presents a similar event study except the outcome is whether a student was recorded as having a severe disciplinary incident. Prior to the home visit, there is no evidence

of any trends in disciplinary incidents among students treated by LEAP relative to not yet treated students. After the intervention, Figure 2 shows a reduction in the likelihood of a disciplinary incident over time with the effect peaking at approximately a 10-percentage point reduction in the likelihood of an incident 5-6 months after treatment.

Figure 2. Impact of LEAP on Disciplinary Incidents



High Dosage Tutoring (HDT)

Many districts in Connecticut used COVID relief funds to build tutoring programs in their schools. In 2023-24, CSDE offered additional grant funds to school districts to build robust tutoring programs with more explicit, research-based parameters for implementation. CSDE awarded funds to 43 school districts, including several charter schools and magnet school systems, to implement HDT in mathematics for 6th - 9th grade students. Under HDT, almost 3,700 students received high intensity tutoring in 2023-24.

To examine the impact of the HDT program, we compared 6th – 8th grade Smarter Balanced test scores in the year prior to tutoring (2022-23) to test scores after receiving tutoring (2023-24). Specifically, we compare how student achievement changed between 2022-23 and 2023-24 among students that were treated by the HDT program during the 2023-24 school year (treatment group), to the change in student achievement across the same years among students that were not treated by the HDT program (control group). We augment this difference-in-differences model by matching treatment and control samples to be very similar on race, ethnicity, free and reduced-price lunch eligibility, whether an English learner, whether the student has one or more disabilities, 2022-23 attendance rates and discipline incidents in 2022-23.

Table 1 presents treatment effect estimates for the probability that a student's performance on the math exam is at level 3 or higher (proficient). The estimated coefficient on the variable "Treated Student" captures the difference in student pre-treatment achievement between students that participated in the HDT program and those that did not. For example, the results in column 1 imply that prior to treatment, students that participated in the HDT program were 38 percentage points less likely to meet math proficiency standards. The estimated coefficient on the variable "Treated Student Post Treatment" captures the impact of participation in the HDT program. For students participating in HDT, there was a 7.5 percentage point increase in math proficiency rates, as well as 6.5% of a standard deviation increase in test scores. Notably, these estimates are very stable as we add controls for student outcomes in 2021-22, suggesting that effects are unlikely to be due to students being selected into the program based on unobserved factors that might have independently led to student test score improvements.

Table 1. HDT Program and Math Proficiency

	(1)	(2)	(3)	(4)
Treated Student	-0.377***	-0.182***	-0.182***	
	(0.0283)	(0.0227)	(0.0227)	
Treated Student Post Treatment	0.0758***	0.0754***	0.0755***	0.0755***
	(0.0174)	(0.0197)	(0.0197)	(0.0197)
Observations	66,298	66,298	66,298	66,298
2021 Math Test	No	Yes	Yes	Yes
All Controls	No	No	Yes	Yes
Student Fixed Effects	No	No	No	Yes

Taken together, these two programs, LEAP and HDT, offer promising effects on student outcomes, and thus are strong candidates for continued funding. As these ongoing evaluations demonstrate, targeted programs with consistent and fully funded implementations are helping Connecticut students recover from the pandemic.

SUPPORTING THE WHOLE CHILD IN CT:
OPPORTUNITIES FOR STRENGTHENING EDUCATIONAL POLICIES

A CT WSCC Brief by Sandra M. Chafouleas, Kathleen M. Williamson, Marlene B. Schwartz & Jessica B. Koslouski

Legislators can strengthen the integration and coordination of whole child policies by (1) enhancing legislative capacity for action in whole child efforts & (2) expanding the capacity of school wellness teams.

Whole Child Education in Connecticut

A **whole child lens** in education is not a new concept.[1] In Connecticut, this lens, however, has come into sharper focus in the aftermath of systemic disruptions such as the COVID-19 pandemic and negative impacts on children's overall well-being. For example, the percent of high school students who report feeling sad or hopeless is higher than before the pandemic,[2] while the population of High Needs students in public schools (i.e., those students with a disability, who are learning English, or eligible for free or reduced-price meals) continues to rise.[3]

The recently adopted Connecticut Comprehensive Plan for Education 2023-2028 includes four strategic priorities.[4] One priority is to provide learning environments that "address the academic and non-academic needs of the whole child". These efforts are closely aligned with the pursuits of the Connecticut General Assembly: Prior to the pandemic, Connecticut's statutes and regulations to address student health and well-being were among the strongest in the country,[5] and since 2020, there have been at least 60 legislative acts passed in support of the whole child, with topics ranging from social emotional learning standards to participation in school meals to family resource centers.

The CDC's Whole School, Whole Community, Whole Child Model [7]

There is much to celebrate in Connecticut in whole child efforts, yet stronger ***integration and coordination*** of these education-centered policies, processes, and practices is needed to maximize impact. Such efforts can reduce inefficiencies, increase communication, and reveal gaps in services.[6]

The CDC's **Whole School, Whole Community, Whole Child (WSCC)** model offers one framework to aid integration and coordination of these efforts. It is a student-centered, ecologically oriented, and contextually flexible model that considers a range of school and community supports that influence student health and learning.[7]

To facilitate whole child work in school districts across the state, the **Connecticut WSCC Partnership** has used the WSCC model in development and dissemination of a suite of freely accessible, evidence-informed tools. The team also provides professional development and technical assistance to build district knowledge and capacity to select, implement, and sustain whole child initiatives. This work is facilitated through current funding from the CDC and rooted in nearly a decade of collaborative research on whole child policies and practices at UConn.[1, 8-9]

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Recommendations for Legislators

To facilitate stronger integration and coordination of whole child policies in education, we recommend a **two-fold approach** to members of the Connecticut General Assembly. The first approach focuses on opportunities for the legislature to enhance their own integration and coordination of policies relevant to the whole child. The second relates to expanding the capacity of federally-mandated school wellness teams in public school districts. In both approaches, de-implementation[10] (discontinuing, reducing, re-thinking, or replacing) takes a prominent role.

Enhance Legislative Capacity for Action in Whole Child Efforts

Legislative efforts to support the whole child often intersect and overlap, spanning multiple committees and impacting the efforts of diverse key groups. To make informed decisions about potential opportunities for new action, it is critical to understand current statutes and regulations related to or adjacent to a particular topic. This requires a continuous improvement process such as:

1. Using the WSCC model domains to map relevant or adjacent policies
2. Reviewing the map to identify areas of strength as well as areas of overlap or gap
3. Evaluating opportunities to de-implement policies that are duplicative, outdated, ineffective, or unsustainable
4. Identifying potential directions for action

Possible action: Consider mechanisms to simplify the whole child policy search/mapping process, and regularly engage strategic planning (particularly across the Education and Children Committees).

