Children, Youth & Family *Consortium*

CONNECTIONS

WINTER 2010

IN THIS ISSUE

University of Minnesota
Driven to Discover℠

Addressing the Interaction of Health and Educational Disparities: The Nursing Perspective

By Wendy S. Looman, PhD, RN, CNP

CYFC's new focus on the interaction between health and education is bold. It challenges researchers, practitioners, and policymakers to use a contextual lens to address deep-rooted problems in a new way. As a CYFC board member I have been participating in some exciting, yet arduous, discussions about this new focus. We have been urged to think outside our proverbial boxes to conceptualize the interaction between health and education, and how this is relevant to children, youth, and families. We are reminded that this interaction works in beneficial ways in some communities, but in detrimental ways in others, often due to factors such as race and poverty. We know that health and educational disparities are undeniable symptoms of some core socioeconomic, racial, and geographic inequities. CYFC's new focus is a challenge to broaden our vision and to think in new ways about that place where health and education *interact*.

Intriguing research in a new field called "cultural neuroscience" considers the relationships between social context and brain biology. Scientists are discovering that one's cultural perspective – specifically whether in a given culture, a person is viewed individualistically or as connected to and part of a larger whole – is actually reflected at the level of neural processes.[1] In other words, the extent to which we see the forest as the trees seems to be, in part, a function of the footprints that culture leaves on our brains. Perhaps this is why I have found it so challenging to keep my level of thinking at the contextual level – my Western brain may be wired to dwell on the trees and tune out the forest. I am working on recognizing the significance of context, however. In my nursing research, I study the relationship between a family's social connectedness and children's health. I have likened the process of trying to view health contextually to looking at Magic Eye posters, popular in the 1990s. These autostereogram images allow people to view three-dimensional images from two-dimensional images, but seeing these three-dimensional images requires skill and practice. The skill of seeing the depth of these images can be learned – vision therapists actually use stereograms to treat vision disorders. So although viewing health and education as interconnected may be challenging for many of us, perhaps with practice we can learn to see health and education contextually. What has been studied, practiced, and politicized in two dimensions might be addressed more effectively as a three dimensional phenomenon, so to speak.

The ecological framework is one way that CYFC situates the wellbeing of children, youth, and families contextually. Nursing is solidly rooted in an ecological perspective. In 1859, Florence Nightingale wrote in Notes on Nursing that children ". . . are much more susceptible than grown people

continues on page 2

Children, Youth & Family *Consortium*

Consortium Connections is published on-line three times a year by the Children, Youth & Family Consortium.

Madge Alberts
Editor

Children , Youth & Family Consortium
McNamara Alumni Center,
Suite 270a
200 Oak Street S.E.
Minneapolis MN 55455
612. 625.7849
Fax: 612. 625.7815
www.cyfc.umn.edu
E-mail: cyfc@umn.edu

Nursing Perspective, continued from page 1

to all noxious influences. They are affected by the same things, but much more quickly and seriously, viz., by want of fresh air, of proper warmth . . . by dullness and by want of light, by too much or too little covering in bed, or when up, by want of the spirit of management generally in those in charge of them."[2] Nightingale was viewing the world from an ecological perspective more than a century before Bronfenbrenner[3] wrote of the interaction between person and environment. She recognized that health and healing required more than simple tending to wounds, and that a healthy environment was key to the difference between wellness and illness. While the scope of the environment she recommended consisted of primarily physical conditions, Nightingale also recognized that children were vulnerable, and that they relied on "grown people" to serve as advocates for their well being. Her environmental theory described nursing as an act of utilizing the environment of the patient to foster recovery.

Today, nursing is the single largest discipline in the healthcare industry. As professionals, nurses have a central role in promoting and advocating for the health of children, youth, and families. According to the American Nurses Association's Social Policy Statement[4], nursing is accountable to the public through the protection, promotion, and optimization of health, and through advocacy in the care of individuals, families, communities, and populations. With an ecological perspective and a scope of practice that touches individuals from birth to death in every environment, nurses are well-positioned to positively influence outcomes related to the interaction of health and education.

CYFC has identified some fundamental ways that health and education interact. The first is that **early health status influences later educational success**, and vice versa. One of the most direct ways that nurses can influence this relationship to benefit children is through developmental screening. Assessment is a foundation of nursing practice. As a pediatric nurse practitioner, I can provide a gateway to early childhood intervention for young children with developmental delays. Early intervention can minimize delays that might otherwise compound over time, providing children the best chance for academic success. Nurses who work with children in primary or specialty settings have critical roles in assessing the developmental status of children. Nursing must see children's early health and development as indicators of wellness not only in the present, but for their future. Nurses practice at the intersection of health and education when they recognize the relevance of early developmental intervention and refer children with developmental needs to well-established local and state services.

Another way that health and education interact is **concurrently**. Healthy children are more likely to be successful learners. Professional school nurses address the physical, mental, emotional, and social health of children, and have as the ultimate outcome the support of student success in the learning process. They address potential health problems that are barriers to learning or symptoms of underlying medical conditions, tuning in to the emotional environment of the schools to decrease conditions that are not conducive to optimal health and learning[5]. One exemplary program that targets the concurrent interaction of health and education is the Healthy Learner Model (HLM[6]). Developed in the Twin Cities, this program evolved from a school and community initiative to manage childhood chronic conditions. The model is an integrated, coordinated effort to optimize the health status and support the academic success of children with chronic conditions. Professional school nurses are integral to the HLM, and through their knowledge, expertise, skills, and care coordination these nurses directly impact children's educational outcomes. Capacity building empowers school nurses and other leaders to adopt evidence-based practice to effectively manage health conditions that potentially affect learning outcomes. The HLM recognizes the value of organizational partnerships, shared vision, and administrative leadership for sustaining change. Through programs such as this, nurses are catalysts for improving the health-education interface to benefit all children equally, regardless of race, poverty or health status.

