Leadership Education for Adolescent Health (LEAH)
Tele conference series
With State Adolescent Health Coordinators

Session one
Healthy Youth Development, Measuring Protective Factors and Positive Outcomes
July 20, 2006**,** 12:00 noon to 1:30 pm ET

Presenters:
Michael Resnick, University of Minnesota
Shirley Hankins Robinson, University of Alabama at Birmingham and
Sydney McDonald, University of Alabama at Birmingham
Moderator, Mary Doyle, Konopka Institute, University of Minnesota

This is Mary Doyle from the Konopka Institute; I'll be moderating the session today. Kristin Teipel is not able to be with us due to a scheduling conflict. So I want to wish everybody welcome, and good morning and good afternoon, depending on what time is it there. What time is it in Hawaii by the way, Noella?

It is about 6:05 am.
You are dedicated.
There are about six of us who are dedicated.

That is fantastic, welcome and thanks for attending so early in the morning. This is our first session in a series of sessions in which the LEAH faculty present on topics of interest to the State Adolescent Health Coordinators. Today's topic is Youth Development, Measuring Protective Factors and Positive Outcomes. We have three presenters today; they are Dr. Michael Resnick, LEAH faculty at the University of Minnesota; Dr. Shirley Robinson Hankens, LEAH faculty at the University of Alabama at Birmingham, and Dr. Sydney MacDonald, LEAH Fellow at the University of Alabama at Birmingham.

I just have a few housekeeping items before we start our presentations today. We will be sending out an evaluation by e-mail and we request that the State Adolescent Health Coordinators distribute it to any other attendees that they may have attending with them today. These evaluations are especially important to us because this is our first session and we will be making changes based on your recommendations and feedback.

We also have Dr. Bonnie Spear (University of Alabama at Birmingham) and Dr. Renee Sieving (University of Minnesota) in attendance who are also LEAH faculty. I want to give a big thanks to them because they were both on the planning committee and have been working to bring this call and this series to fruition for many months. Thank you to Renee and Bonnie!

We do have a number of people attending the call today; we had 21 registrations from State Adolescent Health Coordinators which is fantastic. They include,
Sandy Powell, Alabama
Becky Judd, Alaska
Beverly Plonski Fuqua, Arizona

Anne-Marie Braga, Colorado
Shay Chapman, Florida
Noella Kong, Hawaii
Shelli Rambo Roberson, Idaho
Carol Hinton, Iowa
Stephanie Woodcox, Indiana
Nancy Birkhimer, Maine
Pam Putman, from Maryland
Julia Gaggin Humphreys, Massachusetts
Patti Van Tuinen, Missouri
Linda Henningsen, Nebraska
Cynthia Collins, New Jersey
Dan Green, New Mexico
Angela Smith, Ohio
Kelly Holland, Pennsylvania
Jan Shedd, Rhode Island
Lucy Gibson, South Carolina
Cheryl Cass, West Virginia, sitting in for Patty Snodgrass

Tele conference process
Michael will present for 20 minutes and then there will be a 5-minute Q&A period. We would like to keep those questions specific to his presentation. Then Shirley and Sydney will present for 20 minutes, and they also will have a 5-minute time period after their presentation for questions or comments, and again we would like to keep those questions or comments specific to the content of their presentation. Then we'll have a general discussion for 30 minutes. I will manage the time and will remind Michael and Shirley and Sydney when their time is close to being up for their presentations and the 5-minute question period. If multiple people want to comment at any given point in time, I'm going to ask that they give me their names and I'll put those names on a list and I'll then be able to put those people in line for time to comment. Again, bear with us a little bit, this is our first call and we are experimenting with this process.

Michael Resnick's presentation
I'm Michael Resnick, Professor of Pediatrics and Public Health here at the University of Minnesota, been here about 30 years, much to my amazement and I want to give thanks to Kristin and Bonnie, Mary Doyle, Renee Sieving, everybody involved in bringing us together. My goal, folks, in this initial conversation with you, is to clearly make the bridge between healthy youth development principles and strategies and the world of public health. And all that we are called upon to do in terms of prevention and health promotion and protection. And I fully understand that you as Adolescent Health Coordinators are called upon to make the case to advocate, to do more with less, and you have to answer to multiple and competing constituents. And in order to be effective you have to work from a base of evidence. So part of our message today in this teleconference is that healthy youth development is not a therapeutic, feel-good philosophy. In fact, a decade of research and evaluation studies really gives us a solid platform to stand upon to advocate for these approaches with our public health colleagues.

So let's start by just asking the fundamental question, what is it? Because not too many years ago, healthy youth development or what a psychologist might call positive youth development, could best be described as a philosophy or a perspective. And those who were promoting the use of youth development strategies and their programs and their policies or practices generally had in common a core set of values. They were advocates for youth rights, they believed in expanding opportunities and resources for young people, and they were committed to the idea that young people were resources to be nurtured, not that young people were problems that needed to be fixed or solved by adults.