> **"[Conducting a Strengths, Weaknesses, Opportunities, and Tensions (SWOT) analysis] built a basic foundation to learn about this opportunity to improve what my district does"** – Member of the Connecticut Association of Administrators of Health and Physical Education (CAAPHE)

Expand Capacity of School Wellness Teams

Districts that participate in the federal school meals programs must have a local school wellness policy, maintain a wellness committee that meets four times a year, and assess implementation of that policy every three years. These federal regulations should be considered a minimum standard for the school nutrition and physical activity environments in districts. They also can be used as an opportunity to support the State Board of Education's strategic priority of promoting whole child wellness through actions such as:

> **"I'm always only focused on food service in my area and how it helps with the district's health and wellness goals and the wellness policy, but I liked seeing how everything else kind of fit into that. So not just food nutrition, but also physical wellness, employee wellness, all those other pieces."** – Food Service Director

1. Broadening the definition of wellness to include the whole child (e.g., add social, emotional, and behavioral wellness)
2. Designating district and school coordinators of the whole child wellness (or WSCC) teams, personnel who can provide oversight over coordination and integration efforts
3. Expanding upon who sits on existing wellness teams to include diverse representation across WSCC domains

Possible action: Evaluate legislative opportunity to (1) expand the scope of existing wellness teams to include a whole child focus and (2) strengthen district capacity to integrate and coordinate their policies and practices.

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Policy Brief

Universal Free School Meals

Protecting Our Investment in Public Education

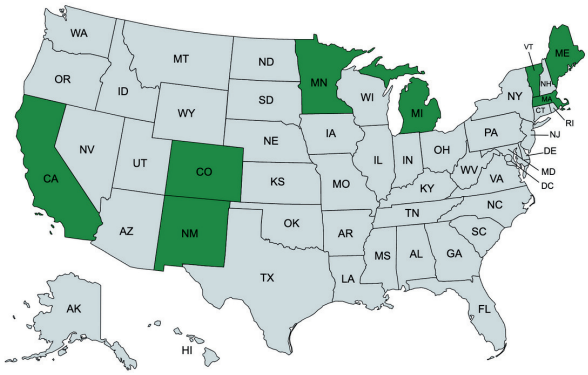
By: Marlene Schwartz, PhD, Director, UConn Rudd Center for Food Policy and Health

Background

The National School Lunch Program (NSLP) provides meals to over 28 million students daily and is a powerful strategy to reduce childhood food insecurity and improve diet quality. The standard "means-tested" approach to pricing provides meals to low-income students at a reduced price or no cost. However, during the COVID-19 pandemic, federal regulations were temporarily changed to allow districts to provide free school meals to all students (i.e., Universal Free School Meals, UFSM), regardless of income.

CURRENT STATE OF SCHOOL MEALS

- Since the federal funding for UFSM ended, eight states have passed legislation to continue to offer free school meals to public school students: California, Colorado, New Mexico, Maine, Massachusetts, Michigan, Minnesota, and Vermont.
- Connecticut provides meals at no cost for students who qualify for reduced-price meals (effectively removing the reduced-price category).
- However, Connecticut has not passed legislation to provide UFSM.



States with UFSM as of November 2024

BENEFITS OF SCHOOL MEALS [i]

The Rudd Center is part a national team of researchers that has been comparing school meal participation rates, and experiences of students, parents, and food service directors, in states with and without UFSM policies. Our work clearly shows that UFSM policies:

increase participation in the school lunch program

reduce stigma related to participation

reduce administrative burden

reduce student food insufficiency

Further, research suggests that:

- On average, school meals provide the **most nutritious foods that a student eats** during the day.[ii] This is because school meals are held to nutritional standards based on the Dietary Guidelines for Americans.
- UFSM policies are associated with **increased attendance and fewer suspensions.**[iii]
- Parents are widely supportive of the program, with many reporting that free school meals **help families save money and time** during the school year.[iv]

Making the Switch to Universal Free School Meals

In Connecticut, a family of four must have an income below $57,720 in order to meet the federal criteria for a reduced-price lunch (and therefore receive a free lunch under Connecticut's current policy); however, the United Way of Connecticut estimates that a family of four needs to earn $126,018 to cover housing, food costs, and other essentials.[v] There is large population of Connecticut families who do not meet the criteria for free meals, but are still struggling to afford healthy meals for their children. These families will benefit from their children receiving healthy meals every day at school.

Conclusion

We collectively pay for public education because we believe that it is our responsibility to our youth – but it's hard to focus in class when you are hungry. In addition to the health benefits of reducing food insecurity and improving diet quality, UFSM protects our investment in the public education of Connecticut's children.

Providing Healthy School Meals for All in Connecticut is a 'win' for students, parents, and schools!

Learn more about the Rudd Center's research on school meals:

uconnruddcenter.org/school-meals

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Farm to School Programs Empower Connecticut Children to Thrive

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University of Connecticut & East Hartford Public Schools

CT children face challenges with food access and obesity, hindering their ability to grow and thrive.

In 2021-22, 1 in 5 CT children "**could always afford enough to eat but not always the kinds of food we should eat.**" Nearly 1 in 5 CT children have obesity. Over 1 in 3 are not fully flourishing, meaning they struggle in either curiosity, finishing tasks, or resilience.[1]

Farm to School empowers children for a healthy future while supporting the state's economy.

Farm to School programs include school gardens, education, and exposure to locally grown food. Farm to School activities improve children's knowledge, willingness to try fruits and vegetables, and consumption of healthy food at school and home.[2] Key stakeholders from East Hartford report Farm to School benefits the whole child. Farm to School programs also boost local economies. Every dollar spent by schools on local food can generate $0.86 more in the local economy.[3] **Connecticut Farm to School needs increased program access, district resources, and school meals access to benefit children, schools, families, and communities.**

East Hartford models Farm to School success (see: VT FEED[4])

Classroom: The program provides hands-on education through three established gardens thriving under the care of a new Farm to School Coordinator and the Sodexo Food Service Team.
Cafeteria: Children frequently eat local food in school meals and taste tests.
Community: The program has grown with rich community partnerships, including the local Handel Family Farm, UConn SNAP-Ed, Intercommunity, American Eagle Financial Credit Union, and the East Hartford Hunger Action Team.

