



## **Parent Involvement in School Health Programs**

**Excerpts from a Research Review**

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Involving parents in school health promotion and prevention programs has a number of benefits. These include:

- Enhanced communication between parents and their children
- Reinforcement of health promoting messages
- Improved communications between the school and the home
- Better health outcomes and behaviours for children and youth

However, not all parents have the time or resources to be fully involved in school activities. Consequently, there needs to be a variety of specific ways that parents can become involved.

**Individual parent** involvement in school-related health promotion can occur in these ways.

- being regularly informed of their child's academic progress in health instruction, as well as, their human, social and healthy development
- receiving additional, regular reports when their child is experiencing difficulty
- being informed of health or social problems relevant to their community
- receiving information on the goals of the school's health programs and relevant community health services
- being involved in home-based learning activities that support the health curriculum and classroom instruction
- responding to surveys on school health issues and programs
- being educated or trained in parenting skills or strategies on specific health problems
- being a parent volunteer for school activities relating to health
- electing parents to school advisory committees or councils that take an interest in health issues

Collectively, parents can be involved as **volunteers** in these ways:

- organizing a parent information meeting, workshop, parenting course or parent resource center in the school
- serving on a parent committee or subcommittee on health
- fundraising for health materials, resources or equipment for the school
- forming or joining a voluntary or self-help group

**Elected or other parent leaders** can also be involved in school health programs by:

- reviewing and approving school health programs as members of the elected parents committee/council of a school or school board
- forming or supporting a group that advocates for school or community health policies, programs or services
- advocating for policy from the municipality, school board or board of health

## **Inform, Educate, Involve and Empower**

Based on the review of the research, it is suggested that schools can develop four different types of approaches to programs to engaging parents in school-related health promotion. They are informing, educating, involving and empowering.

**Informing parents** about health issues, programs and policies. This is the type of approach most often used by schools and health agencies. The strategy is to raise general awareness within the population using the school as a site to transmit information.

**Educating or training parents** in health-related knowledge or skills. There are several programs addressing single health issues, as well as, general parent effectiveness programs that illustrate this type of approach. Often an external agency partners with a school to offer this type of program. At-risk families are often seen as the client for such programs.

**Involving parents** with their children's learning or in school/community decision-making about health education, prevention and promotion. This type of program seeks to change the way programs, services and policies are developed and implemented within the school, district, health agency or community.

**Empowering parents** to influence public policy decisions. The goal of these activities is to share the decision-making process with parents so that self-help or advocacy groups are supported and new or different programs, services or policies are introduced that support parental participation.

## **Parent Involvement In Prevention**

A Health Canada review (Whitehead & Gliksman, 1984) of parenting programs has identified several messages that can be delivered to parents, including how to (1) clarify and explain values, (2) model behaviours, (3) understand children's needs and self-concept, (4) develop communications skills and engage in reflective listening, (5) problem-solve, (6) use appropriate reinforcement techniques, (7) present natural consequences, (8) use behavioural contracts, (9) foster a democratic milieu within the family and (10) understand different parenting styles.

Research on the effectiveness of parent programs to prevent health and social problems is at an early stage. Although the rationale for involving parents is solid (Mangham, 1992), several reviewers (Dembo et al, 1985; White et al, 1992; Tobler, 1986; Bangert-Drowns, 1988) have concluded that the results are inconclusive. This may be because of poor design of parent programs resulting in the exclusion of at-risk parents; not coordinating parent education programs with other health, social, employment training and housing services; and poor implementation of programs (CASH, 1992).

Powell (1990) reviewed the research on parent education and support programs as well. Positive effects of intensive, early childhood education programs included enhanced child competence, maternal behaviours and several family characteristics. The success of these programs depended upon the number of contacts with families and the range of services offered to the families. Successful programs were characterized by collegial relationships between parents and staff, a balanced focus on the needs of the child and the parent to create supportive social networks, tailoring programs to specific groups of parents and allocating significant program time to open-ended discussion.

Researchers are now reporting case studies of parental involvement in prevention programs. They are also beginning to construct theories to explain why parents become involved or choose not to participate.

Hahn et al (1996) used the Health Belief Model (HBM) to guide their examination of parent involvement in a school-related drug prevention program for very young children. HBM suggests that people will take action to prevent health problems based on □ the perceived barriers and benefits □ cues to action derived from their environment □ the perceived threat □ their demographic, socio-psychological and structural situation.