But here we are in 2006 and there is a base of scientific evidence that shows us that when we use deliberate strategies to promote the healthy development of our young people, including young people who come from very challenging environments, we can reduce the risky behaviors that threaten their health and their well being. But I think very importantly, beyond this, by providing opportunities to develop skills, competencies, and to have positive experiences with caring adults who have high expectations and a positive attitude toward youth, we thereby increase the likelihood that these young people themselves will grow up as caring, capable adults with better health outcomes and less risky behavior.

Now some of you might be thinking I work with classic public health people who just don't get this, or they don't understand the evidence or they aren't persuaded, and you know when we are trying to shift someone's perspective and here we are really talking about moving from a traditional risk reduction view to something that we in Minnesota call the dual strategy, the dual strategy, reducing risk while increasing protective factors, more on that later.

When we try to change someone's way of thinking and doing, it really helps to use language that is familiar to them. So I want to use the language of John Last, this will take some of you back to your MPH days, John Last is the editor and senior author of the Handbook of Public Health. It is one of the most boring texts on the market and probably the definitive textbook on public health services, organization, and approaches. And what John Last does in this tome, this bible of public health, is remind us that public health mobilization around any health issue or around any threat to health has to go through four steps. And the first of those steps is to name the problem. You have to know what it is, what it is that is before you, before you can organize and take action. You have to know what the problem is; naming is something that makes things real. So HIV in 1985, the Hanta virus in 1995, it was really in the late 70s and early 80s that Child Trends and the Guttmacher Institute named teen pregnancy as a threat to the healthy development of young people. Violence is a public health problem, not just a morality or criminal problem, identified, named as a public health issue by the Surgeon General back in 1996. That is step one.

Step two, once it is named, we have to articulate the source of the health threat. How does it spread? How is it transmitted? What promotes it? It is probably easiest to think of this in terms of acute disease contagion. So I find it helpful to ask the question with public health colleagues, especially folks who are working in the area of social determinants of health this question, what are the conditions or what are the circumstances that increase the risk of teen pregnancy, or violence, or suicide? Because when you ask a public health colleague to think through what increases the risk of some adverse outcome, we are very good at it. We know that teen pregnancy risk goes up with a lack of knowledge, lack of skills, lack of motivation; it increases with a lack

of access to contraception and health services. When there is heavy role modeling of teen pregnancy, when there are social norms that promote it or expect it, when younger teen girls are in relationships with older guys, or when there are special vulnerabilities. Like a history of physical or sexual abuse, or out of home placement, and so forth. Ask a public health person what increases the risk of teen suicide and what will they say? Depression, friend or family suicide, easy access to non-secured firearms, or copycat behavior because the media has recently glamorized the suicide of a young person. So we are talking about naming the problem, and identifying its sources and how it spreads.

Step three; we identify the means for prevention, reduction, control, or health promotion. Now folks this can mean stopping the source of an outbreak, it can mean providing the skills and the education, the means and the motivation needed to avoid high-risk behavior, it can mean primary or secondary prevention, and in the case of healthy youth development we are really talking about growing the capacity of young people to avoid risk or reduce risk and to engage in positive, healthy, prosocial behaviors. So here we are. We know the problem, we know it causes or perpetuates it, we know how to approach it, and then suddenly we realize that so far we have been really working from a scientific knowledge base that helps us think through those three steps. It is research and intervention studies and evaluation studies that really give us the knowledge base to achieve steps 1, 2, and 3, so here is where it gets tricky, because step 4 is political, and here it is.

Step 4, how do we organize our resources, mobilize our supporters, build the agenda, and implement step 3? Or to put it another way, now that we know what we need to do, which is what step 3 is all about, how do we move to step 4 which is to create the circumstances and the context where we can actually go to the field and move to direct action?

Let me take a step back and ask the question, why now? And the fact is we are in a critical window of time right now, and this is one of the reasons we are having this conference right now because before our next State Legislative sessions begin, we have to mobilize now to undo the damage that has come from federal cuts in 2005 and 2006 and state cuts all over America that are affecting the future of our young people. Whether we are talking about cuts affecting clinics or schools or after-school programs or youth development programs targeted at our young people. And the way we do this, is to be persuasive in our use of evidence. To use the language and the logic of public health in our talk, and to call upon others to move the adolescent health agenda forward so that individual voices are joined together into a loud and insistent and irresistible chorus, that is what we want to do.

So I have been thinking about this, this image of a critical window of opportunity to speak up and to advocate for youth, this idea actually takes me back to my own adolescence, I'm not going to tell you when that was, but back then there was a wonderful weekly public TV program called "The Great Adventure" it was narrated by the terrific TV and stage actor E.G. Marshall. One of those episodes of The Great Adventure told the civil war story of a confederate submarine, called the S.S. Hunley back in 1864. And it was this riveting scene that I'll never forget where the first submarine that really was ever used to sink an enemy ship was deep under the surface, waiting for its opportunity to ram a torpedo into a Yankee battleship. The sailors had to make their move before they literally ran out of oxygen, and their signal of when they were

approaching the point of no return was a small burning candle. That was their oxygen monitor. None of those sailors wanted to be the one to admit they couldn't breath any longer, that the carbon dioxide levels had gotten too high, and slowly the flame on this candle gets smaller and smaller, the candle goes out, they are sitting there in total darkness, they lose their chance to make it back to the surface, and the S.S. Hunley never returns.