East Hartford Stakeholders voice Farm to School successes and need for continued support

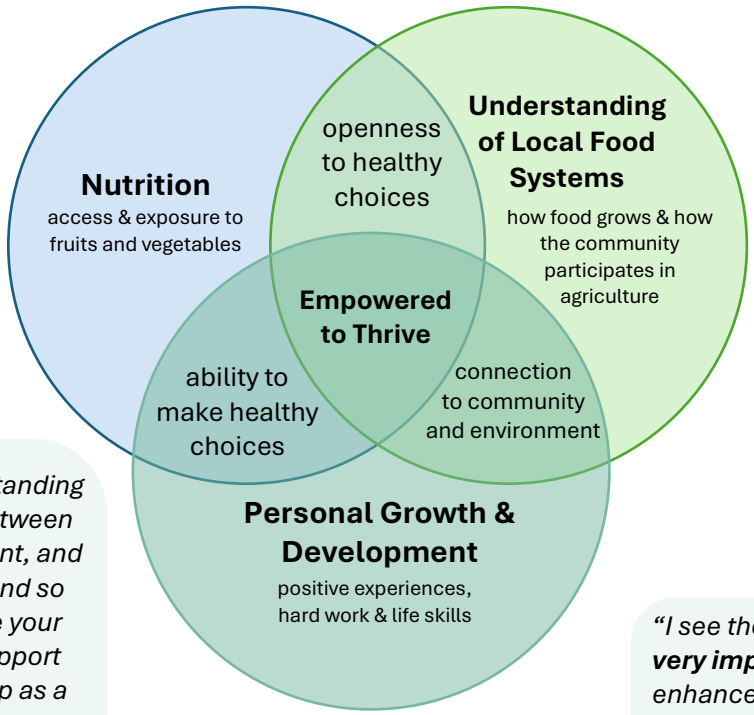
We interviewed 28 stakeholders—teachers, school food service, school administrators, Board of Education, parents, community members and organizations, local agriculture, and local and state government leaders.

Farm to School Empowers Children to Thrive

*"If kids see it growing, then they feel they have a **relationship** with it and they feel more **ownership** and they're more likely to maybe try something that might be unfamiliar, that they might not see at home... If you watch tomatoes grow and then get bigger and turn red, **it's just not such a strange thing when it shows up in front of you**."*

*"Because all of a sudden, this is not just a carrot. **This is MY carrot**!"*

*"But for kids from certain backgrounds or families, **they literally may not know how that food grows. So it gives them that opportunity**. Gives them more access to fresh food, which can be challenging."*



*It's important, especially when they're young to get them involved in eating and seeing how things grow and that's part of life. **That's a life skill. That's a life skill because they're going to have to cook some type of vegetables for their family**..."*

*"The biggest thing is understanding that there's a connection between your health, your environment, and what you put in your body. And so you can control how you live your life and what you want to support and how you want to develop as a human. And so **putting those options in front of the kids helps them understand from an early age that they have that autonomy**."*

*"They feel that **they accomplished something**. They grew something, they learned something. They worked hard on something."*

*"I see the **hands-on learning is very impactful**... That's huge. It enhances the engagement, that academic piece of it, and **it's that nutrition and food literacy, I think, is a piece that is really missing from our curriculum**."*

Farm to School is **a powerful connector of nutrition, personal growth, and local foods** to empower children to thrive.

Farm to School provides children with access to healthy produce. These positive, hands-on experiences help children try and eat healthy foods. Children learn valuable skills of gardening, cooking, and making healthy food choices. Farm to School connects children and families to the community.

Programs need additional staff, funding, and school & community coordination for long lasting success!

Stakeholders talked about challenges maintaining the garden, finding regular volunteers, and making time for Farm to School education. Stakeholders said that staff members are needed to make sure the garden is maintained and used, organize educational activities, and strengthen community connections.

Farm to School is Expanding in Connecticut with Opportunities for Growth

Program Expansion & Successes[5]

High participation: 84% of school food authorities participate in Farm to School.
Recent expansion: 44% of programs are less than 3 years old.
High local food access: 79% of programs serve local foods.
Advancing policy: Established CT Grown Week, local food incentive program, and CT Grown for CT Kids Grant opportunities.

Need for Quality Farm to School Programs[5]

Consistent education: Only 58% of programs provide food, nutrition, or agricultural education. Farm to School Programs need to grow partnerships for consistent education.
Garden access for hands-on experiences: Only 23% of programs have gardens. Successful gardens require funding, staff, and community support.
Agricultural exposure: Only 20% of programs have farm field trips. Only 16% bring farmers to visit. Staff are needed to coordinate and strengthen farm connections.

CT Farm to School Policy Highlights

2006: CT Grown Week Established

↓

2021: CT Grown for CT Kids Program & Grant Established

↓

2023: Local Food Incentive Program Established

↓

Proposed: Increased Program Access, Funding & District Resources, and School Meals Access

Empower Connecticut children to thrive by supporting high-quality Farm to School program access, district resources, & school meals

This research supports policy that:

- **Expands access to Farm to School** programs and extends benefits to more children.
- **Increases district-level resources** for Farm to School programs through funding, incentive programs for local purchases, and designated staff to increase coordinated education, hands-on experiences, and access to local produce.
- **Increases access to school meals programs, such as no cost meals for all students**. The more students that participate in school meals, the more funds that schools have available for to purchase high quality, locally grown food – which ultimately supports Connecticut's economy.

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The Harms and Benefits Inventory

Jennifer Dineen and Kerri Raissian (UConn)
A Brief prepared by the UConn ARMS Center
December 2024

Successful uptake of firearm policy requires citizen-informed understanding of gun users' perceptions.
Researchers from the UConn Center for **A**dvancing **R**esearch, **M**ethods, and **S**cholarship in Gun Injury Prevention **(ARMS)** have developed the **Harms and Benefits Inventory (HBI)**[1] to assist policymakers and advocates in considering citizens' firearm policy perspectives. HBI data will soon be publicly available!

The successful implementation of policy often depends on citizens' behavior change. Evidence suggests that policies such as background checks[2], permitting[3], waiting periods[4], and Child Access Prevention Laws (CAP)[5] reduce firearm injury and death. However, these policies require compliance by gun owners (e.g., willingness to register guns, use federally licensed dealers, secure storage).broad citizen support and depend on gun users' willingness to modify behavior to comply.

Background
In 2022, researchers from UConn ARMS and Johns Hopkins developed the Harms and Benefits Inventory (HBI), a policy-neutral measure that facilitates 1) assessment and understanding of citizens' perceptions of and anticipated policy positions on, firearm-related policies and practices aimed at improving uptake, and (2) assess perceived harms and benefits of specific policies or practices in a direct manner.

In 2024, two years after the New York State Rifle & Pistol Assn, Inc. v. Bruen (Bruen) decision, the UConn ARMS team collected a second wave of data to assess if, and to what extent, Americans perceptions of firearm policy outcomes as harmful or beneficial changed.

