Engaging parents from marginalised groups, including ethnic minorities: Outreach and system change for early school leaving prevention

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A differentiated strategic approach to engaging parents for preventing ESL of their children

Different developmental needs and interests of parents with younger compared with older children

Different developmental needs and interests of parents based on their own age differences

Ethnicity with different levels of ESL

Gender differences for parental involvement and lifelong learning classes

Parents with chronic needs such as intergenerational drug abuse

Single parents

Prisoners and their children

Unemployed parents – more time, possibly lower confidence

Low-paid with long working hours

Parents with many children

Low education

The Balkan Sunflowers' four Community Learning Centres in Fushë Kosova, Gracanica, Plemetina and Shtime respectively support the development of over 600 children from Roma, Ashkanli and Egyptian communities. Their project work involves a school preparatory programme for ages 5-7 and a language club for ages 7-9.

For adults, in 2009-2010, women's literacy programmes were initiated in two centres. A parenting life skills programme has also been developed, which is in addition to the regular meetings with parents and home visits. Each community receives at least 4 programmes during the year inviting parents to participate in parenting skills exchanges. These discussions employ audio visual materials around questions of children support: role models, discipline, supporting school attendance, nutrition, hygiene, care, attention and neglect, etc. Tutors and facilitators undergo a two-week training across all four Centres.

According to figures from Balkan Sunflowers NGO in Fushë Kosova, early school leaving rates over the two years of the Learning Centre operation decreased dramatically, from 120 in 2007-2008 to 14 in 2009-2010. Primary school enrollment has more than tripled in Gracanica since the Centre's opening in 2004 from 25 to 85 children.

None of the children attending Gracanica Learning Centre dropped out of primary school in 2010, while only one child in Plemetina dropped out of school that year. 75% of all registered Roma children in Plemetina attend the Learning Centre, while girls' school attendance has increased and there are currently 58 girls in primary school (Downes 2011).

Outreach and more diverse sites for learning in the community

Outreach to marginalised groups is a strong feature of Citizienne, Brussels:

- Within communities

According to the staff interviewees, it is critical to ensure various learning opportunities as close as possible to the adults. Both interviewees accentuate that one can not expect all participants to come into a classroom. The educational activities should be 'home delivered'. Therefore the organisation makes efforts in providing education within the communities, decentralised all over Brussels (in mosques, sports clubs, pubs, etc.) (Vermeersch & Vandenbroucke 2010).

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- Community leaders

Another important outreach strategy is working together intensely with community leaders (a person who plays a key role in organising or running activities for the community and who is well known and respected in that locality). As the community leaders are already engaged in processes of community building, they have the power and the role to enhance the participation of others in the community. That is why finding those key persons is an essential task of the organisational staff (tutors and educational experts) (Vermeersch & Vandenbroucke 2010).

Youth who are low-income, and/or ethnic minority are even less likely to access health care—often related to lack of insurance or transportation, distance from providers, or stigma attached to seeking mental health treatment (Dey, Schiller,&Tai, 2004).

Bridging health and education for family support

Community outreach – a human right.

The international right to the highest attainable standard of health, Hunt & Backman (2008) refer to the key role of 'outreach programmes for disadvantaged individuals and communities' (p.11) and observe that 'a State has a core obligation to establish effective outreach programmes for those living in poverty' (p.12).

Community outreach and target groups members as staff – cultural competence Community outreach best practice also means that 'recruitment of health workers must include outreach programmes to disadvantaged individuals, communities and populations' (Hunt & Backman 2008, p.17). In a report of the UN Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Paul Hunt (2006) observes international good practice as '7....Properly trained community health workers [who]…know their communities' health priorities…Inclusive, informed and active community participation is a vital element of the right to health'.