And my point is that we can't wait until the point of no return. So when a colleague says to us well what do you mean by healthy youth development? This is what we mean. We are talking about a deliberate process of providing young people with support, relationships, experiences, resources, and opportunities that are needed to navigate adolescence and become successful and competent adults. And in fact we learn from national studies conducted in countries all over the world, surveys in Asia, Europe, Africa, Latin America, North America, New Zealand, Australia that there are clear reoccurring protective factors that appear again and again in the research. Protective factors, by which I mean the events and the opportunities and the experiences that really equip our young people with the ability to avoid or reduce risk and build their competencies in ways valued by society. So these powerful reoccurring protective factors include a strong sense of connectedness to parent and family, a strong sense of connectedness to other adults outside the family, and here we are talking about adults of course who value and reward positive prosocial behaviors, not anti-social behaviors. A strong sense of connectedness to school, where young people report my teacher's are fair, they are interested in me as a person, my teacher's have high expectations and care about my success. The new research that is looking at a sense of spirituality above and beyond any one religious affiliation meaning a sense of connectedness with a creative force in the universe. What this research is showing us folks is that these kinds of protective factors reduce the likelihood that young people will be involved in a whole array of behaviors dangerous to themselves and others. These include less involvement in committing acts of violence against one's self or others, less substance use, less involvement in early and unprotected sex, and less emotional distress. And very importantly, we also know that these protective effects from various forms of connectedness seem to apply across social groups of young people. Again, looking at this wide array of international health studies, we see protective effects for girls and boys, for those in urban and rural and suburban areas, for young people from a variety of racial and ethnic and other social groups. And even for kids both in wealthy highly technological societies and for kids living in nations that are poor and developing technologically.

This research on healthy youth development is also showing us that social connectedness in all these forms is the foundation, it is the basis for developing skills and capacity and experience in young people. We look at the research around carefully evaluated programs and we see successful outcomes when young people are given opportunities to develop skills and decision-making, when they learn skills that allow them to participate in activities that are of help or service to others, both in school and community settings. Here I am talking about service learning opportunities. And when young people have the opportunity to reflect upon and share these service learning opportunities with others, with the help of trained facilitators.

Now these kinds of opportunities for valued contribution, not only reduce involvement in risky behaviors, and I find this next finding very exciting, young people's participation in service learning and community service also predicts greater involvement in civic life as adults. By this I

mean that human beings who are involved in community service during their adolescent years are more likely to be engaged adults involved in their community, involved in community organizations and networks that join them with others. Now I know that Shirley and Sydney will be speaking about affective programs and resources to identify those programs, I will say that since I do a lot of work in the field of teen pregnancy prevention, I'll mention one program like Teen Outreach, strongly grounded in the youth development frame, it engages kids in community service learning, it provide accurate comprehensive sex ed, it provides opportunity for reflection and processing of the experiences with a trained kid-oriented teacher or facilitator. And it is this powerful combination of learning new skills, being of help or service to others and effective sex education that then reduces teen pregnancies and boasts school completion rates. And the cost for this program is relatively low for youth development programs ranges from $100 to $700 per student depending on where and how it is implemented.

But there is more value to this kind of young development as well. The research from 26 countries around the world is teaching us that the opposite of social engagement and civic involvement is social isolation and disconnection. Social isolation and disconnection are huge threats to the public's health. New research being published by Robert Putnam, the guy who wrote Bowling Alone 15 years ago, is showing us that social isolation and disconnection in fact is as big a risk factor for early death as is cigarette use. I find that little factoid an absolute knock out. And furthermore, when we look at the research on adults and health and community life, we find that when grownups have less connection to their community and less civic involvement, guess what, their life expectancy is lower, their emotional health is worse, and interestingly, there is more political corruption when there is less civic engagement by grownups. In adults, the act of joining a social group and this can be a group connected with a school, a community center, a religious group, any organization that brings people together with shared interests and shared purpose, when they join a group the risk of dying in the next year is reduced by half. And this is after controlling for all kinds of other factors, including health status and poverty.

So what this new research on social isolation and social connectedness is showing us, is that the most powerful threats to the well being of our young people is the combination of poverty, isolation, and disconnection. Because even in communities where there is poverty, if there are strong and supportive social networks, physical and emotional health outcomes in fact are improved.

So let me wrap up with a couple of thoughts. If history has taught us anything, and this is straight up public health history, we know that changes in social conditions change the threats to the health and well being of populations. And social conditions for our young people sure have changed, those of you who are very youth-involved, those of you who are parents sure know this. Our young people are more mobile, there is a widening opportunity gap that is based on resources and education, and there is less connection to community and to adult networks. Many of our young people, in fact, are less imbedded in their communities then they ever were. And all of these sociological changes mean we have to be thinking about healthy youth development in a different, deliberate and strategic way. It means we have to do our public health work in a different way. Our vocabulary is changing in response to these changing social conditions. We talk about developmental assets and strengths and positive youth development, we talk about the importance of engagement, well being, and thriving. The goal of healthy youth development is to

promote positive behaviors, not just prevent negative behaviors. Because we understand that even when our young people don't have major problems, or they aren't high-risk, they aren't necessarily prepared for the demands of adult life. And being prepared for adult life is not the same as being fully engaged. Our language has changed. I look forward to the rest of this discussion, lots of Q&A and ways of concretely applying these ideas to your situations, your dilemmas, your priorities and needs.