A third way that health and education interact is through **common root causes**. Public health nursing is the practice of promoting and protecting the health of populations using knowledge from

continues on page 2

"Florence Nightingale's environmental theory described nursing as an act of utilizing the environment of the patient to foster recovery."

Wendy Looman is Associate Professor in the School of Nursing, University of Minnesota. See p. 15, Who's The Consortium, for more details.

Nursing Perspective, continued from page 2

nursing, social, and public health sciences[7]. It is population-focused, community-oriented nursing practice that embodies the vision of care in an ecological framework. The goal of public health nursing is to prevent disease and disability by creating conditions in which people can be healthy. Public health nurses are increasingly identified as leaders in health system reform. Services provided through public health nursing practice *can alter the interaction of the determinants of health*[7], thereby lessening the impact of common root causes of disparities. Primary prevention is the priority of public health nursing, with a focus on strategies that create healthy environmental, social, and economic conditions in which populations may thrive. In this way, public health nurses are essential in the efforts to address common root causes of educational and health disparities.

Finally, nursing has a fundamental role in addressing the fourth way that education and health interact: **prevention and intervention** strategies to address one may also be appropriate for the other. Nurses are active not only as practitioners but also as policy advocates and researchers. Prevention and intervention require systemic action to design and implement policies that facilitate change for populations. Public health and school health services can and should be improved, but they need policy, legislative, and fiscal support to make this happen. Early childhood programs affect children's physical health by requiring that children be immunized and have vision, hearing, and developmental screenings. Evidence suggests that children who attend high quality early learning programs have greater access to health care and improved physical health. Nurse leaders, through research, practice, and political advocacy, influence the development and support of prevention and intervention strategies that ensure equal access to quality health and educational services. Nurses do this by documenting the ways that children, youth, and families are affected by policies and programs. In turn, legislators depend on meaningful and relevant data to support legislation for programs such as early childhood and early intervention programs.

Each of us has a stake in CYFC's success in supporting and creating new knowledge and encouraging the use of evidence in our family related professions. While often remembered for her efforts to improve the physical environment of patients, Florence Nightingale was also a pioneer of evidence-based health care reform, developing new methods for data collection for a uniform classification of disease to aid in comparing outcomes. As political activist, Nightingale used data to support her calls for public health policy changes so that nurses could help the most people in the most effective ways. Like Nightingale, nurses use research to inform policy and improve practice to enhance the wellbeing of Minnesota's children, youth and families. We may just need a bit of vision therapy and perhaps a bit of a culture shift.

REFERENCES

1Han, S. & Northoff, G. (2008). Culture-sensitive neural substrates of human cognition: a transcultural neuroimaging approach. *Nature,* 9. 646-653.

2Nightingale, F. (1859/1969). Notes on Nursing. What it is and what it is not. Dover.

3Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Harvard University Press.

4American Nurses Association (2003). Nursing's social policy statement (2nd Ed.). Retrieved from Nursesbooks.org.

5American Nurses Association (2005). School nursing: Scope and standards of practice. Retrieved from Nursesbooks.org.

6DuPlessis Erickson, C. et al. (2006) The Healthy Learner Model for student chronic condition management (Part I). *The Journal of School Nursing*, 22 (6), 310-318.

7American Nurses Association (2007). Public health nursing: Scope and standards of practice. Retrieved from Nursesbooks.org.

Yingling Fan

Assistant Professor of Regional Planning and Policy

One of four CYFC scholars.

Yingling Fan is one of four CYFC Scholars. An urban planner and traffic engineer by training, Yingling Fan is Assistant Professor of Regional Planning and Policy at the Hubert H. Humphrey Institute of Public Affairs, U of MN. She works interdisciplinarily in the fields of urban planning, social equity, and public health. Her interest in the social and health aspects of planning can be traced back to 2001, when she graduated from college and began work as an Assistant Researcher at the Transportation Research Institute, Southeast University, Nanjing, China. There her work assignments included traveling to various cities and towns in China and designing/redesigning highway networks to reduce traffic congestion. Such experience led her to a deeper understanding of how transportation is inextricably intertwined with land use, economic development, the environment, and social issues such as equity and health. As a result, her interest broadened to the study of cities, how cities are supposed to work, and how to make cities good places to live for all habitants. She later studied abroad and received her Ph.D. in City and Regional Planning in 2007 from the University of North Carolina at Chapel Hill. In her dissertation, she examined the role of neighborhood design and urban form in shaping individual activity engagement and travel behavior.

In her current role, she continues her interest in creating livable and healthy cities, with a specific focus on poor, underprivileged, and underserved communities. She serves as principal investigator on studies examining the role of light rail transit in improving job access among the working poor, the linkage between neighborhood redevelopment and displacement of minority residents, the impact of sprawl on urban-suburban health disparities, and the impact of neighborhood design on family activity engagement and stress levels. Her work has appeared in various urban planning and transportation research journals. In 2008, she won the Pedestrian Committee Best Paper Award and the international Patricia F. Waller Award from the Transportation Research Board, Washington, DC. As a CYFC scholar, she is committed to build a robust knowledge base for creating health-promoting neighborhoods for underserved families.

> "70 percent of employed mothers and fathers feel that they do not have enough time to spend with their children"

Neighborhood Design, Family Outdoor Activities, and Children's Well-Being

By Yingling Fan, Ph.D.

Recent decades have witnessed dramatic changes in American family structure. The number of dual-worker families increased 95% over the past three decades, more than double the overall family growth rate.[1] We have also witnessed increases in single parenthood. By 2008, of the 47 million families with children, about 32% are single-parent families. The increasing prevalence of dual-worker couples and single parents means an upsurge in time squeezes for American families, as dual-worker families face many hours of combined work time and as single-parent families face a constant tug-of-war between the need to support their children and the need to spend time with them.[2] According to a 1997 national survey, 70 percent of employed mothers and fathers feel that they do not have enough time to spend with their children.[3]

Following the socio-ecological model of health behavior,[4] individual activity is influenced by individual, interpersonal, organizational, community, and public policy or society factors. An environment rich in activity opportunities can act as a visual reminder to be active, as well as enforce activity as a cultural norm. Among the many spatial contexts in which health behaviors occur, an individual's neighborhood of residence is deemed

continues on page 5

> "Neighborhoods are where most people spend a large portion of their daily lives, where many of their social and economic interactions take place, and where structural conditions are imposed to shape individual lives and opportunities."

