Children, Youth & Family Consortium
CONNECTIONS
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IN THIS ISSUE

CYFC's Move to Extension **Offers New Opportunities**

By Cathy Jordan, Director
Children, Youth and Family Consortium

How do we best position CYFC for effective work in the future? Who should we partner most closely with to have the greatest impact? How can we expand our reach statewide? In these difficult economic times, how can CYFC create the most secure future? How might we best preserve the legacy of President Bruininks, a "grandfather" of CYFC and strong supporter of community engagement and children, youth and family issues, once he steps down as President?

These are some of the questions CYFC and our supervisors tussled with over the last year. In spring of 2009 CYFC began a process of interviewing deans and administrators across the campus to identify potential new administrative homes for CYFC. We are happy to announce that, effective July 1, 2010, CYFC is joining University of Minnesota Extension. We will work closely with Extension centers for family development and youth development. Our offices will remain in the McNamara Center where we already share part of the second floor with the Extension Center for Youth Development.

The missions, guiding principles and primary functions of CYFC and Extension are well aligned, and there is a particularly close fit with the work of the family development and youth development teams. We each ground our work in an ecodevelopmental model of human development, are committed to serving and learning from communities, and share a commitment to the translation of research evidence to enhance the work of practitioners. CYFC's transition to Extension offers numerous advantages and opportunities for CYFC, as well as for Extension, and we anticipate that we will complement and extend each other's work in exciting ways. Here are some examples:

- Extension offers CYFC a well-established network of individuals, community organizations and Extension staff and faculty across the state. These connections will help us address our statewide mission - to improve the well-being of children, youth and families throughout Minnesota.
- Extension provides a supportive environment for CYFC's policy work. In particular, Extension has strong connections to county government that are likely to be helpful to our policy work with commissioners and others at the county level.
- The episodic collaborations CYFC has had with Extension's family development and youth development centers are likely to become deeper and more intentional and provide greater opportunity for CYFC to make impact within communities.
- Extension will enhance CYFC's infrastructure and provide operational efficiencies that will allow us to spend more of our time on programmatic efforts.
- CYFC offers Extension new resources and opportunities. CYFC has strong working connections to faculty and centers across campus that will enhance Extension's in-reach.
- CYFC's policy education model, and specifically our Family Impact Seminar for legislators and Evidence at Work brownbag series for legislative staff, offers Extension established mechanisms for increasing its capacity to inform policy decisions.

continues on page 2

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CYFC's Move, continued from page 1

- CYFC brings expertise in participatory approaches to research, education and program design and the capacity to generate and sustain reciprocal, culturally sensitive partnerships with communities of color and immigrant communities.
- Finally, CYFC's current focus on the interaction of education and health disparities brings expertise and research capacity within two areas that complement and extend Extension's programmatic work.

CYFC is entering its 19th year. Our transition to Extension, and our approaching 20th anniversary, offer an impetus to engage in a year of reflection and planning. We are committed to discovering, in collaboration with our Extension colleagues, the most strategic opportunities to advance both CYFC and Extension's work, particularly work related to children, youth and families. This year of relationship-building, self-examination, and planning will result in a roadmap for CYFC's future that will help us realize the many advantages that this move offers us. We look forward to launching our third decade, and celebrating our 20th anniversary, with new insights, new friends and colleagues, and far-reaching plans for deeper impact and enhanced sustainability.

School Readiness and Healthy Development: Related? In what way(s)?

By Scott McConnell, PhD

In an article in *Consortium Connections* in 2009, Cathy Jordan described a broad and helpful model for thinking about the relation between education and health disparities. In that article, she discussed the "complex interplay between education and health." For the past several years, I have had the pleasure of working with colleagues from the U of MN, governmental and nongovernmental agencies, child- and family-serving organizations, as well as parents and leaders in the community in North Minneapolis to design, implement, and evaluate a comprehensive effort to promote school readiness for young children in two geographic areas. This effort, first called *Five Hundred under 5* and now part of the early childhood efforts of the Northside Achievement Zone (www.northsideachievement.org), provided rich opportunities to learn about, think about, and act on the interplay between health and one aspect of educational achievement – the development of school readiness. We have learned some valuable lessons, and realized how much we still have to learn, in understanding this relationship.

Background. Researchers have provided ample evidence of the relation between school readiness and healthy development. Some of this evidence is intuitively compelling: we know that children with chronic ear infections often demonstrate lower levels of language development (a key component of school readiness), perhaps because infections distort the sounds children hear or because illness restricts their opportunities to participate in developmentally enriching opportunities. However, there may also be relations that are less obvious – but equally important. As Cathy noted in her introductory article, some emerging evidence exists that environmental stress affects neural and other aspects of physical development and well-being; when children spend time in nurturing environments designed to promote development of school readiness, their physical well-being may benefit as well. Effective early education services also increase the odds that children will benefit from later schooling and life opportunities; while we are not yet sure of the causal mechanisms, we know that

continues on page 3

> "We know that children with chronic ear infections often demonstrate lower levels of language development (a key component of school readiness)."

School Readiness, continued from page 2
educational attainment is associated with improved health – and thus, effective early education might contribute to long-term health and well-being.

To some extent, though, this evidence is correlational – we know that a child's or family's status on 'variable a' is related to their status on 'variable b.' We all remember the common caution in interpreting statistical relations – correlation does not *necessarily* imply causation (although it can). One reason for this – the so-called *third variable* – may be particularly important here. Simply put, are there factors in children's lives that contribute to *both* school readiness and healthy development, and would be (if we identified them) potent variables to include in our interventions and policy analyses?