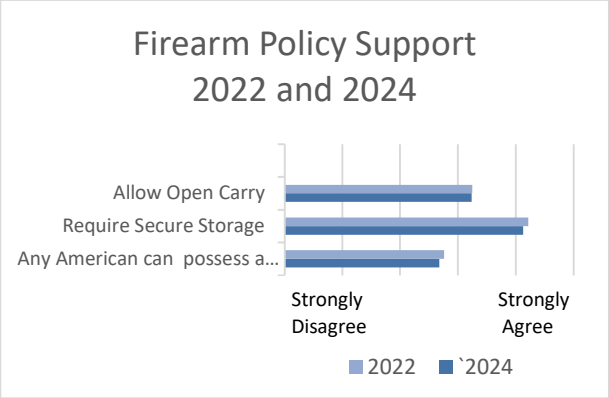
Method
- Data for wave 1 of the HBI is a nationally representative group of 2,004 Adults in the U.S. using the Social Science Research Solutions probability-based panel. The survey was administered online and by phone when requested from April 21 – May 15, 2022.
- Data for HBI wave 2 is a nationally representative sample of 3,086 U.S. Adults from Gallup's probability-based panel. The survey was administered online from October 28 – November 5, 2024. Both samples include both gun owners and non-owners.
- The surveys included the 21 item HBI measure, and questions about gun ownership, firearm-related behaviors, demographics, and experiences with violence and victimization. (See Table 1)
- The 2024 survey added measures of fear to proximal and distal events and a measure of policy support for increasing access to AR-15 style firearms.

TABLE 1 THE FINAL 21-ITEM HARMS AND BENEFITS INVENTORY SURVEY

1. Increases the cost of ammunition	12. Requires a permit to purchase a gun
2. Increases the cost to purchase a gun	13. Makes it easier to purchase a gun without a permit
3. Reduces the number of available licensed gun dealers	14. Requires gun users to receive continuing education around gun safety
4. Makes it more difficult to drive across state lines with a gun	15. Requires new gun owners to demonstrate knowledge of gun safety
5. Increases the time it takes a person to get to and ready a gun in their home	16. Allows a person with a history of violent behavior to obtain a gun
6. Increases government regulation of how guns are handled	17. Allows a person with a domestic violence conviction to obtain a gun
7. Makes it more difficult for a person convicted of violent misdemeanors, such as simple assault to own a gun	18. Allows a person with serious mental health problems to obtain a gun
8. Makes it more difficult for a person with minor, non-violent legal offenses to own a gun	19. Allows a person with a felony conviction to obtain a gun
9. Makes it more difficult for a person convicted of domestic violence to own a gun	20. Makes it easier to participate in hobbies such as gun collection and restoration
10. Makes it more difficult for a person with serious mental health problems to own a gun	21. Makes it easier to participate in shooting sports
11. Makes it more difficult for a person with mild mental health problems to own a gun	

Key Findings
- **Reports of gun ownership increase.** As CT reports issuing record numbers of firearm permits, the HBI surveys shows US adults reporting increased firearm ownership. The 2022 survey found 9% of gun owners report becoming a first time owner between 2020 and 2022. In 2024, that number is 4%. In addition to seeing ownership increase among 18-39 yr olds, 8% report becoming owners within the last 2 years, women (6%) are more likely than men (3%) to report becoming gun owners. Reports of new ownership were higher for Hispanic (9%) and Black (7%) respondents than for their White counterparts (2%). This trend is similar to 2022 data.
- **2022 and 2024 studies show similar levels of support for policies** requiring secure storage, allowing open carry, and that promote allowing any American to own a gun. In both studies, respondents in gun households were more likely to agree that any American can own a gun and that people legal gun owners should be able to open carry. These respondents are less likely to agree that people should be required to store guns securely.

Figure 1: Changes in Firearm Policy Support



- **Citizen support does not equal policy uptake.** Support for secure firearm storage is strong, averaging 4.13 nationally and 4.38 in states that receive an A firearm law rating from Giffords[8] (CT, CA, and NJ). Despite strong support for secure storage, in 2024 nationally 46% of firearm households report keeping at least 1 gun loaded and unlocked on their property. This number is even higher among America's service members (56%) and veterans (58%).
- The 2024 survey investigates citizen perceptions of policy that makes AR-15 style weapons more accessible. **On average, Americans oppose a policy that makes AR-15 style weapons more accessible as harmful.** On a scale of 0 to 10, where 0 means completely oppose and 10 means completely support, respondents gave this policy an average rating at 3.49. Respondents in gun-owning households' owners are more likely to view the policy as neutral (4.81) than those living in households without a gun owner (2.31). Respondents in states with an A firearm rating from Gifford are similar (3.37) to their counterparts in other states.

Understanding citizen perception of policy impact can inform policy development and improve implementation.

Insight as to how citizens view policy as harmful or beneficial, and their rational for support or opposition can improve uptake and reduce unintended consequences of these policies. To aid policy makers in accessing this information, **UConn ARMS will make this this data available to policy makers in 2025!**

Data will be available via a data portal that will provide aggregate means and limited ability to segment the data. Future plans include also providing datasets upon request.

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7. McCourt, A., & Vernick, J. (2018). Law, Ethics, and Conversations between Physicians and Patients about Firearms in the Home. *AMA Journal of Ethics*, *20*(1), 69–76. https://doi.org/10.1001/journalofethics.2018.20.1.hlaw1-1801
8. Giffords allots laws and policies point values based on their strengths or weaknesses, then ranks each state and assign letter grades, ranging from A, states with the strongest gun laws, through F, states with the weakest gun laws.

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Developing an Effective Uniform Training Policy to Support and Improve Connecticut's Direct Care Workforce

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This research aims to identify core workforce training needs for the Direct Care Workforce (DCW) that can serve as a mechanism to grow and retain workers. This workforce is vital in providing essential care and support to older adults and individuals with disabilities primarily in long-term care, community-based settings, and home-based care. While demand is increasing, growing and retaining the Direct Care Workers workforce faces significant challenges, including a low average wage, lack of benefits for many workers, non-standardized training, and the absence of seamless and transparent career pathways to higher-skilled jobs and greater economic mobility. These challenges make it difficult to both quantify the total size of the workforce and understand the exact competencies valued by employers.

Characterizing the size of the DCW sector presents significant challenges. While the federal definition for DCW includes Home Health Aides, Psychiatric Aides, Nursing Assistants, and Personal Care Aides, there is no single Standard Occupation Code (SOC) corresponding to this workforce, leading to challenges in quantifying the supply/demand needs[1]. In Connecticut, we identified a total of 61,060 positions within those SOC codes with an average hourly wage of $18.25.[2] However, this does not capture the entirety of roles related to this workforce as many related occupations may also be counted within other SOC codes, such as Social and Human Service Assistants (21-1093), which had over 8,000 positions in Connecticut.

There are efforts nationally to professionalize this workforce through unifying definitions and trainings to improve retention and growth. Oversight of training varies depending on role and service delivery model and is correspondingly overseen by various state agencies. In over forty states, there have been training standards created for Personal Care Aides while nearly thirty states have training standards above the federal guidelines for Nursing Assistants.[3] As a state, Connecticut compares slightly worse on average compared to an averaged national sample from selected 29 states when it comes to annual turnover rates (44.8% vs. 40.9%) in a recent survey of Direct Support Professional or DSPs (a grouping including Home Health Aides and Personal Care Aides) that work with the Intellectual and Developmentally Disabled (IDD) population.[4]

Evidence supports the connection between improved training and decreased turnover, which forms the basis for our efforts. A comparative analysis of several DSP and front-line supervisor credentialing programs in New York found uniform decreases in annual turnover rates among credentialed DSPs as well as increased retention (i.e., length-of-employment).[5] Similarly, Massachusetts experimented with a career ladder and skill development program for Certified Nursing Aides through their ECCLI program and reported decreases in job vacancy rates among participating facilities.[6] Our goal is to similarly develop employer partnerships in such a way that

we can develop core trainings that can be portable across multiple settings (e.g., institutional, community, and home-based) and are recognized by providers statewide.