Neighborhood Design, continued from page 4
critical. Neighborhoods are where most people spend a large portion of their daily lives, where many of their social and economic interactions take place, and where structural conditions are imposed to shape individual lives and opportunities.[5,6]

However, despite the increasing recognition that neighborhood contexts play an important role in shaping daily activity patterns of residents,[7] it is rarely recognized that neighborhoods may play a much larger role in influencing activity patterns of families than individuals. Family activities require the coordination of family members' timetables, and such coordination is likely to reduce the potential locations for family activities to a small space around the residence. Consequently, neighborhood contextual factors such as the amount of nearby activity opportunities and neighborhood safety matter more to activity choices of families than of individuals. Neighborhood contextual influences may be especially important for single-parent and dual-worker families with school-age children, as they face stricter time constraints that translate into further spatial and mobility limitations. To date, little research has examined the relationship between neighborhood environments and activity engagement in the family context. This is especially disconcerting given:

- the growing time squeezes for American families (especially for single-parent and dual-worker families),
- the ongoing sprawl that distances families from outdoor activity opportunities, and
- the fact that a lack of family-engaged activities poses a serious threat to child health and school performance.[8]

As a CYFC scholar, I am committed to find policy solutions that may reverse the ongoing declining trend of family outdoor play. My CYFC project explores how neighborhood design can promote family outdoor play and, ultimately, enhance children's well-being. The project began last fall with efforts to build new community-University partnerships comprising faculty, students, city planners, private developers, designing consultants, and community activists. With the new partnerships, we have identified a specific community on the Northside of Minneapolis for potential built environment interventions. The basic functionality of the intervention will reflect widely-used features of neighborhood revitalization programs (e.g., park improvements, sidewalk upgrades, trail construction and open space development), and will be carefully tailored to emphasize the needs of families with children.

Parallel to the planning and design of the targeted built environment interventions, we are in preparation of a baseline, before-intervention survey to be carried out in the identified Northside community in summer 2010 to gather information on activity engagement and well-being status from children and families who live there. We have also identified a control neighborhood that has similar socio-economic characteristics with the intervening neighborhood but will not have any major revitalization efforts during the study period. It is intended for the control and intervening neighborhoods to comprise a matched comparison pair. Children and families in the two neighborhoods will be asked again about their family outdoor play and well-being status after the targeted built environment interventions. Finally, the before- and after-intervention data from the two neighborhoods will be analyzed and compared to determine whether the positive, family-friendly changes in the neighborhood built environment improve children's well being through increasing their participation in family outdoor activities.

The project, with the goal of establishing causality between neighborhood design and family togetherness and then to good outcomes for kids, addresses the contexts of family and the built environment simultaneously to understand barriers to children's well-being. The research coincides with the CYFC's Circles of Influence Framework, which considers five major layers of influence (child, informal supports, communities, policy and society) to understand the child-family dynamics. The research also fits into the CYFC's commitment to understand and positively impact the interaction of education and health disparities

continues on page 6

Neighborhood Design, continued from page 5

among children. With the emphasis on neighborhood-level environmental factors, the project will lead to understanding of educational and health disparities across geography—across different neighborhoods. And based upon such understanding, policy makers may tailor urban planning and design strategies to be area-specific so as to promote family-oriented activities and improve children's well-being. Further, both the intervening neighborhood in Northside Minneapolis and the control neighborhood contain significant proportions of low-income population and minorities including African Americans, Somali immigrants, Hmong, and Hispanic ethnicity-both foreign and native born. By focusing on children from socioeconomically disadvantaged families, the project will help policymakers identify urban planning and design solutions to reduce children's educational and health disparities across racial and income groups.

To conclude, American families are facing unprecedented difficulties in finding time and space to play, given the ongoing sprawl and the rise in single-parenthood and female labor force participation. I am very grateful for the CYFC's Scholars program as it offers me an opportunity to conduct timely research on these important issues facing American families. I also believe this program will assist me in demonstrating and reinforcing my commitment to create health-promoting neighborhoods for underserved families. Please do not hesitate to contact me at yingling@umn.edu should you have any questions or comments about my research.

REFERENCES

[1] King, M., et al. (2009). Integrated Public Use Microdata Series, Current Population Survey: Version 2.0. [Machine-readable database]. Minneapolis, MN: Minnesota Population Center [producer and distributor].

[2] Jacobs, J.A. and Gerson, K. (2004). The time divide: work, family, and gender inequality. *The family and public policy (p. 259)*. Cambridge, MA: Harvard University Press.

[3] Bond, J.T., et al. (1998). The 1997 National study of the changing workforce (p. 168). New York: Families and Work Institute.

[4] Sallis, J., N. Owen, and Fisher, E. (2008). Ecological Models of Health Behavior, in Health behavior and health education. In K. Glanz, F.M. Lewis, and B.K. Rimer, (Eds.), *Theory, research, and practice* (pp. 465-482). San Francisco: Jossey-Bass.

[5] Roux, A.V.D. (2001). Investigating neighborhood and area effects on health. *American Journal of Public Health*, 91(11): 1783-1789.

[6] Kaplan, G.A. (1996). People and places: Contrasting perspectives on the association between social class and health. *International Journal of Health Services*, 26(3), 507-519.

[7] Frank, L.D., Engelke, P.O., and Schmid, T.L. (2003). Health and community design: the impact of the built environment on physical activity. Washington, DC: Island Press.

[8] Fiese, B.H., Family routines and rituals. *Current perspectives in psychology*. New Haven: Yale University Press.

The team of Ross Macmillan, J. Michael Oakes and Naomi Duke make up one of four CYFC scholar research projects.