Thank you everybody.

Questions for Michael Resnick
Thank you Michael, I will open this up to questions now.

This is Becky from Alaska. Michael thanks and I'm sure all of us are wowed by your articulateness on this issue. So my question is, you have brought up the issue of connectedness to non-parenting adults, and that happens to be one of the protective factors of most interest to me, but the one that I have had the most difficulty in finding the research to support. I'm wondering if you can help us with that citation (electronically to all of us), because that is the one I have trouble with. Other then kids who are supported by teachers, I'm looking for non-school, non-parenting adults.

You bet. There are different kinds of evidence out there. If you want to take a look at the 32 year longitudinal research of Emmy Werner looking at the children of the Island of Kwai, starting with this cohort of kids who are impoverished, vulnerable, she follows them absolutely forever, what her work demonstrated, Beck I know you know her stuff, what Werner's research has shown is the powerful role of other adults outside of the family. If you take a look at the website for Karen Pittman's group, The Forum for Youth Investment, you'll see some materials also about the role of other adults outside of the family. And finally some evaluation studies that take us back to this idea of community service and service learning, where it may be a teacher, but it also might just be a trained facilitator who is engaging kids, helping them to learn new skills, and to directly apply those skills and then process the experience with all kinds of positive outcomes, ranging from teen pregnancy to violence to prevention of school dropout. But, I also want to acknowledge that you are right, the body of research that documents the power of other adults in the lives of kids is not yet as well developed as things like connectedness to school and connectedness to parents and family. But it is out there and it is growing. So as you go back and search this stuff out, if you are still not satisfied, well you know where I live. Drop me an e-mail.

Okay, thanks, I know of Werner's work, I was looking for more recent, but I'll go back. Thanks.

This is Jan Shedd from Rhode Island. I have a question; in what way is social connectedness different and what is similar to the work of Travis Hershey?

I don't know the work of Hershey in particular, I know the Hershey candy bar, to which I feel very bonded at times. But, what you'll find are some very, this is a social control theorist, what you'll find is that bonding, attachment, connectedness, these are all different words that are describing some of the same similar underlying dynamics. So you are talking about kids who are attached to adults who recognize reward and value positive behaviors. Okay. And part of that is a

social control function where kids have internalized positive norms, positive behaviors, and not anti-social kinds of norms. So I would guess that if I went out and learned more about Hershey's work, we would see an awful lot of similarity with all this kind of stuff too.

And sorry I'm not familiar with his stuff directly.

There is time for one last question.

This is Nancy from Maine. My question relates to the issue of limited resources and the limited missions of some of our colleagues. For example, I once had a supervisor say, you know, if we put all our money into poverty reduction we'd probably see some public health benefits, but we don't have enough money to eliminate poverty, so we need to do more focused interventions and what I'm responsible for is tobacco reduction. So if we have limited amounts of money and a tobacco-specific piece or a broad social connectedness strategy, how do we get people to prioritize the latter when the payoff doesn't seem to be as great for their issue?

Great question coming from the wonderful State of Maine. Let me answer that in two parts. The second part is advocacy. Advocacy is needed for more resources and building the agenda, but you folks already know that. Now let me go to the heart of the problem which is that public health is funded in silos. Public health has so much categorical funding, what's the strategy here when you've got categorical funding? In situations such as tobacco only, I think the appeal of youth development programs is that many of the youth development strategies that turn out to be effective relative to one outcome, like prevention of tobacco use, also turns out to be effective in other areas as well.

So I go, and let me make an analogy, I go and talk to teachers in a school, and I tell them that the more work they do on literacy, keeping kids engaged in school and helping them to graduate the more they help us in the field of teen pregnancy prevention. They say, "what"? What are you talking about, we're educators. And the reason is the building of a lot of these protective factors does double, triple, and quadruple duty and that is how you bring your colleagues on board. So if you've got money focused on tobacco, there is no reason why you shouldn't join with folks around teen pregnancy prevention and violence prevention. What do we know from the research about cross-cutting strategies that will give positive outcomes in all of our areas? And that is when the silos open up and people realize that through a common intervention they can have multiple positive outcomes. So it is a case of widening the lens, knowing the research, and understanding where youth development strategies can have multiple payoffs for multiple public health colleagues. Does that help?

I think the difficulty for me when the resources aren't necessarily equitable, I mean when I and teen pregnancy can't offer the same amount of resources as my tobacco colleague, or as my certified prevention colleague and they have a very specific evidence-based strategy that just addresses their issue, then it is hard to make the argument that they should work on something that is broader.