They concluded that parents become involved when certain cues are received. These are: their children's enthusiasm, transportation, child care and other incentives, positive attitudes from school personnel, a combination of communications strategies and having multiple channels for their participation.

Brock & Beazley (1995) also use the Health Belief Model (HBM) to explain parents' decisions to participate in at-home learning activities in a grade nine AIDS/HIV and sexuality education program. They found that 44% of the 100 parents who responded to the survey reported that they were either moderately or highly involved in the five at-home activities. The authors noted that 20% of the parents never received a guide from their children. They recommend a variety of communication strategies to ensure that parents are informed of the existence of the activities including direct mail, adaptation of materials to lower literacy levels, use of local media, cooperation with parent councils and a covering letter from the principal.

Hearn et al (1992) reported that 75% of parents of 4th grade students participated in at-home learning activities relating to cardiovascular health. Parents reported positive changes in some nutrition habits, physical activity and role modeling as a result of the combined at-home and classroom program. Parents with lower socio-economic status did not participate or benefit as much, thereby requiring specific attention in programming.

Werch et al (1991) reported on the effects of a take-home drug prevention program using at-home correspondence and other activities. 90% of mothers reported helping their children complete at least one-fourth of the materials. Parent-child communications had no apparent impact of children's intent to experiment with drugs. The authors recommended changes in program messages and content.

Perry et al (1990) studied parental involvement in a smoking prevention program for students in grades four to six. 95% of the parents participated in the program, with the child initiating the activity in the vast majority of cases. Behavioural impacts were restricted to parents who were smokers reporting that they intended to quit. Family discussions about smoking definitely increased as a result of the program.

Perry et al, (1989) and Crockett et al (1989) have examined the behavioral impact of involving parents of third grade students in at-home learning activities that complemented the classroom instruction. The students that had home-based activities were compared to those with just the classroom instruction. The results showed that home-based learning with instruction had a significant effect on nutrition habits.

Brannon et al, (1989) report that a combination of parent, TV and classroom instruction was able to involve students in discussions with their parents and to gain wide participant acceptance.

Simons-Morton et al, (1984) reported that a combined instruction, parent and media program was able to influence the snack choices of third and fourth grade students, at least for period of up to eight weeks. However, the effect of the combined interventions declined after that time period.

Meininger (2000) found that studies combining behaviourally focused interventions with students with efforts to change the social environment of the school by involving families and community had little effect.

Good et al (1997) describe an approach to neighbourhood-based consultation that emphasizes collaboration with advocacy for local citizens. The primary goal is to facilitate involvement of families and other citizens in collective action. It illustrates the assessment, collaboration, and organizing activities dictated by an open-system, ecologically oriented community approach. The authors define an open system as one that is understood to be part of its local context. In this case, school boundaries are assumed to extend into the neighbourhood, and vice versa. Considered within the school boundaries are families of the school children, neighbours, local businesses, churches, and other community resources. Similarly, the school is viewed as a potential resource for each of these. Practice involves assessment of direct interests as defined by participants, development of bridge-building activities between school and citizens, small wins over time, and long-range commitment to creation of organizational structures that connect the culture of the school and the interests of the neighbourhood. Three types of participation structures were identified: (a) settings and opportunities for families to have two-way communication with the school; (b) settings and opportunities that promote communication among families; and (c) active parent organizations that participate in decision making and planning, allowing for families to communicate their interests as a group of stakeholders. Bridging activities include special event and program planning along with spontaneous "moments of opportunity" that express family and neighbourhood interests. The entry, assessment, and development of bridging activities in search for more permanent structures is described in the context of the school district

and its historical relation to the neighbourhood. Questions addressed in the article included: 1) How can low-income families be involved in schools in ways that benefit both their own empowerment and the well-being of their children? 2) Where do barriers exist for meaningful participation of families in schools?, and 3) What are the characteristics of meaningful family involvement?