Ross Macmillan is Associate Professor of Sociology and Director of the Life Course Center at the University of Minnesota. He is also a fellow of the MN Population Research Center and directs the University's Graduate Minor in Population Studies. He is an active researcher who has published dozens of articles on various issues around child, youth, and family. He has expertise in both survey administration and statistical analysis and is widely known for his contributions to adolescent development and his work on statistical models for developmental processes. Among other honors, he serves on the editorial boards of the *Journal of Marriage and Family, Advances in Life Course Research, and Journal of Quantitative Criminology.*

J. Michael Oakes is McKnight Presidential Fellow and Associate Professor in the Division of Epidemiology & Community Health, U of MN. He is also a fellow of the MN Population Research Center and an Adjunct Professor of Sociology. His is an active researcher and frequent principal investigator on a wide variety of studies addressing a vast array of methodological, health, social and ethical topics. Among other honors, he is an associate editor of *Evaluation Review* and Senior Scientific Advisor to Robert Wood Johnson Foundation's *Healthy Eating Research* program. He is also the coordinator of the Minnesota Child Welfare Research Collaborative.

Naomi Duke is an interdisciplinary Adolescent Health Post-Doctoral Research Fellow at the Center for Adolescent Nursing and the Divisions of General Academic Pediatrics and Adolescent Health & Medicine at the U of MN and is in the PhD program in Sociology at the U of MN. She is a physician, holding a medical degree from Harvard Medical School, and has completed residency in Internal Medicine and Pediatrics at the University of Michigan Hospitals. Board certified in Internal Medicine, General Pediatrics, and Adolescent Medicine, she has served patients and families in impoverished and designated physician-shortage areas as well as academic medical centers. She has an MPH from the U of MN (core concentration: maternal & child health). In 2008-2009, she received a Viking's Children Fund grant-in-aid to study cultural identity development and its relationship to health behaviors among severely impoverished African American youth. She has published in the areas of youth mental health and best practices in adolescent health services and policy.

"Study after study shows that those with greater educational attainment have better health."

Unpacking the Education-Health Connection in the Era of 'New' Immigration

By Ross Macmillan, PhD, Michael Oakes, PhD, Naomi Duke, MD, MPH

Health and education are strongly intertwined. On one hand, the association between educational attainment and good health is an accepted fact. Study after study shows that those with greater educational attainment have better health.[1] They report better health, they have less exposure to diseases, they are less likely to engage in risky behavior such as smoking, they are less likely to experience accidents, and they live longer lives and live them freer from disabilities. At the same time, good health is implicated in educational attainment. Although specific mechanisms are less understood, health limitations, including childhood disabilities and chronic diseases, undermine school performance, increase the likelihood of drop-out, and limit successful completion of higher education.[2]

Yet, while social and medical science has documented the importance of the education-health connection, the face of America is changing. We are witnessing a new era of immigration that has changed and will continue to change the American population. Unlike earlier periods, the vast majority of immigrants now come from Southern hemisphere nations, and are a mix of people leaving impoverished nations, immigrating in the wake of devastating wars, fleeing environmental disasters, or escaping from on-going civil unrest. They are locating in a wide variety of metropolitan areas that span the entire country (e.g., Atlanta, Dallas, Minneapolis, Phoenix, Seattle, Washington), and have strong "replenishment" where a steady influx of new immigrants shapes and perhaps even stalls assimilation processes. Importantly, the scale of the new era of

continues on page 8

"Health limitations, including childhood disabilities and chronic diseases, undermine school performance, increase the likelihood of drop-out, and limit successful completion of higher education."

Unpacking the education continued from page 7

immigration parallels the massive transformations of the early 20th century; as of 2007, the size of the immigrant population in America is a mere three percentage points below its all time high and shows a strong pattern of growth. A country that was founded as a nation of immigrant is re-establishing its unique character as it enters its third century.

Contemporary immigrants will both challenge educational institutions and introduce unique health issues. In terms of the former, educational institutions through American history have been the central vehicle for assimilation.[3] Yet, contemporary immigrants bring a wide variety of languages and educational backgrounds. Moreover, their sheer diversity creates a spectrum of educational experience. Those emigrating from stable nations are more likely to bring high quality educational credentials and considerable experience and knowledge of formal education. Those fleeing famine, war or other instabilities may have little to no educational experience. Also, because they represent such diverse background, languages and customs, educational accommodation is increasingly challenging. For example, Minneapolis-St. Paul, a "re-emerging gateway," has seen large influxes of Latino, East African (Somali and Ethiopian), and Southeast Asian (Laotian, Thai) immigrants, and there is little history of such groups in the local school systems. Finally, immigrant replenishment means that traditional ethnic culture is continually reinforced and hence is inter-connected to rather than replaced with assimilative processes such as formal education.

From the standpoint of health, the implications of new immigration are equally profound. Perhaps most importantly, contemporary immigrants increasingly come from countries with comparatively poor health states that reflect exposure to disease (e.g., HIV in Africa and SE Asia) and limitations in health care. For example, recent data show Somalia to have an average life expectancy of 49 years and an infant mortality rate of 113 (per 1000). By comparison, life expectancy in the United States is 78 years and infant mortality rate is only 6.3. Given that health is a cumulative process, baseline differences in health in countries of origin can translate into important differences in health vulnerabilities and susceptibilities during the post immigration period.

Contemporary immigrants also have varied conceptions of health and causes of diseases that make self-recognition of health issues, including even serious conditions, more complicated and also challenge, rightly or wrongly, the Western biomedical model of health and health care. Language barriers can further inhibit communication with physicians and undermine the development of trusting relationships with health providers. There is also the added complication that many types of trauma experienced by new immigrants, particularly those fleeing war torn nations, produce mental health problems that reinforce difficulties in working with providers and using health care information effectively. The increase of immigrant gateways further decreases the ability of immigrant groups to act collectively to activate and enhance health care opportunities, and the capacity of health care institutions to cost-effectively provide culturally relevant services are undermined. As a final point, the differences in vulnerabilities and cultural/linguistic barriers to effective health care are reinforced by the replenishment process that ensures a continual influx of traditional values and norms regarding health and health care, so adapting to the new environment is a slower process.