You know, do you remember in 7th or 8th grade in math class we all got introduced to the concept of the Venn Diagram, and the teacher would draw a couple of circles on the board, and then there

would be the overlapping intersecting area that was gray or shaded in. Our task, I think, when we work with categorically-funded colleagues is to demonstrate that those areas of overlap and synergy are big. And then we need to see if we can move together. I hope we can all work in a time when funding isn't so restricted categorically, but as long as that is the case, we have to be able to make the case for strategies that cross-cut multiple outcomes.

Thank you Michael. I am sure we will be talking about some of these other issues later on in our discussion period, too. But now I think we need to move on to Shirley and Sydney's presentation.

Shirley Hankins Robinson's presentation

Okay, thank you, this is Shirley. This is a great lead-in. We developed a little packet of materials that Mary sent out yesterday for developing a positive youth health prevention program. It includes a little paragraph case study just based on our recognition of some of the issues that you all are dealing with that you have already brought up today as well. This packet, we are not going to fill in the blanks specifically today, but I thought this might be helpful to you that you try to make some of these things we are talking about concrete over time. There is such a wide variety of materials and tools out there that we are hopeful that some of the materials that Michael and we have identified for you will help you kind of synthesize things down to some core ideas that you can put on paper using, as Michael suggested, language from the field. And even, you know, helping to identify the different definitions for some of these, especially in the evaluation mode, some of the times that your other colleagues will use. My thinking is that a lot of you are probably involved in not working just with your public health department, but some interagency workgroups, am I correct in that thinking?

Yes.

Okay, I think one of the things that we have found here in Alabama with some of our interagency groups is that it is difficult to come to grips with what was mentioned a minute ago, how if one agency is taking a categorical approach and it doesn't match our's, how do you pull that together? So I think some of those cross discipline working groups set a good infrastructure for kind of helping determine how categorical your work will be. If you know what your local community or your state level, goals and objectives and even the mission statements are of the agencies and the performance measures that they are working under with their funding development, then you can do a better job of identifying the gaps and the overlaps that will help put together a continuum of care in your community, even if it is not with one particular program.

That is the way we tend to try to think of it here, because it is difficult, some of us are competing for the same funding sources sometimes, so we try to coordinate that competition when we can and cover as many of the bases as possible so that when we look at the broad objectives, like the Healthy People 2010 objectives related to a targeted goal, we also are mindful of those objectives under Healthy People 2010. We do this in particular in terms of the critical adolescent objectives that other agencies are looking at, at the same time. We are fortunate enough here to have an infrastructure that leads to collaborative grant writing on a broad basis and then sometimes we collaborate with three or four agencies. And then sometimes the agencies kind of do their own

thing. But we have all begun to try to use the same language and know each other's goals and objectives over time. The youth organizations have mechanisms like that other then Kids Count that people input from specific programs. Okay, what I am meaning there is we share our outcomes from our programs and we know that in the long-run a lot of our individual programs are not going to meet what we call the distal goals that people look for over time, or the broader impact evaluation goals. But when we looked at the outcome goals and the more proximal kinds of goals, we can put them together and show how we are changing programs and the whole environment for our adolescents in our county or our community.

So this little exercise here is just to begin to think in those terms, what would you need as a state coordinator and a lot of you probably already have some of these resources or know who you can go to within your agency to get them. I think that some things that are helpful are the MCH performance measures, the Healthy People 2010 goals; a lot of you have access to Kids Count which uses Healthy People 2010. If you can start identifying those broad goals that your community is trying to meet over a period of say 5 or 10 years, then you can start looking at the more proximal goals that you can use to help address the programs that look at the specific concepts that Michael is talking about like, competence, confidence, connections, character, caring, the 5 C's kind of goals for adolescents.

This is Jan Shedd in Rhode Island. I just want to say that we have a new medical director for our Department of Health and he is really keen on every program laying out outcome measures and process improvement measures and every program has to sit down with him. And his thing is that we have to connect school-based health centers with graduation rates. Other then saying our goal is to increase graduation rates, which is a positive measure, we have to say we want to increase graduation rates in the schools as a result of having school-based health centers. So that we can connect what we are doing around school based health centers with graduation rates. There are other youth developments kinds of examples with the particular schools; kids are in schools, so then we can say this works and we can scale it up. Where if we just say in general that we are going to take on responsibility for all graduation rates, we are not going to be able to scale up those initiatives that we know can impact developmental assets. When I met with him I laid out a logic model framework that was very, very simple and all it had was on the left you know the inputs were the kinds of things that we know contribute to adolescent development like parenting information, skills and service learning and you know positive role models and all that stuff, which leads to nurturing parents and schools, communities, children with the external/internal assets, positive behaviors, and then by cross-cutting outcomes and that just made it very clear for him to see how what we were doing around youth development connected to concrete outcomes. So I'm just putting that out there.

No, that's great, and that was where we were trying to get to with this, knowing that we are very time limited in doing this. But if you have other tools that let you just go ahead and go straight, cut to the chase so-to-speak and then show your administrators and the task forces that you work with, the people that you deal with, how those goals during the program implementation whether it is short-term program or whether it is a longer term program, how those goals then fit with the broader national and state indicators and how the baseline can change. Because obviously none of us in smaller programs can change those big numbers, we can't hope to do that. But if we coordinate what we do can improve outcomes.