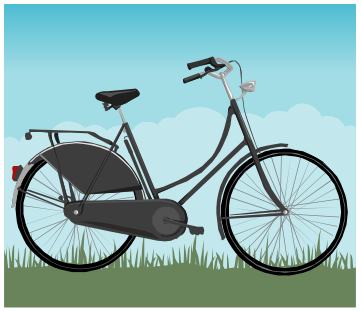
Need to go beyond the information approach (Downes 2011) - finding people with local credibility, community leadership (present, recruitment, accreditation)

Beyond an information based approach (of leaflets, advertisements in papers etc.)

Word of mouth from people they know and trust (see bicycle example in Nantes)

Community leaders to spread word among their community

Safe community spaces- an awareness of the importance of local territories when designing services



* **Differentiated responsibility between cities**

* **Diversity training for teachers? (what kind of indicator?) This can be a structural indicator with the questions:**

- Do all teachers in your city receive conflict resolution skills and diversity training as part of their professional development ?

- Do all pre-service student teachers in your city receive conflict resolution skills and diversity training as part of their professional development ?

Models of parental input into school policies and practices – examples of good practice that could become structural indicators ? Beyond tokenism and manipulation (Arnstein, 1971)

- **Manipulation**
- **Therapy**
- **Informing**
- **Consultation**
- **Placation**
- **Partnership**
- **Delegated Power**
- **Citizen Control**

Arnstein, Sherry R. "A Ladder of Citizen Participation," JAIP, Vol. 35, No. 4, July 1969, pp. 216-224

Targeting parents from marginalised groups as community leaders – accredited community leadership courses, nonformal education – see Council Rec 2009

Building on strengths, resources – key role of the arts in nonthreatening approaches to overcome fear of failure

Parent volunteers in afterschool clubs (sports, arts, academic) for students – key role of afterschool clubs in preventing ESL, though only if chronic needs addressed elsewhere

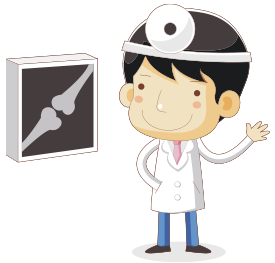
Bridging health and education: Supports in multiple domains

In the US context, Freudenberg & Ruglis (2007) strongly advocate the importance of interpreting early school leaving as a health related issue: Although evidence shows that education is an important determinant of health and that changes in school policy can improve educational outcomes, public health professionals have seldom made improving school completion rates a health priority…With a few important exceptions, health providers have not developed lasting partnerships with schools, nor have researchers provided the evidence needed to improve or replicate health programmes that can reduce school dropout rates (p. 3).

Reinke et al.’s (2009) focus in the US context on combining school and family interventions for the prevention of disruptive behaviour problems also bridges the gap between a public health approach and an educational one. They highlight the need for systemic, multidimensional interventions with regard to disruptive behaviours though not as part of an early school leaving strategy specifically:

In addition to targeting malleable risk and protective factors, successful programs tend to be multifaceted ecological models aimed at multiple domains changing institutions and environments as well as individuals (p.34).

Community or school based emotional and family supports ??



A US nationwide survey of school-based service models and school-linked models involving 90 programmes suggested that the two models are not that different from each other (Shaw et al 1996). In the words of Reeder et al (1997):

In general, the survey results suggest that the physical location of school health services is of minor importance with regard to the range of services provided and the types of health professionals affiliated with the program…Physical proximity of the clinic to educators does not guarantee that the more traditional educational functions of the school will be integrated with the enhanced health services offered by the clinic

Community or school based emotional and family supports ??

Yet there is a growing recognition of what are in the words of Suldo et al.(2010), ‘problems inherent to using schools as the site for service delivery’ (p.362) in relation to mental health intervention and emotional supports for early school leaving prevention. These barriers include space constraints, scheduling problems, maintaining student privacy, resistance from school personnel to students missing classes, a school accountability focus on academic success only (Suldo et al., 2010).