Five Hundred under 5. Three sources of information – two formal, and one less so – have helped us think about important third variables for F*ive Hundred under 5* (FHu5) families. First, we have been designing and evaluating a parent education and engagement program called *Family Academy*. Family Academy is an 8-week session, held on Saturday mornings, where parents and their children come together for a structured play/meal/educational experience. The curriculum was designed to reflect both evidence-based and best practices working with young families living in poverty, as well as the local exigencies of North Minneapolis and FHu5. We provide a healthy meal, structured opportunities for children and adults to have fun together, and a series of parent education lessons and focused discussions designed to increase information about child development and resources available to support it. And we have asked families, both in knowledge and attitude, what they gain from this experience.

Second, we have surveyed families about health, health services, and life circumstances. To date, about 75 families have completed this health survey (and several focus groups), providing us a peek into the ways FHu5 families are thinking about, and acting on, their young children's development.

Last, we have engaged families – and provided opportunities for them to engage one another. Through formal contact with FHu5 Family Support Advocates, as well as opportunities for semi-formal focus groups and numerous informal conversations, we have heard from families about what they have, what they want and need, and what is particularly important.

Across these three sources of information, we've begun to see some hints of third variables that might be important for developing health and school readiness. Some of these lessons learned seem, again, intuitively obvious: General life stressors, logistical supports (particularly transportation), linguistic and cultural factors, and finances directly affect families' access to services and supports, including health care and early care and education. But some of the lessons are a bit more subtle, and perhaps a bit more surprising. We have noticed that families want, and appreciate, stronger social connections with other families and with individuals who can help them access various services and supports. Some of this increased engagement is pretty straightforward: Through these connections, families learn about and access resources that might not otherwise be available. But increased engagement also seems to relate to another potentially important factor, a sense of agency or effective control over variables in one's life. Families (and professionals) with whom we've worked sometimes express concerns that nothing, or very little, can be done to address challenges or wishes. As they engage with others, learn about potential resources, and have support to seek those resources, they tell us that they have more control over the factors that affect their lives – and they appear to

continues on page 4

"We have noticed that families want, and appreciate, stronger social connections with other families and with individuals who can help them access various services and supports."

School Readiness, continued from page 3

access more resources to support their children's development.

Is it possible, then, that creating formal and informal social networks that help families access comprehensive and coordinated services and supports and that increase their experiences with making decisions and seeing those decisions implemented might together contribute to school readiness and healthy development? Without question, targeted and effective services (e.g., high-quality early care and education, preventive health care) matter...but do these "third variables" add power to targeted interventions and produce more comprehensive, more powerful, and more meaningful results? And if these are true, can we design interventions that promote school readiness and healthy development by attending to these common factors?

These questions animate our thinking about health and school readiness (and other factors) in our ongoing work. Like other areas of "emerging research," we probably have more questions to answer than we do information and tactics to share, but we hope that continued attention to both the "first variables" (things like language and early literacy development, access to healthy food, well-child visits and physical activity) and to the "third variables" (increased social engagement and increased sense of agency) will be worthwhile for FHu5 families and the professionals who serve them.

Dr. Scott McConnell is Professor of Educational Psychology (Special Education Program) and Child Psychology and Fesler-Lampert Chair in Urban and Regional Affairs at the University of Minnesota, and an affiliate of the Center for Early Education and Development. He is particularly interested in the design, evaluation, and implementation of general outcome measures of young children's development for use in RtI and other intervention models. His current projects include:

- Directing *Five Hundred under 5*, a multidisciplinary community-based research and service development program to understand and improve school readiness for high-risk youngsters,
- Co-directing evaluation of the Minnesota Early Learning Foundation initiative, large-scale efforts to enhance systems for promoting school readiness for at-risk children in Minnesota.
- Leading the Minnesota site for the *Center for Response to Intervention in Early Childhood*, a federally funded research and development center working to develop Response to Intervention for programs serving preschool children.
- *Promise Neighborhood Research Consortium*, a consortium of prevention scientists working with high-poverty neighborhoods to identify and implement evidence-based practices.

Scott is a member of the Board at *Ready4K* and a member of the Northside Achievement Zone Management Team, and has served on or consulted to various committees of the United Way, the Minnesota Legislature, and St Paul Schools. He is also the father of two teens, Nora and Reid.

"The early years of life are important in part because they set a stable or shaky stage for all that follows."

From the Capitol to the Cradle: **Public Policy's Impact on Infant/Early Childhood Mental Health**

By Karen Cadigan, Ph.D.

The early years of life are important in part because they set a stable or shaky stage for all that follows. This is true not only for language, cognitive, and school readiness skills, but also for emotional expression, self-regulation, and social-personal skills. This latter set of abilities is referred to as infant/early childhood mental health.

Infant/early childhood mental health is all about relationships. Specifically, the mental health of young children, including those with biological risk factors, has everything to do with the "wellness of the actual care giving relationship between the caregiver and the child".[6] As such, families are in the best position to promote infant/early childhood mental health, but other important grown-ups play a role, too. The good news about this is that environments, unlike genetic codes, are changeable and can adapt to best support a child's development. Certainly the family, the neighborhood, and other proximal environments in which a child lives and learns are critical environments for impacting development. More distant environments, too, impact children's development, including all levels of government. Urie Bronfenbrenner's ecological model - adapted as Circles of Influence[3] - first described and provided a visual mechanism for illustrating the many ways that these environments interact with one another, including how a seemingly distant factor such as public policy has important impact on human development, and thus direct implications for children and their families.[1]

How, then, do public policies impact infant/early childhood mental health? One litmus test is to examine how a public policy (or lack of policy) supports or erodes the family's ability to provide stable, responsive, and loving care giving for children during the earliest years. Like the Circles of Influence, the Family Impact Checklist can be useful for examining the above question and for considering how policies influence or "push on" other environments in order to create healthy growing conditions for children. The Checklist is based on six key principles – family support and responsibilities, family membership and stability, family involvement and interdependence, family partnership and empowerment, family diversity and support of vulnerable families, and it provides a framework to critically examine a policy or program in relation to the family. It provides the user an opportunity to formally or informally assess the possible benefits, as well as the possible negative impact, of a policy or program on families.[4] Importantly, it is also a non-partisan tool intended for initiating conversations and building consensus across parties and sectors.