There is a lack of available training to address skills that are universal to all home care workers, regardless of level of care being provided. An effective uniform training program requires both holistic buy-in from employer partners, an understanding of the needs of DCW trainees, and labor requirements. It should be noted that a significant percentage of DCWs are PCAs, who are covered by the Collective Bargaining Agreement between the PCA Workforce Council, and 1199 SEIU-NE. Statute requires that all training for PCAs under this agreement be provided by the Union's Training and Upgrading Fund.[7] Therefore, at this time, 1199 SEIU-NE must be part of any development of a uniform training program. Additionally, training the direct care workforce with the intention to grow and retain workers should not exclude workers such as homemakers and companions whose functions mirrors PCAs.

We additionally identify a need to co-develop the core training with providers and through trusted training partners. Core training should ideally be based on the core competencies identified by the Centers for Medicare and Medicaid Services (CMS).[8] Training models implemented by other states should be considered for guidance in this work. However, the planning should proceed with the knowledge that each state is unique, and not all training models are directly transferable. Moreover, we identified a need to develop an advisory group consisting of Direct Care Workers to understand factors that contribute to valuable training including soft skills and valuing lived experience. Such advisory group design mirrors the process undertaken by DMHAS in their development of a peer specialist certification. Similarly, OPM is currently exploring a pilot program with AARP to test universal "soft skills" that everyone in the DCW should possess to ensure quality service and allow workers a baseline of transferrable skills. Finally, we recognize that such efforts require comprehensive marketing and supporting credentialing infrastructure, such as a registry, to be actualized.

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[1] https://www.law.cornell.edu/uscode/text/42/295p#16
[2] CT DOL OEWS (July 2024)
[3] https://www.nga.org/wp-content/uploads/2021/10/NGA_SectorGrowth-DirectCare_report.pdf
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[7] *Sec. 17b-706e. Provision of training and related services to personal care attendants.* Notwithstanding the provisions of sections 17b-706 to 17b-706c, inclusive, where authorized by a collective bargaining agreement negotiated pursuant to section 17b-706b, the parties may contract for the provision of training and related services to personal care attendants, as defined in section 17b-706, at cost directly with a nonprofit labor management trust authorized by 29 USC 186(c)(6).
[8] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/dsw-core-competencies-final-set-2014.pdfhttps:/www.medicaid.gov/medicaid/long-term-services-supports/downloads/dsw-core-competencies-final-set-2014.pdf

December 2024

UCONN
SCHOOL OF SOCIAL WORK

Addressing the Needs of Formerly Incarcerated People: How Beneficiaries of Public Act 15-84 Can Help Improve Prison Conditions

Sukhmani Singh, Fernando Ricardo Valenzuela, Josh Adler, James Jeter, Rich Sparaco, Alex Tsarkov

In an effort to comply with several Supreme Court rulings that made it unconstitutional to impose life sentences without parole for young people under 18, the Connecticut Sentencing Commission introduced a proposal enacted by the General Assembly as Public Act 15-84 in 2015. This law created established pathways for parole hearings of individuals who committed their offenses when they were under the age of 18. Despite the enactment of this law, virtually no understanding exists of its impact on beneficiaries. This brief highlights research conducted by the first four authors in which beneficiaries of P.A. 15-84 were interviewed to better understand their experiences throughout incarceration, the parole hearing process, and access to programs and services during re-entry. **Preliminary findings offer two key policy recommendations that would provide more rehabilitative support for incarcerated people:**

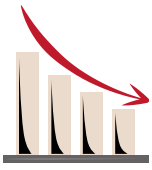
1. Expand access to programs and services at correctional facilities for all incarcerated people, particularly for those with longer sentences
   a. Incarcerated people serving long sentences are **often barred from accessing programs and services** to prioritize those with shorter sentences. **Expanding access** would promote **personal** and **educational growth**, **positive behavioral changes**, and could **reduce recidivism** upon release.
2. Increase age of eligibility through age 25 and eliminate the pre-2005 cut-off for potentially eligible individuals of P.A. 23-169
   a. Expanding eligibility through age 25 would **promote decarceration** in Connecticut, **reduce** the **financial burden** of long-term incarceration on state resources, and allow for **successful community reintegration.** Currently, eligibility is arbitrarily limited to those who committed a crime between ages 18 - 21 and were convicted before October 1st, 2005. This **restricts eligibility** and **does not reflect any substantive difference** across individuals' capacity for change. Removing this cutoff date would better **promote fair sentencing**.

Long-Term Juvenile Incarceration in the United States

Although incarceration rates in the United States have been declining since 2007, few legislative reforms aiming to further reduce these rates have looked at individuals serving long-term sentences for violent offenses, **who make up over 50% of the state-prison population** [1]. Part of this population are those who, at the time of their offense, **were under the age of 18 and sentenced to juvenile life without parole (JLWOP)** or "de-facto" life sentences that exceed the natural life span [2].

Advances in brain science over the last 25 years highlight **key biological characteristics** in the developmental stage **that distinguish adolescents from adults** [3] through the age of 25. This resulted in three major Supreme Court rulings that made it **unconstitutional** for courts **to sentence adolescents under the age of 18 to life or de-facto life sentences** without parole.

Facts about Long-Term Incarceration:



Individuals who served long-term sentences, including life, have **the lowest recidivism rates** of any other previously incarcerated population [4].

Financial Costs of Incarceration in Connecticut:

Annual costs for **incarcerating a single person** in Connecticut ranges from **$90,855 - $102,942 per year** [5].

This is an **increase of over 46%**, up from **$62,159 in 2015** [6].

Our Research at a Glance

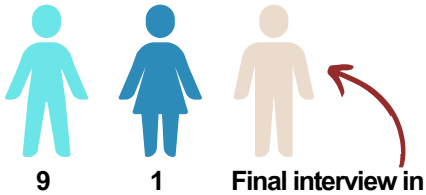
Our **participatory qualitative research** project examined the experiences of previously incarcerated beneficiaries of P.A. 15-84. Semi-structured, **one-on-one interviews** were conducted, **focusing on the following key areas**:

- participant experiences with incarceration, specificaly their access to programs and services
- the P.A. 15-84 parole hearing process
- access to services and support during re-entry into community

Participants [n=10] are:

- Beneficiaries of P.A. 15-84 and released to parole supervision
- Not living at any court-mandated housing
- Ages 31 - 52
- People who were incarcerated for ~9 - 30 years
- Black and/or Hispanic
- 5 participants were still under parole supervision at the time of the interview

Participant Demographics:



9 Men | **1 Woman** | **Final interview in progress (male)**

Policy Recommendations

1 Expand access to programs and services at correctional facilities for all incarcerated people, particularly for those with longer sentences.