I think there are a couple of points that I wanted to make without going through everyone of these tables, it is just that there are a lot of resource specific tools, like you mentioned, and you may be willing to share that with your colleagues. The CDC improving the health of adolescents and young adults, a guide for state and communities has got some great tools to help bring those things and put them on paper, and actually Michael Resnick was one of the folks who is cited in here quite frequently, so you are talking to the head honcho there. But those are excellent resources.

Some of you, I think, work with Karen Pittman and the Youth Forum, there are resources there. The Community Tool Box is another excellent resource, are any of your familiar with that? It is the University of Kansas I think that puts that out. There is a web site, and I've got the website on the last page of our little handout. But it has got quite a bit on the ways of how to and tools to actually help you as you try to go through that process. And you all know from having a public health background, we talk about needs assessment, needing to know what's all ready there as well as what kids need. We need to know the existing programs and as our colleagues, mentioned, it is helpful if you know the existing measures for those programs, who are the key leaders in the community and who are the youth leaders in the community. When we talk about positive youth we want to include youth as much as we can in decision-making and moving forward.

And then who are the evaluators in the community. Are they within the School of Public Health, is there someone in the Health Department, are there other areas in the Universities that you can utilize, and then who are the consultants that those folks and you can utilize to help move the task force or your planning forward? And I think that is where also NAIIHC and Konopka, and the LEAH programs can be helpful in terms of helping to identify resources and how to move forward.

So everything we have talked about, using existing performance measures, goals and objectives; knowing the asset needs, identifying the gaps, tying your ideas to the language and definitions and when you don't know that, trying to find out what definitions folks are using, framing the ideas in concrete work sheets and tools, looking at risk and protective factors with a big message of all of this being that those risk and protective factors are in many cases measurable, there are tools out there and there are ways of finding those and that's beyond the scope of what we will do today, but we would be happy to follow-up with you on some of those more specific measures if you were interested. And then building that into your grantwriting and your funding sustainability efforts for existing programs, so broadening programs that are there by adding additional goals in budget crunch times, advocating for programs to be a little longer so that there is time to do more of the connectedness kinds of pieces in programs. Using more comprehensive inputs and gaining more comprehensive outputs and above all being very focused on youth orientation and the positive aspects that some of our earlier programs that just tried to reduce risk weren't able to get at.

So with that I'm going to turn our part of this session over to Dr. Sidney MacDonald who will talk to you a little more about those things.

Sydney McDonald's Presentation

Hello everybody, it is great to be a part of this networking across the nation, I just think this is a great opportunity for all of us to bring our intellects and our experiences together and to try to make things as concrete as possible, so I am going to try to focus a little bit on just a couple of very concrete tools and skills that were highlighted particularly in the article by Jody Ross and Jeanne Brooks-Gunn. So I think this goes back to the question from Maine about how can we begin to think about generalizable skills as opposed to looking at concrete outcomes and I think that these five core constructs that were discussed in this article is one way that maybe we can do that. So when we are talking about reducing tobacco use, or preventing suicide and violence, I think that those are very specific goals with specific outcomes related to those behaviors, but I think that if we are looking from a youth development perspective and looking more at skills and competencies, these are some of those things that I think will not just be in one domain but will cross over and will be valid and important to look at in terms of all domains and all programs.

So I'll just speak a little bit about what these five C's are, and the basic tenant is that these should be included in evaluations of youth development programs. And so, youth development programs as we all know measure and are aimed at not just decreasing health compromising behaviors or risky behaviors, but in increasing enriching experiences, improving socialization, enhancing skills and so it kind of captures this paradigm shift from not just focusing on problem prevention, but to ease youth development preparation. So one of the ways that we can kind of transfer our thinking from just preventing tobacco use or just preventing suicide and violence is to look at what are we providing with these programs other then just lack of risky behaviors. And so some of the ways that we can look at that are through these five C's and I'll just go over each one of these and talk about measurement real briefly in each one of them.

So the first measure is Competence. This is in multiple arenas so Brooks-Gunn talks about competence in the areas of social life, academic life, cognitive and vocational life. And so some of the things that relate to that are interpersonal skills, including communication and assertiveness, using logical and analytical thinking as that relates to goal-setting as well, looking at school grades specifically, and attendance, high school graduation rates, and test scores, and also looking at vocational competence through work habits. I think what it is important to know about this particular area of competence is that you can gather data from multiple sources on multiple levels. So you can gather that data from an individual level in terms of self-report and asking somebody to gather information around what they perceive as their own skills, you can also collect data from others including family members and teachers and that can be observational or behavioral checklist or information related to grades and outcome measures in the school system. Also you can look at the community and the neighborhood and through these concentric circles because you work outwards from the individual to the family to the neighborhood to the school to the community at large, all of those places are sources of data and I think that if we can really look at competencies in these multiple areas and gather that data from those sources, it can be a very rich source to examine and evaluate competencies in those multiple arenas. So that is the first "C".