A reality of the policy making-context for researchers, providers, and children is our society's emphasis on individual, rather than the family unit's, needs and concerns. Our country has one of the few constitutions that does not use the word "family" and, indeed, our founders were intentional in supporting *individual* potential and opportunity, rather than on the family patronage from which they fled. These roots are still with us in the way policy is made. The all-important legislative committees focus typically on an individual – some the child, some the parent – rather on the family as a system. In Minnesota one example of this individual-focused policy-making is the early care and education "system." Of the $300 million+ of public money spent each year on early childhood programs, about half the funds support child care, where the primary purpose is for parents to work or get training, and about half the funds support early learning programs, where the primary objective is to get children ready for kindergarten.[5]

continues on page 6

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> "Legislators and policy implementers would do well to consider the impact of these decisions on the strength and ability of families to best support their member's (in this case, children's) early development."

From the Capitol, continued from page 5

While there may be particular programs or specific policies that aim to support or ameliorate infant/early childhood mental health, many policies can have unintended consequences on the wellness of family relationships, including the parent-child relationship. Legislators and policy implementers would do well to consider the impact of these decisions on the strength and ability of families to best support their member's (in this case, children's) early development. As Bronfenbrenner succinctly states, "The family is the most powerful, the most humane, and by far the most economical system known for building competence and character."[2]

Head Start professionals frequently are the first to observe stress, trauma, and behavioral concerns in young children.

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Tasoulla Hadjiyanni
Interior Design
CYFC Fellow

Tasoulla Hadjiyanni, PhD, is Assistant Professor in the Interior Design program at the University of Minnesota. She holds a B.Arch and an MS in Urban Development and Management from Carnegie Mellon University as well as a doctoral degree in Housing Studies from the University of Minnesota. Her doctoral work led to her book *The Making of a Refugee: Children Adopting Refugee Identity in Cyprus* (Praeger, 2002), which established her scholarship's focus in the interrelationship among design, culture, and identity under conditions of displacement. Hadjiyanni is now investigating the role of residential environments in cultural identity construction among five of Minnesota's new immigrant and minority groups: Hmong, Somali, Mexicans, African-Americans, and American-Indians. An advocate for culturally sensitive designs and an internationalized curriculum, she disseminates her teaching pedagogies, theoretical and practical research findings, and outreach activities in leading interdisciplinary academic journals, conferences, and exhibits.

"Culturally sensitive housing, can facilitate culturally appropriate food preparation and healthy nutritional choices."

Addressing health disparities through **culturally sensitive housing**

By Tasoulla Hadjiyanni, Ph.D.

Refugees, immigrants and people of color experience disproportionate poor health outcomes.[1] In Minnesota, occurrences of nutrition-related health concerns for example, such as obesity and diabetes, abound among minority and immigrant groups.[6] As revealed by my cross-cultural study of differences in housing needs, residing in culturally insensitive housing, or housing that is **NOT** supportive of varying ways of living, can be part of the problem:

- Lacking appropriate space to cook traditional meals, which tend to be healthier, both Mexican and Ojibwe families often resort to eating out or using frozen or ready-to-eat meals that are not as nutrient-rich as home-cooked meals with fresh ingredients.[4]
- Cooking in open kitchens can be uncomfortable and dangerous when a Somali woman has to cook when veiled in the presence of male visitors. The smells can also be overpowering when ventilation is not adequate to account for the oils and spices used in traditional Hmong cooking.[3,5]
- Furthermore, without space to eat as a family around the table or on the floor, as is customary for Somalis, some members choose to eat alone or move away from traditional eating patterns.[3,4] These spatial constraints diminish the many benefits of eating together, such as nurturing healthy nutritional habits and strong family relationships.[2]

Understanding and responding to cultural differences in ways of cooking and eating in the home through housing that supports various ways of living, i.e. *culturally sensitive housing*, can facilitate culturally appropriate food preparation and healthy nutritional choices and improve the health and wellbeing of Minnesota's diverse communities, helping reduce health disparities.

As a CYFC Fellow, I was able to contribute to these efforts by working toward the development of *Culturally Sensitive Housing Guidelines*. An interdisciplinary undertaking that crosses the intersections of design, health, anthropology, and sociology among others, the project inherently intertwines with CYFC's Circles of Influence framework: housing and the designed environment are among the systems that shape the well-being of children, youth, and families. The research also fits CYFC's commitment to understand and positively impact health disparities among children, including minority and immigrant children and families. Uncovering the role that parameters such as housing design and space layout play in whether or not a family will engage in healthy practices adds new dimensions to CYFC's work.

By supporting the generation of knowledge as to when and how housing can act as a barrier to health and well-being, CYFC strengthens its mission in terms of informing policy and enhancing practice to improve the well-being of Minnesota's children, youth and families.

Designers, affordable housing providers and funders (like the Family Housing

continues on page 8

"With housing that is more inclusive and that can be used equally well by all groups of people, the needs of children, youth, and families can be accounted for while the gap in educational and health disparities can be reduced."