As CYFC scholars, our research seeks to enhance the scientific and public policy base of knowledge on immigrant health and the critical role of education in shaping health trajectories over the life span. In doing so, we recognize the importance of families and educational environments as key features of the "circles of influence" that shape human development in a variety of ways and are among the more important determinants of health and well-being. First, to update knowledge and health among contemporary immigrants, we will analyze data from several high quality surveys collected by the federal government over the past twenty years. This includes data on large samples of children, samples of adolescents transitioning into adulthood, and samples of early, mid-age, and older adults. We are able to distinguish different immigrant groups, and our specific focus is similarity and difference in education "gradients' in health and disease, as well as risk behaviors, knowledge, and access to and utilization of health care that should link education to health outcomes.

The second phase of our work involves dissemination of research findings and relationship building among key stakeholders, including community organizations, education providers, state and local government, public health

continues on page 9

"Contemporary immigrants also have varied conceptions of health and causes of diseases that make self-recognition of health issues, including even serious conditions, more complicated and also challenge, rightly or wrongly, the Western biomedical model of health and health care."

Unpacking the education continued from p. 8

practitioners, medical providers, as well as the general public. We plan a series of information sharing forums that involves the various stakeholders, as well as a series of information gathering meetings with local community organizations where we visit their organization to better understand its workings. Our goal is to develop an on-going dialogue on how we might work with the specific organization to achieve mutual objectives on enhancing education and health. Given the need for multi-disciplinary and multi-organization input, we will also sponsor workshops that bring together the full range of stakeholders for collaborative work on education-health issues among immigrant populations. The central themes of these workshops will be the identification of research issues (i.e., what do we need to know?), the identification of education/health priorities (i.e., what do we need to address?), and the development of strategies (what do we need to do?).

Our third phase involves a pilot study with immigrant (and non-immigrant) populations in the Twin Cities metropolitan area. Through consultation with community partners, we envision three components. The first will involve detailed assessment of educational attainments and experiences, both pre-immigration and since arrival to the U.S. The second facet will focus on health knowledge, information, and decision-making. We expect that key factors that link education to good health are knowledge, awareness, and information on health and health care. The third facet of the pilot study will be a detailed health questionnaire organized around a life history account of preventative measures (e.g., immunizations), disease diagnoses, functional status, health behaviors, self-perceptions of health and limitation, mental health, and healthcare access and utilization. In all cases, we will pay attention to cultural specifics and cultural variation in the meaning and measurement of health concepts.

The final phase involves a longitudinal community study with experimental interventions. Integrating knowledge gained from the earlier phases of our research and incorporating an understanding of the necessity of bridging and linking spheres "of influence" that are guiding principles of the CYFC, this work will involve:

1. Stratified sampling of multiple immigrants groups in the Twin Cities with a specific focus on the larger and growing populations of Somalis, Latinos, and Hmong, coupled with 'control' groups of non-immigrant African-American and White;
2. A three wave longitudinal study that allows for initial assessment of health, and evaluation of stability and change in education and health and the mechanisms that link them;
3. Interventions focused on educational enhancement and health information that explicitly use children's involvement in schools as a means of introducing families to educational and health enhancement opportunities;
4. Rigorous evaluation of the experimental interventions for both short term (one year) and longer term (two plus years) effects;
5. Collection of detailed contact information that would allow for subsequent follow-ups to assess long-term outcomes and life course variation in health profiles.

In the end our project seeks to enhance health among immigrant communities by marshalling the power of families and schools who are the fundamental pinions of educational attainment that is the foundation for better health. To achieve this, we seek to both enhance scientific understanding of the processes and mechanisms that link education to health, as well as draw upon the strengths and power of local communities, organizations, government, and health care providers to jointly formulate better policies and practices for healthy living among immigrant communities.

If you have any questions or wish to talk with us about the research, contact Ross Macmillan through cyfc.umn.edu.

REFERENCES

[1] Ross, Catherine & Wu, Chia-ling. 1995. The Links between Education and Health. *American Sociological Review*, 60, 719-745.

[2] Palloni, Alberto. 2007. Reproducing Inequalities: Luck, Wallets, and the Enduring Effects of Childhood Health. *Demog-raphy*, 43, 587-616.

[3] Alba, Richard & Nee, Victor. 2003. Remaking the American Mainstream. *Assimilation and Contemporary Immigration*. Cambridge, MA: Harvard University Press.

Planning a Family Impact Seminar for State Policymakers: A Race Against Time

By Sara Benning

CYFC is one of 27 states that host Family Impact Seminars for their state legislators and legislative staff. On February 18th and 19th we hosted our 3rd annual seminar. Every state conducts their seminars differently to fit the unique needs of their legislature. We thought readers might be interested to know what is involved in planning and implementing a seminar in Minnesota.

Karen Bogenschneider, director of the Policy Institute for National Family Impact Seminars (PINFIS) based at the U of Wisconsin-Madison is known for saying that planning seminars "is not for the faint of heart or weak in spirit." It is by repeating this mantra that we embrace the exciting and unpredictable yearlong process of making our responsive, nonpartisan, research-informed policy seminars happen.

Planning for our most recent seminar began 12 months ago when attendees at the February 2009 seminar picked their top three topics (from a list of about 20) that they wanted to hear about at the next seminar. In the months following the seminar, policy director Karen Cadigan and I followed up with legislators who attended the 2009 seminar to talk about how they used the information, and to learn about the issues they felt were coming up during the next session that could be informed by research. In addition, we made contact with every legislator's office to request meetings to gather input to help identify seminar topics. Between spring and summer 2009, we met with 50 of the 201 legislators, as well as additional legislative staff.