Why This Matters:
Incarcerated people serving long-term sentences are **often barred from programs and services** to prioritize others closer to release. It is not clear whether this is an official policy of DOC. Preventing access to these programs, especially for younger people, often results in those with long sentences spending years without participation in any meaningful or enriching programs. Such inequitable conditions undermine the rehabilitative imperative of DOC.

How This Benefits Connecticut:
Expanding access to programs would promote personal and educational growth during incarceration. More so, access to programs **reduces recidivism** and promotes **positive behavioral changes,** including **fostering accountability** and **self-awareness,** which ultimately support success after release [7]. **The state can in turn reduce costs associated with re-incarceration and long-term supervision.** Similarly offering programs to individuals regardless of sentence length prepares them for potential sentence modifications, parole, or release through clemency. **This creates safer communities as individuals reenter society with tools to succeed.**

2 Expand parole eligibility by increasing age from 21 to 25 for those individuals who committed their crimes on or before this age.

Why This Matters:
Increasing eligibility established under P.A. 15-84 and P.A. 23-169 from 21 to 25 at the time of their crime would **promote decarceration in Connecticut**, allowing more individuals to go through the parole hearing process and **return to their communities under supervision**. This change **aligns with decades of research** showing that **brain development continues well into the mid-20s,** particularly in areas related to impulse control and decision-making [8]. Expanding age eligibility acknowledges these developmental trends and creates opportunities for fairer sentencing outcomes. Furthermore, eligibility for P.A. 23-169 is limited to those who committed their crimes on or before October 1, 2005. This cutoff date arbitrarily restricts eligibility to a specific group rather than reflecting any substantive difference in the capacity for individual change. Therefore, expansion of eligibility to age 25 should also remove the October 1, 2005 cutoff to ensure fair sentencing.

How This Benefits Connecticut:
Making these changes to eligibility would **promote decarceration** in Connecticut, support the **successful reintegration of suitable individuals**, and allowing more incarcerated individuals to **reunite with their communities.** Tax-payer dollars that would be used for continued incarceration could instead be used to **increase capacity** for and quality of **programs and services** across correctional facilities.

Moving Beyond Just Living in Connecticut: Supporting the Needs of LGBTQ+ Older Adults to Thrive

December 2024

Context

- Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) adults aged 50 and over are a growing population[4]
- LGBTQ+ adults aged 50+ face many challenges, such as disparate health outcomes, including higher rates of chronic diseases, higher rates of mental health disorders, higher disability rates, and overall worse health[7,8,9,10]
- LGBTQ+ individuals may not be thriving as they could be, with studies showing early mortality rates compared to cisgender/heterosexual counterparts[3,7], especially in Connecticut, where the general population's life expectancy is two years more than the national average[2]

Summary of findings

- My current study[1] aimed to further understand the health needs of LGBTQ+ adults aged 50+ as they age in New England
- Participants expressed what impacts LGBTQ+ people's health as they age in Connecticut, and what solutions they felt would lead to better health outcomes for older LGBTQ+ adults.

Introduction

LGBTQ+ adults aged 50 and over are a growing population[4] but may not be thriving as they should be. For example, they often experience health care access issues, added life stressors, limited choices for aging care supports, isolation, financial stability issues, discrimination, and even early death[5,7,8,9,10]. With the proper supports, they could be flourishing, as research shows LGBTQ+ older adults are a resilient population, collectively successful at adapting to their environments[5], enjoy good health, strong relationships, and overall happiness[6].

The Current Study

My doctoral work aimed to support this resiliency in LGBTQ+ adults 50 and over in New England by partnering with them to determine what exactly affects this community's health. While their observable health disparities have persisted, the health needs of LGBTQ+ older people have not been adequately addressed. Therefore, my study aimed to:

- Investigate how social health factors such as health care environments, social engagement, resiliency, and others that may contribute to their health outcomes as LGBTQ+ people age
- Gain knowledge about what specific local and state policies, interventions, and/or future research will help support a decrease in negative health outcomes in LGBTQ+ adults over 50 years of age

Many LGBTQ+ adults age 50+ who participated in this study stated that there was a general lack of supportive services for LGBTQ+ people as they aged. This specifically included a discussion of supports such as LGBTQ+ friendly housing, home care services, long-term care, meals, and socialization services.

Findings

LGBTQ mid-life to older adults in the New England region called for health and aging services that would not only educate providers but also change current practices[1]:

1. **Improve** services so that they are specifically designed to meet their needs
2. **Connect** health and aging services, such as meals, housing, and socialization programs that are geared towards the LGBTQ+ community.
3. Ensure these services are designed with **competence** to ensure older LGBTQ+ identities are affirmed.

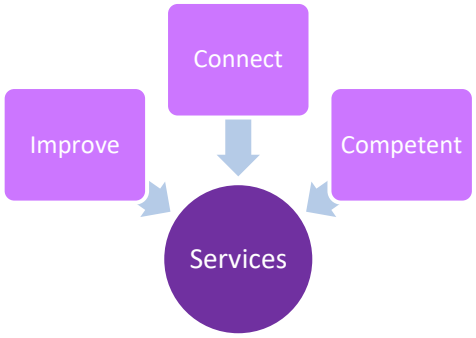


Fig. 1 Model of Change for Services to Support LGBTQ+ Aging

Policy Recommendations

Connecticut recently published a draft for public comment for the Connecticut's State Plan on Aging[2]. This draft for public comment explains that Connecticut is working to address the goals of long-term care supports, healthy aging, and elder rights[2] for its older constituents. The Bureau of Aging[2] notes in this state plan on aging that they have a working group of inclusive communities which has aimed to meet the needs of LGBTQ+ people as they age by adding educational outreach programs to improve their health. In a public comment and the materials I've produced in conjunction with this study,[1] I question whether adding only training services for providers that more could be done to support older LGBTQ+ people in Connecticut is adequate to meet the state's goals for the quality of life for all older adult populations.

LGBTQ+ adults 50 and over in the New England region in the current study[1] ask for larger, systemic changes in our region:

1. **Building long-term care facilities and affordable housing that is geared towards the LGBTQ+ community.**
2. **Implementing specific LGBTQ+-friendly health and aging services, such as congregate meals and socialization activities.**

These suggestions by older LGBTQ+ adults living in our region could be incorporated into a central hub for LGBTQ+ aging services, such as other models that have a one stop shop approach to aging care that could be funded and built right here in their state.