Addressing Health continued from page 7

Fund - FHF, a project collaborator), as well as policy makers are also perplexed by how to effectively respond to the state's changing demographics and improve their services for new immigrant and minority groups. The questions can be puzzling:

1) What are the particular housing needs of these newcomers?
2) How can we best help them integrate into our community?
3) Which cultural practices should we be considering when building new housing units and when planning for suitable and healthy housing arrangements?
4) How do we educate others about cultural differences?

The *Guidelines* can be used by researchers in the context of understanding how housing matters to family members' health; design professionals and affordable housing providers to increase the cultural fit of housing for immigrant and minority residents; and policy makers to inform thinking about cultural sensitivity in debates and decision-making. Armed with this tool, community advocates can help establish Minnesota as a catalyst for re-evaluating what inclusive affordable housing means and how it is pursued, helping reduce health disparities in the process.

Content for the *Guidelines* comes from a literature review and a detailed data analysis from my large cross-cultural study that explored differences in housing needs. In-depth in-home interviews were completed with 76 families from with five Twin Cities' cultural groups: Hmong, Somali, Mexicans, Ojibwe, and African-Americans. The diverse samples (in terms of cultural background, ages, incomes, years in the US, living conditions, etc.) provide both quantitative and qualitative information including demographics; descriptions of current and preferred housing characteristics, such as types of spaces/rooms, users of spaces, and the activities that take place in these spaces (ranging from activities that support basic needs like cooking, eating, sleeping, socializing, grooming, and storage needs to religious customs and cultural traditions); traditions they value and wish to pass down to their children; and meanings associated with home. Along with the narratives, the data includes house plans and furniture, interior and exterior photographs, and observations by the researchers. Questions related to understanding differences include:

- How are spaces, like living rooms, dining rooms, kitchens, bedrooms, and bathrooms used by the different cultural groups?
- Which uses are similar and which are different?
- What kinds of spaces support basic practices like cooking, eating, sleeping, grooming, and storing possessions?
- How do activities, like decorating for a preferred aesthetic, dressing according to one's cultural norms, and practicing a religion, manifest themselves spatially?
- What difficulties arise as a result of these differences?
- How are these difficulties related to social, economic, educational, and health discrepancies?

In conclusion, being a CYFC Fellow helped me work toward the goal of reducing educational and health disparities by strengthening the study's interdisciplinarity, challenging me to re-evaluate the questions that I am asking through the eyes of other disciplines. It also expanded my approach to the data interpretation and level of analysis by enticing me to rethink for example, what is important and why. Lastly, along with refining and strengthening the policy implications of the study and helping define targeted dissemination plans, CYFC connected me to community partners and identified funding opportunities that can expand the study's impact. With housing that is more inclusive and that can be used equally well by all groups of people, the needs of children, youth, and families can be accounted for while the gap in educational and health disparities can be reduced. If you have questions or comments about my research or culturally sensitive housing please contact me at thadjiya@umn.edu.

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Vienna Rothberg
Adolescent Health Research Program
CYFC Fellow

Vienna Rothberg is finishing a dual degree program in the Schools of Social Work and Public Health at the University of Minnesota. She is one of three CYFC fellows and is also a fellow in the interdisciplinary Adolescent Health Research program at the Divisions of General Academic Pediatrics and Adolescent Health & Medicine at the U of MN. She is an active member of her South Minneapolis neighborhood, where she finds ease and excitement bringing public health theory and social work methods into the community in the form of community gardening projects. She is interested in social determinates of health, health disparities research, and working with adolescents in community settings. Vienna is also an artist and has a small handmade clothing business with her sister. She is committed to working toward greater social justice through the completion and dissemination of ethical and thoughtful research.

"Young people begin to make choices that may influence health outcomes over the lifespan."

The Potential of Self-Reflection in Adolescent Health Behavior Change

By Vienna Rothberg

Adolescence provides a valuable window during which young people begin to make choices that may influence health outcomes over the lifespan. Health providers, educators, parents and other caring adults can be instrumental in helping to guide a young person toward healthful choices. Health promotion efforts range in both efficacy and form: from classroom-style lectures to dinner conversations to motivational interviewing with clinic staff. As a CYFC fellow, I am involved in a study that is part of Prime Time: a longitudinal community-based health intervention study with sexually active girls aged 13-17 in the Twin Cities Metro area.[4] Prime Time includes 256 girls who, at baseline, reported a significant health risk, a significant educational risk, or a combination of the two.

The study measures the effect of one on one case management paired with peer education training and employment. The intervention is based on previous research, social cognitive theory and the social development model and lasts 18 months. Participants are surveyed at 6-month intervals for 30 months. The surveys are self-administered using Audio Computer-Assisted Self-Interviewing (ACASI) technology. Trained interviewers are on hand to answer questions and update contact information for the participant but do not interact with the participant on the content of the survey. The ACASI technology reduces bias due to social desirability, especially on items concerned with sexual behaviors or socially undesirable behaviors such as unprotected or risky sexual practices and drug or alcohol use.[7] The survey includes questions about relationships with friends and family, connections to teachers and school, family demographics and housing stability as well as questions about health behaviors, substance use, sexual relationships and sexual health behaviors.

As we began 18 and 24 month surveys, interviewers on the project reported that participants were engaging them either personally (such as inviting them to graduation parties) or spontaneously offering how they were feeling about taking the survey (e.g. 'I feel proud answering these questions because I used to get in a lot of trouble and I am doing so much better now' or 'I feel bad answering these questions because I know I should not call people names but I do'). I was intrigued by the consistency of the comments at these intervals and the variety of the details offered. Our evaluation staff attempted to keep participants paired with the same

continues on page 10

"The concept of self-reflection is commonly understood to be an important educational tool among adult learners."