During these meetings, we shared CYFC's philosophy on policymaking and the background of Family Impact Seminars. Then we sat back and listened. We heard their thoughts on the issues that were important to them, and when they thought the best (and worst) times for a seminar would be. These face-to-face meetings not only gave us important information for planning purposes, but also served to strengthen personal relationships with policymakers. Relationships are a critical component of the Family Impact model.

By the end of the summer, we had a good understanding of the issues the legislators we met with were interested in. We noticed there was a major theme among the interests of legislators, even though the specific topics were different. No matter what their political party, caucus membership or length in office, they wanted to know how to know "what works." It appeared that we needed to use their specific topical interests, largely related to children's learning, as a springboard from which to talk in general about how they could use evidence to inform their decision-making.

We discussed our ideas with other university colleagues who work with policymakers to help us narrow down the scope of such a broad topic. We also convened our 2010 Family Impact Seminar Legislative Advisory Board, made up of eight members (four from each party and caucus), to discuss and finalize plans for seminar topics and timing. We discussed how the seminar could use "case studies" to highlight how evidence is utilized to create, guide and evaluate programs impacting children's learning. These case studies used issues that are timely to legislators in the current session and would serve as specific contexts within which to learn some of the transferrable lessons of evidence informed policymaking. With some additional vetting, we decided on three case study topics:

1) A metro, seven-county early childhood home visiting program;
2) A statewide parent-youth survey on community learning opportunities for youth;
3) An evaluation of Minnesota's Alternative Education Programs. Besides sharing how evidence can be used at a variety of points along the policymaking path, the case studies also highlighted children's development across the lifecycle.

Timing the seminars is always a challenge due to legislators' busy and ever-changing schedules. Getting the timing right was even more critical because we planned to host the 2010 seminar twice in order to better meet legislators scheduling needs.

continues on page 11

The 2010 Family Impact Seminar **"Evidence-Informed Policymaking: Improving Accountability and Outcomes for Children, Youth and Families"** featured national expert Dr. Dave Riley of UW-Madison, who discussed best practices for evidence-informed programs and policies. Local experts Dr. Dale Blyth (UMN-Twin Cities Extension, Center for Youth Development), Judy Randall (Office of the Legislative Auditor) and Frank Forsberg (Greater Twin Cities United Way) highlighted Minnesota examples that illustrate how the collection, use and evaluation of evidence has informed their understanding about a program, problem or issue. The briefing report, presentation slides and report glossary are available on CYFC's website at: www.cyfc.umn.edu/policy/poli_seminars.html.

Family Impact Seminar continued from p. 10

We were entering unexplored territory because we were the first state in our national network to attempt this. Using our advisors' recommendations, we determined two dates early in session that seemed like they would interfere as little as possible with committees, could best accommodate the schedules of legislators (especially non-metro legislators who travel great distances to get back to their families and constituencies) and occur at a time before session got too busy for legislators to attend.

With the dates set, we moved forward identifying and meeting with potential speakers.

Our colleagues at North Carolina's Family Impact Seminars had focused their 2009 seminar on the use of evidence in policymaking. Working with their help and permission, we retooled parts of their briefing report to include in our briefing report.

During December and January, seminar speakers crafted their sections of the briefing report, while we worked with a copy editor and designer to format the content. Save the date flyers and invitations were dropped off in person at legislators' offices, and several reminder phone calls to each office were made.

So, you might be asking, with all of this planning, how is planning a seminar a race against time?

At the beginning of the year and before session started, we had been hearing from legislators and legislative staff that they were already busier than usual. As the seminar days grew closer, we began to see legislative committee schedules and agendas become solidified. At the beginning of the seminar week, everything seemed to be going at a reasonable pace at the capitol. But in the days right before the seminar, the House and Senate were busy deliberating and voting on a major bill, requiring their attendance in sessions. Because of this, attendance at the first of the two seminars was minimal.

House fiscal committees were called into a meeting at last second on Friday morning, during the time of the second seminar, so while day two of the seminar was not quite as hectic as day one and allowed for better turn out, it still created the need for flexibility by seminar planners and speakers. The deliberation of bills resulted in a lower than expected attendance, but we were pleased with the seminar turn out, presentations and discussions. Across both days, the seminar drew twenty-five attendees, twelve legislators and thirteen legislative staff members.

There were over thirty legislators registered for this year's seminar, so we know there was interest. But a part of the seminar process is recognizing that the real time realities of our state policymakers and their staff, who are working hard to represent their constituents during a time of economic uncertainty, required them to be elsewhere. We want to thank them for the time they continue to make for us, and for their service to the state.

Now the cycle begins again. As session slows down, we will once again gather feedback on this year's seminar and learn what legislators want to hear about at next year's seminar.

Given the reality of the legislative schedule, is it worth it to do Seminars, and to do them during session? It absolutely is. First, legislators continue to tell us that not only are they busy during off session months (the vast majority have other jobs), but many of them live far away. During session is the only time when it is possible for everyone to have a real opportunity to attend. A non-session Seminar would likely convene mostly metro area legislators, thus limiting the important dialogue among unconnected groups (House-Senate, Republican-Democrat, Urban-Rural). Second, in-session means that relevance rules. If we want legislators to find research relevant and useful, then providing space where they can ask real world questions about their real world decisions strengthens the application of their knowledge. Finally, we believe it is a responsibility. As the state's land grant institution with the luxury of being only nine miles from the Capitol, formal efforts to connect research and policy making are important for us to make good on our commitment to the advancement of learning and the well-being of the our state.

Center for Exellence in
Children's MENTAL HEALTH

Poverty as a Root Cause of Poor Educational and Mental Health Outcomes for Young Children

By Leah Pigatti, Ph.D and Fran Rethwisch, B.S.