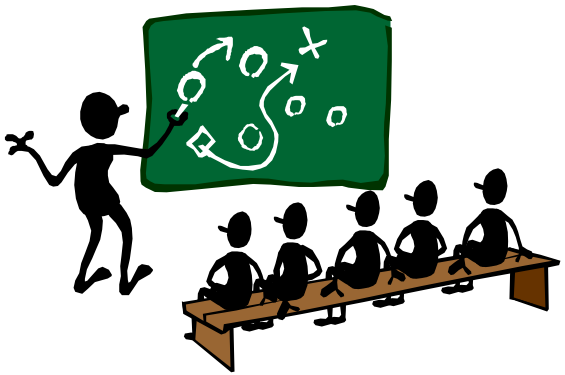
A barrier observed in an Irish study across a number of schools in a socioeconomically disadvantaged area was the perceived lack of parity of esteem between teachers and other professionals working onsite in the schools (Downes, Maunsell & Ivers 2006). This was especially the case at post-primary level rather than primary level.

Difficulties in reaching families – lack of trust, lack of culturally competent services, lack of outreach, lack of dialogue Weist et al. (2009), who recently detailed a school mental health quality intervention that emphasized family engagement and empowerment, note that despite the widely acknowledged importance of family involvement in school mental health, actual practice typically does not reflect best practice in this dimension. Providing support to parents has been found to be very difficult and is rarely provided (Wagner et al., 2006).

Based on 35 interviews, 27 with mental health clinicians, Langley et al. (2010) perceived that one of the main 'barriers' to the implementation of CBITS (cognitive behavioural intervention for trauma in schools) was parent engagement, with Lack of Parent Engagement (Ranked #1 by Implementers and #2–3 by Non-Implementers).

Langley et al (2010) continue: 'Many clinicians described difficulties in contacting parents. One clinician described clear difficulty in ‘‘reaching parents’’ and working with parents of impoverished students... Clinicians who implemented CBITS also described challenges in engaging parents in treatment. For example, one clinician reported that ‘‘It [the main barrier] was parent participation. We had only one parent session and parents did not help kids with getting their practice and homework done’’' (p.109).

Downes (2011) “these findings also point to the need for both a community based team approach and not simply a school based team, in order to facilitate family involvement and gain greater credibility and trust. It also highlights the need for a family outreach dimension for such multi/interdisciplinary teams based in the community”.



Good examples:

Mellin et al. (2011) conducted qualitative research in a US context on multidisciplinary teams. They engaged in focus groups interviews, using a semi-structured interview guide, conducted with school professionals (e.g., teachers, school-employed mental health professionals) and mental health professionals from a collaborating agency who are involved in a district-wide urban school mental health program in the mid-Atlantic region of the United States (N = 26). Participants included:

- 20 women (77%) and 6 men (23%) ranging in age from 24 to 59, with a mean age of 33 (SD = 8.71).
- 16 (62%) identified as White (non-Hispanic),
- 8 (30%) identified as Black/African-American,
- 2 (8%) identified as multiracial.

A major theme that emerged was the need for Improved Access and Consistency for Youth and Families:

Both community and school participants frequently commented on how the nonformal affiliation of community providers with schools helps provide attitudinal access (affirming positions, values, beliefs,) to services for youth and families.

More specifically, participants commented on how it creates safety for youth and families; ‘‘They [families] understand that I am not part of the school and that I can’t tell the school what they are telling me. It’s safe’’ and …”the first thing I do is remind them [youth] that you are not in trouble when you are with me. I have no administrative power, I cannot give you detention or suspend you and that is not what I am here to do…9 times out of 10 the scowl goes away and they calm down because I can remind them of that” (Mellin et al. 2011, p.87).

Outreach Example: Familiscope Morning Programme and School Attendance Gains

The **Familiscope Morning Programme** is an intervention used to support children with
chronic absenteeism. It involves:

- supporting parents to implement appropriate morning and night time routines
- monitoring and tracking children's attendance
- offering practical support and advice to parents to overcome the issue
- rewarding children for improved school attendance
- promoting an awareness of the link between poor school attendance and early school leaving
- resolving transport issues
- engaging the necessary outside supports to benefit the child.