Adolescent Health continued from page 9
interviewer to ease the survey scheduling process. Were participants enjoying the survey? Were they using the survey to think about their lives more critically? Were they feeling connected to the interviewers? Dr. Sieving, the Primary Investigator on the project, supported my intrigue and offered me the opportunity to develop and implement a number of measures aimed at capturing and describing these as yet unsolicited data. With input from colleagues from a variety of disciplines, we developed measures of self-reflection and added them to the final survey interval taken at 30 months.

The concept of self-reflection is commonly understood to be an important educational tool among adult learners.[2,3] Group reflection and guided self-reflection are important aspects of service learning curricula used with adolescents.[6] I posit that unguided self-reflection may be a tool for health behavior change among a certain group of young people given to self-reflection, and that offering a tool for self-reflection may be an effective health behavior intervention tool for this group of high reflectors.

My CYFC project will see the completion of an analysis of the first 50-70 responses to the 30-month survey. This primary analysis will assess the quality of the self-reflection measures. I seek to understand and describe the different characteristics of those reporting the strongest self-reflection effect and those reporting a lesser effect. I hope to better understand how self-reflection among adolescents might be used as an effective and economical intervention strategy aimed at both health and educational outcomes. I will look for differences in reflection as they relate to measures of school, friend and family connectedness, demographic characteristics such as age and ethnicity, levels of sexual risk taking and involvement with violence. With this preliminary analysis, I hope to illustrate that beyond the intent of the researchers to use the survey to study health behaviors over time, some high-reflecting participants may be using the survey as a unique opportunity for self-reflection and ultimately as a mild behavioral intervention.

Participating in this project as a CYFC fellow has increased my sensitivity to the intersection of health and education in both the study design and in our population. By recruiting a sample at mixed risk for poor outcomes in either health or education and treating the sample to the same intervention, we acknowledge either a root cause theory or a dual effect theory that this kind of tailored and holistic intervention approach treats both health and educational trajectories. Prime Time intervention seeks to improve participants' contraceptive use consistency, reduce number of sexual partners, and reduce unwanted sexual activity. The hallmarks of this intervention programming are a consistent connection with a caring adult, a tailored approach that responds to an individual's case management needs and engagement with peers on health issues. The dual effect theory is supported by the healthy youth development perspective that these types of interventions can increase positive outcomes related to many aspects of life- including educational attainment, reduced sexual risk taking and an increased sense of self-efficacy in both health and educational matters.[1]

My particular research is focused on the effect that the survey alone seems to have for high reflectors. While the survey is intended merely to evaluate the intervention, it could be the case that some aspects of the evaluation process mirror effective health and educational intervention strategies (the pairing with a consistent adult, survey and contact methods responsive to participant needs, space for reflection, etc). These preliminary analyses, supported and informed by my fellowship participation with CYFC serve to validate the measures so we can then take the next step toward understanding how this type of self-reflection relates to self-reports of behavior.

Self-reflection is an understated construct in several health behavior change models. Self-reflection may perform a variety of processes in the complex web of social context and the multitude of factors that result in behavioral choices. Many health behavior change models often rely on a change in knowledge, cognition, belief or social context.[5] Most notably, the Transtheoretical model maps the stages of behavior change from pre-contemplation- through Maintenance

continues on page 11

> **"The relevance of self-reflection as an outcome lies in the power of self-reflection to move an individual from one stage of change to the next. Preliminary findings support this hypothesis."**

Adolescent Health continued from page 10

TRANSTHEORETICAL MODEL STAGES OF CHANGE	
Precontemplation	No intention to take action within the next 6 months
Contemplation	Intends to take action within the next 6 months
Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction
Action	Has changed overt behavior for less than 6 months
Maintenance	Has changed overt behavior for more than 6 months

The relevance of self-reflection as an outcome lies in the power of self-reflection to move an individual from one stage of change to the next. Preliminary findings support this hypothesis.

Our final question on the 30-month survey reads: "Over the last 6 months, how has the survey changed your thoughts, feelings, or behaviors?" This open-ended question offer a wealth of insight into the impact the survey might have on this population. Some of the most exciting responses include several "It hasn't" responses. These responses suggest that we are getting an accurate representation of the variation of the effect rather than only the most socially desirable answers. But the punch line is found in our affirmative responses. Reflecting back to the stages of change, we might begin to map these exciting responses to the various stages.

"it show me how much unpertected sex i have and how my famliy views me.." *(Precontemplation)*

"talking about the sex and drugs made me think about how much we have sex while using" *(Contemplation)*

"Taking this survey has Somewhat helped in talkin openly about birthcontrol with my friends, and about relationships well just made more concious about I've been doing with each boyfriend." (Preparation)

"in the last six months i have not had as many sexual partners as i usually would because i acctually had to think about it last time and it kinda made me feel bad that i had so many." *(Action)*

"This survey helps with making important decisions more aware and is kind of like a friendly reminder to stay on top of everything. It was nice to remember the answers to questions years ago and reflect now because i no longer have the issues and I am more responisble." *(Maintenance)*

While more research needs to be done to understand these responses and the health behavior change constructs that they seem to reflect, it is clear that some positive unintended outcomes are at play. Within this group, vulnerable to poor health and educational outcomes, is a high reflecting subgroup who are filled with possibility and ripe for developing positive health habits under very little direction. And when we ask ourselves what positive impact this type of research has had on our participants, we need not stop at "it hasn't".