Today, please consider walking in hand with LGBTQ+ mid-life to older adults in the state of Connecticut by being an ally in support of their goal of not only living but thriving as they age.

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Achieving More Effective Justice by Addressing Juvenile Lifers' Mental Hygiene

Marisol Garcia, Yale Prison Education Initiative

Juvenile lifers (individuals sentenced to life without parole for crimes committed as minors) face unique and profound mental health challenges. Understanding the socio-psychological factors contributing to their mental hygiene underscores an effective response for improving their mental health outcomes—and in turn, better achieving the health and safety outcomes that communities seek when looking to appropriately address young people's serious crimes. Fostering a rehabilitative approach that acknowledges the developmental differences between juveniles and adults ensures a more humane *and* a more effective justice system.

Political Factors Affecting States' Treatment of Juvenile Lifers

1. **Legislative Landscape**: The U.S. Supreme Court rulings in cases like *Miller v. Alabama* (2012) and *Montgomery v. Louisiana* (2016) have significantly influenced the legal framework for juvenile lifers. These rulings emphasize the potential for rehabilitation and the need for sentencing that reflects the unique status of juveniles. Despite these rulings, implementation varies widely across states, leading to inconsistencies in how juvenile lifers are treated—but the precedent to move toward a more rehabilitative framework in Connecticut is solid.

2. **Political Climate**: U.S. political climate plays a crucial role in creating disparities among states in sentencing, treatment, and mental health outcomes of juvenile lifers. States with conservative political ideologies and a strong Republican presence tend to impose harsher sentences, including life without parole for juveniles. Additionally, racial politics influence sentencing, with higher rates of juvenile life sentences observed in states with larger minority populations.

Socio-Psychological Factors Affecting Juvenile Lifers' Behaviors

1. **Exposure to Violence**: Many juvenile lifers have been exposed to high levels of violence in their homes and communities. This exposure has a profound impact on their mental health, often leading to trauma, anxiety, and other psychological issues. The constant exposure to violence can also normalize aggressive behavior, making it more likely for these individuals to engage in criminal activities.

2. **Family Dynamics**: A significant number of juvenile lifers come from backgrounds characterized by neglect, abuse, and poor adult supervision. These adverse family dynamics contribute to their criminal behavior and exacerbate their mental health issues. The lack of a stable and supportive family environment can hinder their emotional and psychological development, leading to long-term mental health challenges.

3. **Developmental Science**: Adolescents are inherently more susceptible to peer pressure and less capable of long-term planning compared to adults. Their decision-making processes are still developing, which makes them more likely to engage in risky

behaviors without fully understanding the consequences. This developmental immaturity should be a critical consideration in sentencing and rehabilitation efforts, as it underscores the potential for change and growth in juvenile offenders.

Recommendations

1. **Mental Health Screening and Treatment**: It is imperative to implement comprehensive mental health screening for all juvenile lifers upon entry into the correctional system. Providing ongoing access to mental health services, including therapy and psychiatric care, is essential for addressing their unique mental health needs. Regular mental health assessments should be conducted to monitor progress and adjust treatment plans as necessary.

2. **Trauma-Informed Care**: Developing and implementing trauma-informed care practices within juvenile detention facilities is crucial. Training staff to recognize and respond to trauma can significantly improve mental health outcomes for juvenile lifers. This approach ensures that the care provided is sensitive to the experiences of trauma and aims to create a supportive and healing environment.

3. **Educational and Vocational Programs**: Offering educational and vocational training programs tailored to the needs of juvenile lifers can provide them with a sense of purpose and improve their self-esteem. These programs should focus on equipping them with skills that will be valuable upon their release, enhancing their chances of successful reintegration into society.

4. **Family Engagement**: Encouraging and facilitating family involvement in the rehabilitation process is vital, since family support can play a crucial role in the mental health and rehabilitation of juvenile lifers. Programs that promote family visits, counseling, and communication can strengthen family bonds and provide a support system for the juvenile lifers.

Reforming Policy for Juvenile Lifers' Mental Health Supports Community Wellbeing Too

Addressing the mental hygiene of juvenile lifers requires a multifaceted approach that considers political and socio-psychological factors and acknowledges the developmental difference between juveniles and adults while emphasizing rehabilitation. By implementing these recommendations, we can improve the mental health outcomes for juvenile lifers and provide them with a chance for a better future. This approach not only benefits the individuals but also contributes to a more just and equitable society. Supporting legislation that allows for the possibility of parole and emphasizes rehabilitation over punishment can lead to more humane and effective outcomes. Policymakers should work towards creating a justice system that recognizes the potential for growth and change in juvenile offenders.

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Addressing Public Health Needs through Policy Change

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The Endometriosis **R**esearch, **I**nnovation, **S**upport and **E**ducation (**EndoRISE**) program, established under Connecticut's Public Act No. 22-33, represents a landmark in healthcare policy aimed at addressing endometriosis. This state-supported initiative is the first of its kind in the United States, combining research, education, and public outreach to tackle a condition that affects approximately 190 million individuals assigned female at birth globally and **one in ten women in Connecticut**. The program is implemented through a partnership between UConn Health and The Jackson Laboratory, with the objective of improving diagnostic outcomes, developing new treatments, and increasing public awareness about endometriosis.

Policy Background and Legislative Support

The creation of EndoRISE is rooted in legislative efforts aimed at addressing the healthcare gaps surrounding endometriosis. The Connecticut General Assembly, following policy recommendations from the CT Endometriosis Workgroup, a group led by Representative Jillian Gilchrest, spearheaded House Bill 6672, which emphasized increasing public awareness and expanding care for endometriosis patients. This legislative groundwork evolved into Public Act No. 23-67, which formally allocated state support to establish the framework for endometriosis research and clinical education.

Connecticut's decision to establish EndoRISE reflects a significant policy shift toward prioritizing women's health—an area that has historically lacked sufficient funding and attention. The legislative framework mandates a multi-institution collaboration that includes healthcare providers, researchers, and public health officials. By directly linking policy to research infrastructure and education, the program has set a precedent for other states to follow, ensuring that more resources are devoted to under-researched health conditions such as endometriosis.

Key Objectives and Components of EndoRISE

1. **Biorepository and Research**: One of the most innovative components of EndoRISE is the establishment of a public biorepository, where surgical, clinical, and biological data from endometriosis patients are collected and made available for research. This resource allows for advanced studies into the causes and manifestations of the disease and enables clinical collaborations to develop non-invasive diagnostics and more effective treatments.