The second "C" is Confidence. And confidence relates to improving adolescent self-esteem, self-concept, self-efficacy, or the belief that they can do something well. It includes having a sense of identity and belief in the future. And the reason that this is important is because these beliefs

assist in healthy planful decision-making and subsequently reduce health-compromising behaviors. So there is kind of like this weight, and as one goes up, the other also comes down, and so they are inter-related in that way, that risky behaviors decrease as prosocial and as healthy behaviors increase and so by increasing that sea of confidence we can see that the risky behaviors will ultimately decrease and that is supported in multiple years of research around health compromising behaviors and self-efficacy and self-esteem and teen pregnancy, so the research is out there to support that.

The third "C" is Connections, and Michael spoke about this a little bit already, so I'll sort of briefly just talk about how important relationships with others are, and how these aren't just relationships with the family, but also relationships with peers and institutions such as schools and mentors. And the key concept here is that adolescents don't live in a vacuum, they don't live in isolation, or at least we are trying to ensure that they don't and that this is a risk factor. And so the more connected adolescents can feel to themselves, their communities, their families, the more valuable and productive and healthy members of society and their own families and communities will become down the road. So Michael has talked a lot about connections and that can also be measured with some of these evaluative tools that we have talked about with regards to multiple levels with the individual, the family, the school and those sources of data.

The fourth "C" is Character. And that relates to increasing self-control, decreasing healthy-compromising behaviors, having respect for cultural and social rules, developing a sense of right or wrong or morality, and again goes back to what Michael mentioned regarding spirituality. So a sense of character, a sense of positive self is important for these youth to develop in terms of good outcomes down the road and that is something that we can also measure with these various sources.

And the last one that I'll just talk about briefly is Caring and Compassion. This primarily relates to a sense of empathy and caring for others. And this can lead to a sense of community responsibility and again goes back to what Michael talked about with regards to the idea that if people are engaged in civic activities as adolescents, they are going to be much more engaged in those activities as adults and subsequently they will help to create a better environment for future generations. So caring and compassion are something that we want to increase and highlight for all of our adolescents.

So, the article that I am talking about specifically the Ross and Brooks-Gunn article, really talks about how few programs integrate all five of those "C's" and how if more programs did that effectively and successfully, we would have more successful programs in general. And again, kind of goes back to what Shirley said about how these programs should be lasting for at least one school year where prosocial behavior is recognized, expectations are clear, and where connectedness can really occur, because developing relationships takes time and adolescents need the time to see that. That concludes my didactic piece, thank you for the time.

This is Shirley again, I want to mention one thing before we switch to questions, and that is we have given you a sample also of two publications put out by Child Trends and again, some of your colleagues are involved in these publications. But they look at the evidence-based programs, best practices kinds of things or what works, and then just weighed best bets when

things aren't, as evidence-based as we would hope they would be at some point in time. But there are lots of resources like that to look for a specific program and then there are a lot of resources to look for specific measures for components of those programs. And so part of your role I am assuming will be to help your working groups or your administrators with those resources as well, to see how things fit together in your community. And then just to continue to be an advocate for life-long learning for youth, for good experiences, broadening horizons, developing supports and connections and I think that is a very strong voice that is needed at this critical time. And I think you guys are in a wonderful position to do that within your states and across the regions as well. So thank you.

Thank you Shirley and Sidney. I'm going to open it up to questions now.

Go ahead and ask questions, everybody.

Do we not have any questions at this particular point in time?

This is Becky Judd, not quite so much a question, it is a comment perhaps. And that is you have alluded to the idea of the measurements and that this isn't the time for it and I think, or my own sense is that different adolescent health coordinators are in different stages of readiness, of how they can take this information around healthy positive youth development and what they do with it in terms of their advocacy related to measurement. So how do we use population-based measures whether it is through the MCH performance measures or use it as one issue of measure. Have something that is standardized so it is population-based; and then how do we help our grantees, or the people that we have in contracts and make sure that they are asking questions that get at some of these five "C's". What are the specific tools? So I am hopeful that there is either another teleconference or there are references to what are some of the tools that people are using that have been validated. You know I know of plenty myself, but it is just one of those things that I think that is useful for all of us across the country that are wanting to move in this direction know what those are and the more we use some of the same ones, at some point we will be able to make some comparisons. I add that if we want to change some of the measures that are in Kids Count, so we start measuring the positive not just the negative, there has got to be some standardization across the country and across our different states.

Thanks for that Becky, this is Michael in Minneapolis. We have been having conversations with the folks at the CDC about incorporating more indicators of protective factors and positive behaviors and positive outcomes for young people in the youth risk behavior survey so that it doesn't stay at the level of all risk all the time. And there seems to be some receptiveness to that as well. Now, honest to God Becky Judd did not pay me to do this, but I want to recommend to all of you something that was published this year in 2006 by Becky and put out there by the Forum for Youth Investment, and that is her publication called "Incorporating Youth Development Principles into Adolescent Health Programs". It is a guide for state-level practitioners and policymakers. It is just great stuff. Very concrete, very applied, and also in the back all kinds of examples of measures and resources and sources to use as we do this kind of work. So congrats to you, Becky, for getting this out there, and I want to make sure that people know about it.

I wanted to add to that, this is Shirley, the appendixes in there are really probably very helpful to folks, especially in terms of just quick and easy lists that you can take to your administrators, you know when you are having these discussions.