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Elaine Hernandez
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Elaine Hernandez is a doctoral candidate in the Department of Sociology at the University of Minnesota, where she is focusing on the sociology of health and illness. She received her BA in anthropology from the University of Notre Dame and her MPH, in public health administration and policy, from the University of Minnesota. As a graduate student, she has experience working for the Minneapolis Veteran's Affairs Medical Center, the Minnesota Department of Health, and the Flexible Work and Well-Being Center at the University of Minnesota. In her work, she blends perspectives and methods from medical sociology, life course scholarship, and social stratification research in order to understand social inequalities in health. In collaboration with University of Minnesota sociology professors John Robert Warren and Phyllis Moen, her work has appeared in the Journal of Health and Social Behavior as well as The Craft of Life Course Research. For her dissertation, "The Unintended Consequences of Biomedical Advances: Social Inequalities in Health Behaviors Among Pregnant Women," she examines the process by which health inequalities are reproduced. She hypothesizes that peer networks provide new health information and influence health behaviors by defining acceptable behaviors, which affect the social and economic hardships experienced by disadvantaged groups over time. To assess this process, her dissertation combines quantitative and qualitative primary data collection with secondary data analysis. Her dissertation research is supported by the Department of Sociology, the Graduate School Thesis Research Grant and the Children, Youth and Family Consortium at the University of Minnesota as well as the Foundation for Informed Medical Decision Making and the National Science Foundation.

"In the decades that followed the 1964 U.S. Surgeon General's report on the hazards of smoking, people with higher levels of education were more likely to quit smoking, and less likely to begin smoking"

Social Influences on **Health and Education Inequalities**

By Elaine Hernandez

Examining inequalities is a classic sociological aim and, recently, scholars in medical sociology and public health have turned their attention to the reproduction of inequalities in health.[1,2,3] These scholars contend that broader social and economic inequalities contribute to unequal rates of disease and mortality: people with more money, power, prestige and knowledge live longer and healthier lives. These inequalities persist, in part, because people in more socially advantageous positions are better able to avoid newly identified health risks when biomedical research advances. At the crux of this argument is the notion that over time, as health knowledge emerges and people learn new health information, those in more favorable social positions will continuously adopt advantageous health behaviors.[1] Over time this results in social inequalities in health outcomes—the unintended consequences of biomedical advances.

Familiar examples lend credence to the assumption that new health knowledge influences behavior changes: In the decades that followed the 1964 U.S. Surgeon General's report on the hazards of smoking, people with higher levels of education were more likely to quit smoking, and less likely to begin smoking. These differences support the premise that people with a higher social status are more inclined to alter their behavior upon learning new health information. Previous research has attempted to account for the association between education and smoking behavior by considering individual smoking risk knowledge with limited success.[4]

Although this explains why social inequalities in health are reproduced, much less is known about the process by which these inequalities are reproduced. One possibility is that social relationships play an integral role, providing individuals with new health information and influencing their decision-making about various health behaviors. This idea builds upon a bedrock of sociological and public health research, which emphasizes the importance of social ties for both health and medical decision-making, as well as more recent research, which indicates that individuals' social contacts influence their health behaviors.[5,6,7,8]

The idea that social relationships influence health behaviors is hardly new. My approach

continues on page 13

"Social relationships play an integral role, providing individuals with new health information and influencing their decision-making about various health behaviors."

Social Influences continued from page 12
combines this social networks research with the emerging approach in medical sociology that focuses on the importance of new health information in reproducing health inequalities, and I delineate specific mechanisms by which social ties influence health behaviors. The theoretical framework for my dissertation aligns with the Consortium's ecological approach, which anticipates that individual health behavior decision-making is embedded within a larger context of social influences. To evaluate this explanation, I focus on women who are pregnant for the first time—an ideal empirical example because *(1) they must navigate a plethora of new health information, newly acquired pregnancy information and emerging biomedical pregnancy information; and (2) their behaviors have a direct and measureable effect on birth outcomes and infant health*.

To assess the role of social factors and social relationships on pregnant women's health behaviors I am conducting a first trimester survey interview and a third trimester in-depth interview with pregnant women at three local clinics in the Minneapolis/St. Paul area. In the survey interviews I inquire about their socioeconomic background, assess their health behaviors, test their prenatal health knowledge and ask about the opinions and behaviors of their social contacts (e.g., friends, family members, co-workers, or health care providers). The social network component of the survey interviews will allow me to assess the importance of their peer network—friends or family who have had a baby in the past ten years—compared to other members of their networks. A randomly selected sub-sample of women are invited to participate in an in-depth interview, which focuses on their decision-making process in more detail. In addition to these interviews, I am also conducting in-depth interviews with health care providers at each of the clinics to understand how they interact with pregnant women during their prenatal appointments. The data collection began in November 2009 and will continue through October 2010. When completed, I intend to situate my sample of pregnant women within Minnesota and the United States using state- and nationally-representative samples of pregnant women.

Understanding this example will not only advance our knowledge about the processes that contribute to inequalities in health, it will provide insight into decisions about health behaviors that lead to unequal health among women and infants. Focusing on how health inequalities are reproduced during pregnancy has the potential to improve our ability to intervene and promote healthy behaviors among pregnant women. Even more, this topic is particularly timely given recent recommendations that pregnant women should receive H1N1 influenza vaccinations and increase their vitamin D intake.

As a fellow with the Consortium, I have benefited from the opportunity to interact with scholars from across the University of Minnesota community. Being a part of this interdisciplinary network has enriched my research and introduced me to new networks of scholarship. Interdisciplinary collaboration is a priority for me, and over the past year my research would not have been possible without help from Dr. Jane van Dis, Dr. Krista Reagan, Dr. Laura Cudzilo, Remy Wong, Sarah Simpson, Whitney Weber, Victoria Dutcher and Melissa Fousek. Upon completing my data collection, I intend to translate my dissertation research into recommendations that enhance the visibility of healthy behaviors during pregnancy using the Consortium's community-engaged approach. It is my intent to provide empirically driven, actionable advice about healthy behaviors during pregnancy.