CYFC's current emphasis on exploring interactions of Education and Health Disparities in the context of an ecological perspective is a significant area of necessary discussion, especially for programs such as Early Head Start and Head Start. Head Start programs are concerned about supporting educational and mental health well-being for children and their families. Head Start Performance Standards require every program to obtain a mental health consultant, provide timely and responsive intervention, along with family centered mental health services and education.[1]

In 2008, Head Start/Early Head Start programs enrolled nearly 18,000 children from birth to age 5 living in 16,657 families in Minnesota. Children and their families come from every ethnic and racial group including African American, American Indian, Asian, Hispanic, Caucasian, and Pacific Islander. Overall 75% of enrolled families are employed; in 22% of those households both parents are employed. The common thread that draws Head Start/Early Head Start families together is their income. Over 90% of enrolled families fall within 100% of OMB poverty guidelines.[2] In 2009 for a family of four, that translates to an annual income level of $22,050.

Families living in poverty have a multitude of challenges inherent to securing basic needs such as finding and maintaining affordable housing, accessing health and dental care, and food security. Low income parents often are so overwhelmed trying to meet daily needs, they are unable to address academic, social, and emotional developmental needs of their children. Young children who live in low income households are at risk of decreased cognitive and language development, decreased levels of social competence, and decreased ability to self regulate. The complex relationship of social/emotional development and intellectual development are addressed daily by staff working in Head Start and Early Head Start programs. This relationship becomes more challenging as mental health concerns are identified in young children as well as their families.

Every Head Start/Early Head Start program utilizes mental health curricula and has practices in place for prevention, identification, screening, and referral of mental health concerns. In 2005, Minnesota programs provided 13,741 children (81%) with screening for developmental, sensory, and behavioral concerns. Staff consulted with mental health professionals regarding 1,699 children or 10% of the enrolled population and referred 284 children for professional mental health services.[3]

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

continues on page 13

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

Poverty as a Root, continued from page 12

Types of behaviors observed in classrooms include:

- Physical and verbal aggression
- Difficulty following a consistent routine
- Emotional "meltdown"
- Inability to enter and sustain appropriate play
- Socially and emotionally withdrawn
- Irritable
- Hyper-vigilant or fearful.

With this observation comes the responsibility to address behavioral concerns in a community environment frequently ill equipped to provide effective mental health services to very young children. In addition, families typically have few resources available to access mental health support. Because parents struggle to provide for basic family needs, the educational and mental health development of their children is sometimes not a priority. It is important to recognize that parents care tremendously about these issues; however, they are usually too overwhelmed with other issues to plan for successful intervention. In addition, parents are often challenged by:

1) inexperience in addressing social/emotional and educational developmental issues
2) lack of knowledge about the availability of appropriate resources,
3) inability to pay for mental health services
4) unwillingness to admit that there is anything "wrong" with their child.

Because of our diverse experiences working with children and families living in poverty, we believe integration of family mental health services is necessary for effective intervention. Addressing social/emotional needs of children is most successful when approached using an ecological perspective of intervention. We believe mental health services could be greatly enhanced by institutionalizing the concept of mental health prevention and intervention for young children and integrating mental health services with parental support. We also acknowledge and are encouraged by the fact that we are on the cusp of forward movement in development of mental health services for the very young.

From our perspective, four levels of mental health involvement and support need to be present for successful outcomes.

Community Support - There must be community recognition and acceptance that mental health needs exist in young children, and to be effective their parents must be linked to resources. Communities need to have a variety of mental health resources and a range of treatment options available which recognize that services must be provided to jointly to children and families; one cannot be isolated from the other. Community support should come from a variety of agencies such as social services, faith communities, business, higher education, and child care as well as traditional educational and mental health clinics.

Professionals – Mental health, early childhood special education teachers, and classroom teaching professionals need to be trained in providing services to young children, and their parents. Professionals need to understand family dynamics and relationships that lead to patterns of family interaction. Professionals also should have experience working with families living in poverty, an ability to understand the culture of poverty, and strategies to effectively address relationship issues as they relate to low-income families. Mental health and teaching professionals must work as a team with parents to address areas of concern and provide consistent steps toward educational milestones and mental well-being.

Families – Families need help to overcome the stigma attached to mental health concerns and they must feel support and acceptance when seeking assistance. They need to establish linkages to mental health professionals and community clinics. Parents (or primary caregivers) need to understand various mental health treatment options and payment assistance that will enable them to utilize an on-going system of care rather than a sporadic approach. Parents also need technical assistance, modeling, and support in developing healthy parenting techniques with their children; this may even require them to break entrenched patterns of behavior. Parenting classes must be offered

continues on page 14

"We believe mental health services could be greatly enhanced by institutionalizing the concept of mental health prevention and intervention for young children and integrating mental health services with parental support."

Poverty as a Root, continued from page 13

that address a broad range of family family issues from accessing basic needs of food, shelter and clothing to building strong relationships with their children.

Children – Systems that support children are at the core of the ecological perspective of intervention. Children must be enrolled in developmentally appropriate programs with highly skilled teachers. Children need consistent and developmentally appropriate educational experiences. They need guidance in developing self regulation techniques, and opportunities to safely explore their environment and develop trusting relationships. Mental health professionals are key players in observing children and planning classroom intervention strategies in coordination with teachers and parents.

Implementing this type of ecological perspective of intervention offers a comprehensive, community-based approach to improving educational and mental health outcomes for children who experience challenges as a result of living in poverty. Teachers, mental health professionals, and parents can work together to effectively identify and respond to the needs of children as well as help families develop coping strategies to address their concerns and linkages to appropriate community resources.

REFERENCES

[1] U.S. Department of Health and Human Services, Administration for Youth and Families, Head Start Bureau. (2003). Head Start Performance Standards. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc

2 Minnesota Head Start Association. (2010, February, 15). Minnesota Head Start Facts and Stats. Retrieved from http://mnheadstart.org/fact.htm.