This is Jan Shedd in Rhode Island, and I had a question, I lost it and then it came back to me around the youth risk behavior survey. And again, getting back to those performance measures, if I want to be able to connect a local youth development initiative with an outcome, I need to have some of that data on a school district or community basis. And I am just wondering if you know if it would be worth pushing the issue around the youth risk behavior to be able to get some of that data on a more local basis, and that is something that we just started talking about in Rhode Island.

This is Nancy in Maine and I guess this is somewhat a more of a comment as well, or two. One is that we are also looking at the local piece, not because we think there is going to be great variance for trend reasons across communities, but for that very evaluation piece is that we need our communities to feel like their information is local and that we can track things locally. We are also hoping to include more of the positive protective factors in a new version of our surveying instruments and have found that CDC is willing to work with us up to a point in trying to be flexible, but you know definitely wants to maintain their standards and wants to you know maintain a reasonably length survey. So I think I would echo what Becky said in terms of trying to come up with a consensus of what are one or two questions or, five or six that could capture you know, all five "C's" in different domains in a way that gives us a sense of the overall trends without adding 50 questions or even 20 questions. And New England is actually working towards using the Maternal and Child Block Grant performance measures to look at positive indicators and using our school surveys as a possible place to collect those, but it is moving slowly because of that need to standardize and get everybody on the same page. If the Rhode Island people want to add to that, feel free.

I'll just say that even the information that is already in the YRB, if I have a you know positive role-model initiative in a certain school district, if I could show for that school district that their numbers had changed, it would be helpful, or I am going to have to say to them, look you loved this program in your community, will you please let me do another survey on top of all the other surveys that you are doing so that we can show you know that it is effective. So it is a little bit of a challenge.

Michael Resnick: One of the things that I would mention so that folks don't become overly discouraged is that it is really hard to capture and show school-wide change on the basis of interventions that may not involve the entire school. I mean we have seen this in research over the years looking at the impact and the effectiveness of school-based clinics. An example would be the expectation that the presence of a school clinic would be able to drive down school-wide pregnancy or birth rates. The more pertinent question is, is it having an impact on the kids who are actually utilizing the service. So, a lot of times the results will be pretty washed out or diluted because you are looking at outcomes for a whole school population, but not everybody in the school got the intervention, and then a naïve reader looks at it and says, ah ha, the intervention didn't work. And then it can kind of let the air out of your balloon.

That performance measure that I have, I have to narrow it down even more, I shouldn't just say graduation rates of schools with school-based health centers, but graduation among the kids who are enrolled and using the school-based health center.

Now you are talking. You are right on target.

Thank you.

I am assuming, Becky, some of the other adolescent health coordinators participated in some of the sessions that we had at our last conference and both Washington and Oregon talked about how they have included positive measures in their state-wide surveys. And so for those who didn't know that, you know you have some wonderful resources from Oregon and Washington that could talk a little bit about how they integrated positive measures into their state. That having been said, Michael back to both what you said and Nancy, and that is, the interest in working with the CDC and I know that there are a few of us on-line and many that are out there that aren't who would be willing to help and support that effort. It is something that the network has been working on since gosh, 1999 or something like that, where we began with he push of the Healthy People 2010 objectives and asking how to measure the positives.

There is one other resource that is relatively new that folks might like to take a look at and decide whether it has utility for your communities, your settings, a lot of you know that last October, October of '05 the first Lady convened a White House Conference called Helping America's Youth. This built upon a conference that Hillary Clinton had convened in 2000, called Raising Responsible and Resourceful Youth. The current administration didn't acknowledge that previous conference, but in fact two points make a line, so it is pretty nice to see two different White Houses involved in adolescent health conferencing. One of the things that came out of that that has impressed me is a website and if you just goggle "helping America's youth" you'll get to that website. It is a community toolkit and it is designed specifically for planners, advocates, program people, all kinds of folks to take a look at a whole wide array of demonstrated effective programs, the kinds of criteria that you use when you are making selections among a menu of programs, and ways of conducting community needs assessments, identifying gaps, and then acting upon that. I've gotten feedback from a number of public health colleagues who said that that website turned out to be a pretty good resource for them. So if you have not seen it, I think it would be definitely worth a peak.

This is Shirley at UAB, also in kind of exploring some of the resources for this presentation did come across a publication called "Psychometric Characteristics of Measures of Positive Development" that lists a lot of measures that are population measured and faith validity, internal consistency, and gives you all those kinds of stats. And some of these things may apply too, I'll be glad to send that resource out through Mary as well. Unfortunately that is one of those when you printed the PDF file I don't have the full reference for it, but I believe it was on the Youth Forum website. I'll be glad to send that out in case somebody wants to take a look at that too.

Thanks, Shirley.

Maybe we should sign off at this point and I just want to mention that the next session will be on October 19, it is called “Ensuring Adolescent Reproductive Health, Vaccines and Beyond”. So you’ll be hearing a lot about that.

But for this session I want to thank Michael and Shirley and Sydney for some wonderful presentations and I also want to that the coordinators for some very thought-provoking and informative questions.

Thank you all, very much.