Please do not hesitate to email me if you would like more information about this research: hern0120@umn.edu.

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Center for Excellence in
Children's MENTAL HEALTH

Marilyn Larson has worked in the field of early childhood education, community collaboration in child and family support, as both a program administrator and consultant. She supervised Minnesota's Early Childhood Family Education and School Readiness and Head Start for Duluth Public Schools. During that time the district was the recipient of a federal Early Reading First grant, which helped to re-tool Head Start with scientifically based curricula and coach teachers to become proficient in the latest early literacy teaching strategies. In addition, the district was funded by the Southern St. Louis County Family Services Collaborative to "bridge" the fields of early childhood and mental health in the classroom, using research-based curricula and strategies to help young children develop social-emotional skills. Larson worked for 15 years as a private consultant in the following areas of expertise: Early literacy, Transition from pre-K to kindergarten; Working with At-Risk Populations; Early education 0-5; Parent Education and Support; Comprehensive support for families with young children. Her clients included: Northland Foundation, several Minnesota School Districts and Family Services Collaborative; Wisconsin Great Lakes Intertribal Council; Search Institute; Seattle's *It's About Time for Kids*. Ms. Larson also served during the Perpich and Carlson administrations as Executive Director of *Action for Children Commission*, a 30-member governor-appointed board to advise on children's issues. During that time she was responsible for the publication, *It's About Time for Kids*.

The Interaction of Educational and Health Disparities: **The Mental Health Perspective**

Staff from the Center for Excellence in Children's Mental Health (CECMH) interviewed Marilyn Larson, Supervisor of Early Childhood Programs (Head Start, ECFE, and School Readiness) for Duluth Public Schools, for this article.

Disparities in children's mental health and education are evident as early as the preschool years. For the last fifteen years, Marilyn Larson has been a leader in the Duluth Public Schools in an effort to illuminate these disparities, and to help teachers, families, and school systems best meet the needs of young children. Larson is the Supervisor of Early Childhood Programs for Duluth Public Schools. She generously provided her perspective about the overlap in health disparities and educational disparities for this article.

In the last decade, Larson notes that not only have children's mental health needs increased, but that these needs have also seemed more severe. The needs of children are inevitably displayed in the classroom and affect the child's ability to learn. "Initially, we were concerned about kids who had mental health issues. In the classroom, staff felt overwhelmed and needed some direction on how to approach children who could not self-regulate emotional states, could not sit for extended periods of time, and could not communicate their wants and needs in a healthy manner." Through a Safe Schools/ Healthy Students grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Duluth Schools were able to introduce Mental Health Consultants to early education settings in order to enhance understanding of the specific needs of young children and the best ways to accommodate those needs

continues on page 15

"In the last decade, Larson notes that not only have children's mental health needs increased, but that these needs have also seemed more severe."

Mental Health continued from page 14
in the classroom. A significant component of this program was to engage teachers, mental heath professionals and parents in a collaborative effort to improve learning.

The Children, Family, and Youth Consortium (CYFC) has identified four fundamental ways in which mental health and education interact. The first is that early health status influences later educational success. Larson states: "Take, for example, a child with a history of acute or prolonged trauma. We know that when the brain is occupied with working with trauma, children aren't able to learn. We need strategies to help children lower cortisol (a hormone released in the body during periods of high stress and trauma) levels in the brain, to help children become more comfortable and trusting, and to help them learn readily." If these early health needs are not identified and addressed, it could become increasingly difficult for the child to learn. "Children who feel understood and competent are better able to learn."

In its most traditional form, the classroom can be unequipped and unprepared for the child struggling with both internally and externally displayed mental health issues, according to Larson. The Safe Schools/Healthy Students program provided the resources for teachers to contact a mental health consultant when they feel a child needs it. The mental health consultant serves as a neutral observer, evaluates the child's needs and produces a report that outlines the findings. Then the teacher, mental health consultant and parent meet together to identify how to translate the child's needs into adaptations in the classroom. For example, a child may be referred to special education. Or, a child who has experienced trauma may have difficulty with transitions, and is given a pocket schedule with pictures of the day's events to help him/her anticipate what is coming next. Another child who has experiences a loss of a parent may be encouraged to carry a picture of this person in their pocket during school. "We want to help staff and parents see what it means to provide a therapeutic environment for children," Larson states. "We want them to think critically about behavior in the classroom and at home, and to consider behavior as a form of communication. The questions at hand are, 'What is the child trying to communicate?' and 'How can we structure the environment (in the classroom) to address the children's needs?'" These types of adjustments are often simple, and can help children in the classroom relax, feel safe, and learn more effectively.

The second way that children's mental health and education interact is **concurrently**. "You can't do one without the other," Larson states. "Language development, expression of ideas and concepts, and especially the communication of needs and wants is critical for education, but they cannot happen without social-emotional development." Trying to educate children without acknowledging mental health needs can stunt their learning and foster educational disparities. Larson appreciates the cyclical nature of the link between education and mental health. She understands that learning does not occur in a vacuum, nor does it happen in a linear fashion. Learning is constantly influenced by the ebb and flow of relationships. Larson calls on the work of Hart and Risley,[1] which indicates the importance of early communication at home in helping children become the best possible learners and achievers in the classroom. The Safe Schools/Healthy Students program emphasizes the need for the adults children care about to foster regular, thoughtful communication with them, particularly by asking open-ended questions, listening carefully, and valuing their opinions. For the children who participate in this type of regular communication, relationships become deeper and more comforting, and learning can happen more readily.

Another way that mental health and education interact is through **common root causes**. Of the children enrolled in Head Start programs in Duluth, Larson estimates that close to 15% have elevated scores on the ASQ-SE social-emotional screen. In addition, individuals from the lowest socio-economic status are three

continues on page 16

"We know that when the brain is occupied with working with trauma, children aren't able to learn."