Kumpfer et al (2002) tested the effectiveness of a multicomponent prevention program, Project SAFE (Strengthening America's Families and Environment), with 655 1st graders from 12 rural schools. This sample was randomly assigned to receive the I Can Problem Solve (ICPS) program (M. B. Shure & G. Spivack, 1979), alone or combined with the Strengthening Families (SF) program (K. L. Kumpfer, J. P. DeMarsh, & W. Child, 1989), or SF parent training only. Nine-month change scores revealed significantly larger improvements and effect sizes (0.35 to 1.26) on all outcome variables (school bonding, parenting skills, family relationships, social competency, and behavioral self-regulation) for the combined ICPS and SF program compared with ICPS-only or no-treatment controls. Adding parenting-only improved social competency and self-regulations more but negatively impacted family relationships, whereas adding SF improved family relationships, parenting, and school bonding more.

Weeks et al (1997) tested the effectiveness of involving parents in school-based AIDS education with respect to altering AIDS-related knowledge, attitudes, behavioral intentions, communications patterns, and behavior of students. Fifteen high risk school districts (pre-test N = 2,392) were randomly assigned to one of three conditions: parent-interactive (classroom curricula + parent-interactive component); parent non-interactive (classroom curricula only); control (basic AIDS education ordinarily provided by the school). Students were tested over time in grades 7, 8 and 9. Results indicate that both treatment conditions (parent-interactive and non-interactive) had a strong positive impact in enhancing student's knowledge, attitudes, communication patterns and behavioral intentions. However, results also indicate that there were no behavioral outcome differences between the treatment groups and the control condition. Results demonstrate few outcome differences between the two experimental conditions.

In the two treatment groups (parent-interactive and parent non-interactive), the program effects appear to be the result of school-based curricula and of student self-determined intentions and behaviors, rather than the presence or absence of planned parental involvement. Whether or not structured or planned parental involvement becomes part of a school-based educational activity should perhaps be determined by (a) the existing level of parent-school interaction based on the nature of the community, (b) the amount of money readily available to follow through on a program of parent involvement without compromising on student programs, (c) the age of the child and the sensitivity of the issue, and (d) the ability of the parent/family to be involved effectively without extraordinary expense or sacrifice by either parent or school.

Hahn et al (1998) studied the effects of a school and home-based drug prevention program on risk factors for subsequent alcohol, tobacco, and other drug (ATOD) use among children were studied. Data on parent and child risk factors for ATOD use were

collected from fifty-six low-income parents and their children, ages four to six years, using a pretest-posttest design. The parent-child intervention was conducted over a two-month period. The intervention had no effect on parent or child risk factors. However, the program was favorably received by parents and children.

Kumpfer et al (2003) examined the impact of a family-based drug education program. Because "substance abuse" is a "family disease" of lifestyle, including both genetic and family environmental causes, effective family strengthening prevention programs should be included in all comprehensive substance abuse prevention activities. This article presents reviews of causal models of substance use and evidence-based practices. National searches by the authors suggest that there is sufficient research evidence to support broad dissemination of five highly effective family strengthening approaches (e.g., behavioral parent training, family skills training, in-home family support, brief family therapy, and family education). Additionally, family approaches have average effect sizes two to nine time larger than child-only prevention approaches. Comprehensive prevention programs combining both approaches produced much larger effect sizes. The Strengthening Families Program (SFP) is the only one of these programs that has been replicated with positive results by independent researchers with different cultural groups and with different ages of children. Few research-based programs have been adopted by practitioners, partly because of technology transfer issues. Overall, research on ways to improve dissemination, marketing, training, and funding is needed to improve adoption of effective prevention programs.

Werch et al (2003) examined the one-year follow-up effects of the STARS (Start Taking Alcohol Risks Seriously) for Families program, a 2-year preventive intervention based on a stage of acquisition model, and consisting of nurse consultations and parent materials. A randomized controlled trial was conducted, with participants receiving either the intervention or a minimal intervention control. Participants included a cohort of 650 sixth-grade students from two urban middle schools-one magnet (bused) and one neighborhood. For the magnet school sample, significantly fewer intervention students (5%) were planning to drink in the next 6 months than control students (18%),  $\chi^2 = 11.53$ , 1 d.f.,  $P = 0.001$ . Magnet school intervention students also had less intentions to drink in the future, greater motivation to avoid drinking and less total alcohol risk than control students,  $P_s < 0.05$ . For the neighborhood school, intervention students ( $m = 7.90$ ,  $SD = 1.87$ ) had less total alcohol risk than control students ( $m = 8.42$ ,  $SD = 1.83$ ),  $F(1,205) = 4.09$ ,  $P = 0.04$ . These findings suggest that a brief, stage and risk/protective factor tailored program holds promise for reducing risk for alcohol use among urban school youth one year after intervention, and has the unique advantage of greater 'transportability' over classroom-based prevention programs.