2. **Public Awareness and Education Campaigns**: A core goal of EndoRISE is to raise public awareness about the symptoms and prevalence of endometriosis, combating the widespread delays in diagnosis. This includes public events and partnerships with healthcare providers to disseminate information about early warning signs and available care options. The initiative also extends to educational programs for healthcare providers, equipping them with the latest diagnostic tools and treatment techniques for endometriosis. In June 2024, EndoRISE hosted its first awareness event, where providers, scientists, patients and public got together to engage in meaningful discussion on building endometriosis awareness and continued advocacy for endometriosis research and patients.
3. **Provider Training and Healthcare Access**: Through training programs for healthcare professionals, EndoRISE aims to enhance provider competency in recognizing and managing endometriosis. This aspect addresses the chronic under-diagnosis and frequent misdiagnosis of the disease, which often delays appropriate care for patients. These efforts help to close gaps in healthcare access, ensuring that patients in Connecticut receive timely and informed care.

Impact on Healthcare Policy and Broader Implications

EndoRISE represents a pioneering model in how state-level policy can directly improve public health outcomes. By integrating research, education, and advocacy within one framework, Connecticut is transforming the way endometriosis is approached. Programs like EndoRISE demonstrate the potential of multi-institution collaboration and state support to fill gaps in health systems, especially for conditions that are under-researched and underfunded.

Moreover, the biorepository serves as a blueprint for similar initiatives in other regions, promoting the replication of its model nationwide. Connecticut's efforts have already attracted national attention, with media outlets such Science and WNPR highlighting the program as a potential game-changer in women's healthcare.

Conclusion

The EndoRISE program is a groundbreaking initiative that exemplifies how targeted legislative action can lead to meaningful advancements in healthcare. ***With a strong focus on research, education, and public awareness, the program aims to reduce diagnostic delays and improve care for endometriosis patients***. EndoRISE not only benefits Connecticut residents but also sets a precedent for the future of women's health research across the United States. The program's success reflects ***the importance of aligning policy with healthcare innovation to address historically neglected conditions***.

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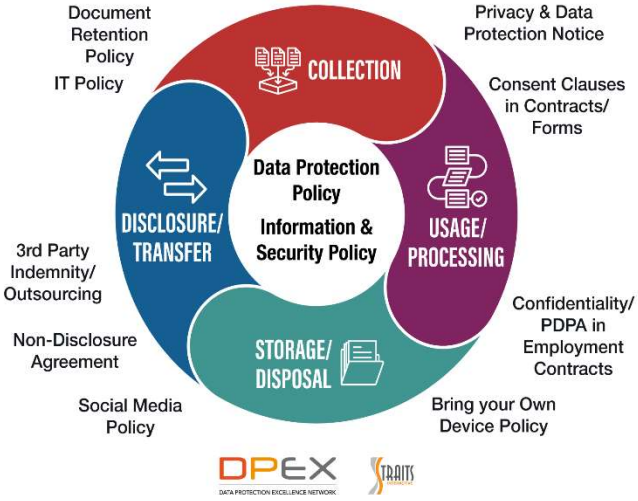
Advancing Health Data Governance and Personal Data Privacy while Balancing Innovation with Privacy Protection in Connecticut

Chin-Fun Chu, PhD and Roberto Vazquez-Muñoz, PhD

Advances in health technology are transforming personalized care but pose significant risks to individual privacy and data governance. The rapid development of health technology generates vast amounts of personal health data, raising critical questions about data governance, privacy, and ethics. The primary purpose of these health technologies is to enhance precision and efficiency in personalized treatments and services, which necessitates the collection of large quantities of personal data. If this data is not adequately and securely protected, it could pose significant risks. In Connecticut, it is essential to implement legislative measures regarding data ownership, data transfer, and consent to safeguard patient rights while fostering innovation for integrative, people-centered care on a population level.



Policies and standard operating procedures aim to address the gaps across the information lifecycle (matomo.org).

Guiding Questions

Recent innovations in health technologies, such as biotechnology and digital health, offer significant potential for improving healthcare delivery and outcomes. However, this progress introduces complex challenges in managing health data governance and protecting personal health information during the development and design phases of such technologies. As health data increasingly becomes digitalized and integrated into advanced tools, such as artificial intelligence-driven diagnostics and strategies,[1][2][3] critical questions arise regarding the collection, use, and security of personal data. Specifically, we ask:

(1) Can a particular data governance framework provide more robust protections for personal health data during the development and design phases of health technologies?
(2) What regulatory mechanisms can ensure the ethical and transparent use of personal health data during the research, testing, and development stages of health technologies, in line with the principles of data ownership, consent, and health equity? [1,2,3]

Recent discussions highlight that recognizing health data ownership as a civil right could empower individuals and foster trust in digital health technologies. [4,5] It is also important to explore how to effectively implement these approaches throughout the health technology lifecycle and ensure that innovation does not compromise personal privacy or lead to data misuse. Addressing these issues will provide valuable insights for policymakers, technology developers, and stakeholders navigating this complex intersection of health technology and data ethics.

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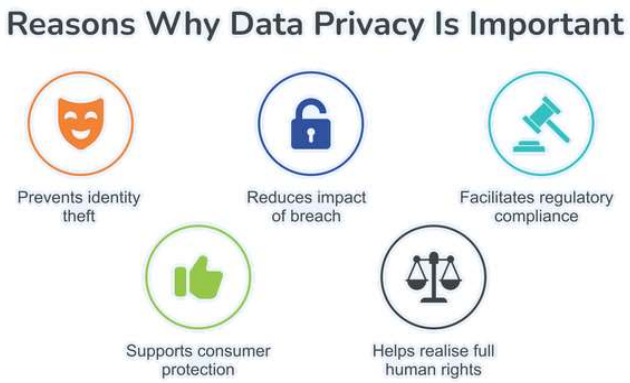
Current Policy Landscape

In 2023, the Connecticut Data Privacy Act (CTDPA) established a comprehensive framework for consumer data privacy and protection, in which consumers would have greater control over the transparency of consumer rights and the processing of their personal data. In addition, the recent updates on the CTDPA focused on health data privacy, especially for emerging health technology; however, issues related to data ownership, consent mechanisms, and secure data sharing within healthcare systems remain.



Privacy refers to the capacity to decide who can access information about our activities and private life (dpexnetwork.org).

Proposed Policy Action

- Recommendation 1. **Data Ownership and Access and Control**
  - A more precise definition of ownership rights: Patients and users should be recognized as the primary owners of their personal health data, allowing them to access, control, and transfer their data while ensuring transparency with all parties involved in data collection and storage.
- Recommendation 2. **Informed Consent and Patient Autonomy**
  - Consent standards for AI-enabled and other health technologies: Implement standardized digital consent processes to ensure that patients and users understand how their data will be used, shared, and retained.
  - Patients and users should have the right to revoke their consent, providing them with greater control over ongoing data use. This needs to include opt-in and opt-out mechanisms that are transparent and easy to understand.
- Recommendation 3. **Ethical Data Use**
  - Ethics Review Board: Establish this entity for health technology companies, healthcare providers, and research institutions that are developing or using predictive algorithms to ensure fair and unbiased application.
  - Continuous, regular security audits and reporting of findings to an oversight body to ensure data integrity.

These recommendations aim to call to action for policymakers, researchers, and other stakeholders.

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