Mental Health, continued from page 15

times more likely to develop a mental disorder than those from the highest socio-economic status.[2] These statistics are significant, and need to be considered when creating interventions. Larson is quick to point out that it's not all about trauma. While there are common root causes for health and educational disparities, there are also common root causes for school success, among children with mental health needs and the general population. Children with healthy concepts of communication and the tools to relay wants and needs are apt to excel in the classroom in both academic and social-emotional contexts. "Hearing language at home at an early age is vital." Larson points out that ideas must be elicited, children must be presented with choices, and challenging concepts must be explained. "Hearing language in a scatter-shot or negative manner is inefficient and unproductive." Rather, Larson notes that explanations and collaborative dialogue between parent and child can provide the best opportunities for success in both mental health and education.

Finally, the fourth way that mental health and education interact is in prevention and intervention. "All parents want to be good parents," believes Larson. "The earliest education of parents is best, because helping parents feel comfortable, empowered, and welcomed pays dividends in both their parenting and in their own lives." Larson says that parents involved in the Safe Schools/Healthy Students program are learning not only about their children, but also about how they can be the best parents possible, and how they can use their own skills to achieve a sense of mastery and competency in their daily lives. Larson outlines some of the features of the work in the Duluth Public Schools that are perhaps most useful:

- Accessible resources for the classroom teacher, including mental health consultants. This helps the teacher know he/she is not alone and has support to meet the needs of the children. It also increases the teacher's skills in identifying specific needs of each child, and in turn helps him/her teach the children that everyone has needs and they are all different.
- Home visits by the mental health consultant in order to observe the child in their home setting and to work with the parent-child dyad.
- Parent groups that focus on the child's behavior at home and needed social and emotional support.
- Reflective supervision with all staff. When adults who work with children can reflect on their own feelings and their responses to children's behavior, they can come up with creative ways to better work with that behavior.

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Thank You Candice!

Candice Bartelle started with the Consortium as the Office Specialist in 2006. She holds a Bachelor of Applied Science from the University of Minnesota Duluth in Elementary Education. Candice was recently accepted into the higher education program at Loyola University in Chicago and she will be leaving CYFC at the end of the summer to begin her studies there. Throughout her tenure Candice provided the Consortium and the Center for Excellence in Children's Mental Health with strong office support. We will miss her and wish her well on her new adventures.

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Who's The Consortium?

In this edition of Who's The Consortium, CYFC wants to recognize the leadership of our new administrative home – The University of Minnesota Extension.

Beverly Durgan is the Dean of the University of Minnesota Extension. Prior to being appointed dean in September 2005, and director of the Minnesota Agricultural Experiment Station in January 2006, Durgan held several administrative positions at the University, including chief fiscal officer and associate dean for the College of Agricultural, Food and Environmental Sciences. As associate dean, she oversaw research and outreach programs of 11 academic departments and six research and outreach centers. In her role as chief financial officer, she provided oversight and strategic management of the research, resident instruction, extension and outreach budgets of the college. Durgan continues to serve as a state Extension faculty member in the department of agronomy and plant genetics, where she is a weed scientist in small grains and specialty crops. As a faculty member, she has conducted research, developed and implemented Extension programs and taught both graduate and undergraduate classes. She teaches an undergraduate class every fall semester and has received several Extension education and undergraduate teaching awards. A native of Montana, Durgan was raised on an irrigated corn and small grain farm. She received a bachelor's degree in business management at Montana State University and masters and doctorate degrees in agronomy from North Dakota State University. She joined the faculty of the U of MN in 1985 as a weed scientist.

Dale A. Blyth is Associate Dean and Director of the Extension Center for Youth Development, which serves as a catalyst, resource, and advocate to ensure quality community opportunities for all young people to learn, lead, and contribute. Prior to joining Extension, Blyth directed research at Search Institute and served on the faculty at Cornell University and Ohio State University as well as developing a center for adolescent healthy development at the American Medical Association. Blyth also worked with the W.K. Kellogg Foundation and its board on several community and service learning initiatives and strategic planning. Blyth serves on the Executive and Strategic Leadership teams of *Youth Community Connections*, the Minnesota Afterschool Alliance. In 2004-2005 he served as chief of staff for U of MN President Bob Bruininck's Minnesota Commission on Out of School Time and its report *Journeys into Community: Transforming Youth Opportunities for Learning and Development.* He has authored and co-authored many youth related articles and publications. Blyth currently serves as the co-chair of the University's Children, Youth, and Family Consortium's Core Advisory Committee, Minneapolis Mayor RT Rybak's Youth Violence Prevention Executive Team, and St. Paul Mayor Chris Coleman's Second Shift Commission of out of school opportunities.

Karen Shirer, PhD is Associate Dean for the Extension Center for Family Development with the University of Minnesota Extension. In that role, she oversees Extension's family related work statewide, including Family Relations, Family Resource Management, Housing, and Food: Nutrition, Health and Safety. Prior to joining Minnesota Extension, Shirer was assistant professor and extension specialist in the Department of Family and Child Ecology at Michigan State University. She held a similar position at Iowa State University, and was a county Extension Home Economist in Iowa prior to serving in her state leadership position. Shirer has been involved in many national Extension programming efforts, most recently its marriage education programming. She has also served as a principal investigator with the Minnesota Department of Human Service's research in its Food Stamp Education Program. Shirer holds a B.S. in Home Economics Education from UW-Stout, and an M.A. and PhD in Family and Consumer Sciences Education from Iowa State University. She has authored and co-authored numerous peer-reviewed journal articles on family-related issues and research.