3 Brooks-Gunn, Jeanne and Duncan, Greg J. (1997). The Effects of Poverty on Children. *The Future of Children,* 7 (2), 55-71

Leah Pigatti is Executive Director for Mahube Community Council in Detroit Lakes. She has worked for 32 years with children, families, and elderly individuals who struggle with the challenges of poverty. Mahube Community Council provides programs such as Early Head Start/Head Start, Energy Assistance, Weatherization, Homeless/Housing Assistance, Food Support, Health Insurance Counseling, and Senior Services, all designed to help alleviate the effects of poverty. Dr. Pigatti holds a Ph.D. in Human Development from North Dakota State University and is an adjunct faculty member for Minnesota State University in Moorhead teaching Research Methods and Educational Psychology.

Fran Rethwisch is Disabilities Services Director and Children's Mental Health Coordinator for the Mahube Early Head Start and Head Start program serving a three county area. She holds a B.S. degree and some graduate credits in Early Childhood from Minnesota State University Moorhead, and holds pre-kindergarten and parent education licensures. Fran is a Certified trainer in the MN state Infant & Toddler Training Intensive Project (PITC) and in the 2nd Step Curriculum, and was a reveiwer and evaluator for the draft of the "Guide to Early Childhood Mental Health."

2009-2010 CHILDREN, YOUTH & FAMILY CONSORTIUM CORE ADVISORY COUNCIL

Roberto Aviña
La Familia Guidance Center

Dale Blyth
Center for 4-H Youth Development

Marcie Brooke
Working Family Resource Center

Andrew Collins
Institute of Child Development, University of Minnesota

Betty Cooke
Curriculum and Instruction, University of Minnesota

Amy Crawford
Jay and Rose Phillips Foundation

Diane Cushman
Co-chair National Council on Family Relations

Rep. Matt Dean
Minnesota House of Representatives

Emmanuel Dolo
Minnesota Minority Education Partnership

Rep. Robert Eastlund
House of Representatives

Michael Golden
Program in Health Disparities Research

Lynn Haglin
Northland Foundation

Rep. Jeff Hayden
Minnesota House of Representatives

Nancy Jost
West Central Initiative Foundation

Wendy Looman
School of Nursing

Mary Marczak
Co-chair UM Extension Family Development

Kristine Martin
Hennepin County – Research, Planning and Development

Senator Geoff Michel
Minnesota Senate

Melanie Nadeau
Grad Student – Public Health

Senator Gen Olson
Minnesota Senate

Kent Pekel
College Readiness Consortium

Rep. Sandy Peterson
MN House of Reps

Senator Sandy Rummel
Minnesota Senate

Jean Sanderson
Law School, University of Minnesota

Karen Seashore
Ed. Policy & Administration, University of Minnesota

Karen Shirer
U of M Extension Family Development

Connie Skillingstad
Prevent Child Abuse - MN

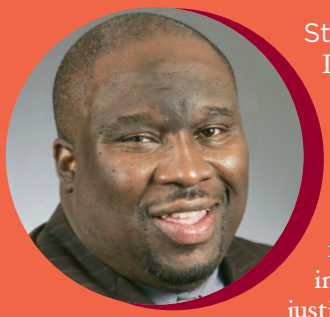
Senator Patricia Torres Ray
Minnesota Senate

Vallay Varro
Office of the Mayor

Noya Woodrich
Division of Indian Work

Who's The Consortium

State Representative Matt Dean represents District 52B in the Minnesota State Legislature, which includes the cities of Dellwood, Mahtomedi, Hugo, and Stillwater. First elected in 2004, Rep. Dean is now in his 3rd term as a legislator. Rep. Dean serves as the ranking minority member on both the House Health Care and Human Services Finance Committee and the House Licensing committee, and is a recognized voice for innovative, bipartisan health care reform. He also serves on the Saint Paul, Minneapolis Archdiocese Marriage, Family and Life Board. The goal of Board is to provide input to the Archdiocese in its effort to support good marriages, raise awareness of violence and abuse, and promote respect for the unborn, elderly, sick, dying and disabled. Rep. Dean holds a Bachelor of Architecture from the University of Minnesota. In addition to serving in the legislature, Rep. Dean owns an architecture business in St. Paul. He and his wife Laura, an obstetrician, have three children.



State Representative Jeff Hayden has represented House District 61B since 2008. He is on the Health Care and Human Services Finance, Health Care and Human Services Policy and Oversight and Housing Finance and Policy and Public Health Finance committees, co-chairs the Minneapolis Delegation and is Vice Chair of the committee Rules and Legislative Operations. In the Legislature, Hayden advocates for the progressive political change that he has fought for in his community for decades, including issues on economic justice and enacting a single payer health care system to cover every Minnesotan with quality affordable health care. Prior to his election, Jeff managed Heart Connection, a Minneapolis non-profit. He attended both Metro State University and Bethel University. Rep. Hayden has been active in his community, serving as Coordinator of the 38th Street Business Association, a Board Member of the Community Action Agency, and the Board Chair of MAD DADS. He has also served as Board Chair of the Powderhorn Park Neighborhood Association and Board Member of the Bryant Neighborhood Association. Jeff is on the board of Amateur Sports Commission, The Council on Black Minnesotans and the Midwestern Legislative Conference Innovative Selection Committee. He resides in Bryant neighborhood of Minneapolis with his wife Terri and their two children.

Wendy Looman, a member of CYFC's Core Advisory Council, is Associate Professor in the School of Nursing at the U of MN. She received her Masters and PhD degrees in Nursing from the University of Michigan, with an emphasis on Human Ecology and Health Promotion. She teaches in the graduate and undergraduate programs, focusing on pediatrics and family health theory. She is a member of the Center for Children with Special Health Care Needs, which prepares pediatric nursing leaders to improve the quality of care and systems of care for children and youth with an added emphasis on those with special health care needs. She is a Pediatric Nurse Practitioner and practices clinically with a multidisciplinary team that serves children who have craniofacial conditions. Looman's research focuses on the social connectedness of families who have children with special health care needs. Her work has included the assessment of quality of life among families of children with genetic conditions, and the development of a tool to measure social capital among families raising children with chronic conditions. She is a member of the National Association of Pediatric Nurse Practitioners, the National Council on Family Relations, and the International Family Nursing Association.