The Child Welfare Worker will regularly call to the child's home to

- support the parent implement morning time routines,
- enable the breakfast, uniform and schoolbag preparation,
- ensure the child gets to school on time
- support the parent to be firm and follow through when a child is school refusing.

Work is also carried out with the parents to support them with night-time routines i.e.
homework and bedtimes. The Child Welfare Worker will often transport the child to
school or arrange for the child to take the school bus when available.

familiscope

The ultimate goal is to improve school attendance for children living in families that are often quite chaotic. Long term the goal is to pass these skills to the parents and children so they will no longer require support. Children who are consistently absent in their early school years rarely catch up.

It was observed that 16 out of 19 children on Familiscope's Morning Programme demonstrably improved their school attendance. 3 out of 19 did not improve attendance.

The attendance gains are sizeable in a number of cases for those children who are most marginalized

Summary of features of good practice for family support and collaboration with schools

Fiks et al (2010) review states that 'Each of the partnership models includes key characteristics that foster collaboration across home, school, and community systems. These characteristics include an emphasis on strengths and assets (rather than problems or deficits), a focus on building trusting, long-term relationships, an emphasis on shared ownership across systems, an attempt to build capacity for sustainability over time, and use of participatory Action Research methods for model evaluation' (p.49).

As Stephan et al (2011) observe, school-based health centres (SBHCs) are a common site for collaborative school-based care in the US context. SBHCs employ a multidisciplinary team of student-care providers, including registered nurses, nurse practitioners, physicians, physician assistants, social workers, alcohol and drug counsellors, and other health professionals.19 SBHCs in six states: Colorado, Louisiana, Michigan, New Jersey, North Carolina, and West Virginia. However, no outreach dimension to families is described.

Processes for parental feedback

Stephan et al (2011) conclude that 'In addition to an increased focus on family engagement, the MHET [Mental health and emotions] initiative would have benefited from evaluative feedback from families (and other stakeholders, including students and teachers) on the value and impact of the intervention' (p.79).

Downes (2011) ‘Again a community based multi/interdisciplinary team rather than a school-based one offers an improved pathway into parental engagement, for families especially marginalized from the formal system and their children at heightened risk of nonattendance at school and early school leaving’.

Softening boundaries with schools for multi-professional collaboration

From experience of a range of multidisciplinary teams engagements with Dutch primary and post-primary schools, Van Veen (2011, personal communication) also emphasises the need for school leadership to be open to engage with such multiservice teams and recommends:

- school leadership: making bridge-building a priority

- leadership is key to change and turnaround under-performing and under resourced Schools

- from a building-centred, walled-in approach to leadership and management towards building leadership skills for engaging families, youngsters, organisations, communities and local authorities (outcomes-focused, collaborative, distributed and adaptive leadership)

- resources for the preparation and use of school-family-community coordinators

In the Netherlands context, van Veen (2011a) observes that multiservice schools are predominantly school linked (75%), i.e., community based, with only 15% being school-based. From research findings on multi-service schools in the Netherlands between 2002 and 2010, van Veen (2011a) concludes that:

- services provided are inconsistent with objectives
- policies and practices are fragmented and do not effectively address barriers to learning
- few comprehensive, integrated programmes (including OST, school culture/climate, extended pupil services)
- few programmes for family support and youth care/mental health and for community development and adult education
- multi-service schools need to be supported by comprehensive policy planning atthe local and provincial level: school boards/school leaders and local authorities need to provide a clear agenda, implementation support and resources
- tasks and responsibilities of key service providers need to be formulated realistically (resources)
- school-based and school network-based support structures need to be developed (from referral and co-location models towards integrated intervention models).

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