An earlier study, also led by Werch (1991) of 500 fourth, fifth, and sixth grade students and their parents from six schools in northwest Arkansas no significant differences were found between groups on student intentions to use drugs. However, students who received four weekly correspondence lessons designed to be completed at home with a parent reported significantly less perceived peer use of alcohol, tobacco, and marijuana, as well as significantly less peer pressure susceptibility to experiment with cigarettes.

Mothers in the KACM program reported significantly more recent and frequent communication with their children about refusing drugs, and significantly greater discussions with their children regarding how to resist peer pressure to use alcohol, tobacco, and marijuana. Intervention program fathers reported significantly more communication with their children concerning how to resist peer pressure to drink alcohol and use tobacco, and significantly greater motivation to help their children avoid drug use. These data suggest a print medium that emphasizes parent-child activities holds promise for accessing families and enhancing drug prevention communication.

The research on school health promotion programs has also described how several changes can be made to the physical environment of schools in order to promote health. The following list is directly relevant to addictions and mental health

Dishion et al (2002) found that a school-based program to engage parents in drug reduction was successful, despite lower than expected levels of engagement of parents. The Adolescent Transitions Program (ATP) promotes student adjustment and reduces risk within a public school setting, focusing primarily on parenting practices using a tiered, multilevel prevention strategy. A description is given of the program, levels of engagement, and intervention effects. Within each school, multiethnic students (N = 672) and their families were randomly assigned at the individual level to a control condition or the ATP intervention. Analyses focus on the longitudinal effects of the ATP intervention on self-reported substance use through middle school and the 1st year of high school (Grades 6, 7, 8, and 9). Levels of engagement in the selected and indicated interventions were somewhat less than expected. Despite relatively low levels of engagement, the intervention reduced initiation of substance use in both at-risk and typically developing students. These findings are discussed with respect to lessons learned about parent engagement, optimizing strategies for schoolwide implementation, and the promise of embedding family interventions within the public school ecology.

### Reaching At-Risk Families

Liontos (1991, 1992) has been prominent among researchers studying how parents of at-risk students can be involved in schooling. She suggests that the obstacles can be overcome by: not assigning blame; building on family strengths rather than trying to correct for deficits; building trust; helping parents learn new techniques; recognizing cultural differences as valued and valuable; respecting the many different forms of families; asking parents first what they are interested in, and creating partnerships with community agencies.

Good et al (1997) have also described how schools can overcome barriers in working with low-income families.

## References

Bangert-Drowns J (1988), "The Effects of School-based Substance Abuse Education: A Meta-Analysis", Journal of Drug Education, 18(3).

Brannon SD, Tershakovec AM, Shannon BM, 1997, "The Cost-Effectiveness of Alternative Methods of Nutrition Education for Hypercholesterolemic Children", American Journal of Public Health, 87:1967-1970..

Brock GC, Beazley RP. (1995). Using the health belief model to explain parents' participation in adolescent at-home sexuality education activities. Journal of School Health, 65(4):124-126.

Canadian Association for School Health (1992), Working With Parents: Training, Supporting and Empowering. Some Evidence and Issues, Canadian Association for School Health, Surrey, BC.

Crockett SJ, Mullis RM, Perry CL. (1987). Parent nutrition education: A conceptual model. Journal of School Health,58(2):53-57.

Dembo MH et al (1985), "An Evaluation of Group Parent Education: Behavioural, PET and Adlerian Programs", Review of Education Research, 55(2), 155-200.

Dishion TJ, Kavanagh K. (2000). A multilevel approach to family-centered prevention in schools: process and outcome. Addict Behav. Nov-Dec;25(6):899-911. (ADAI jl).

Dishion TJ, Kavanagh K, Schneiger A, Nelson S, Kaufman NK. (2002). Preventing early adolescent substance use: a family-centered strategy for the public middle school. Prev Sci. Sep;3(3):191-201.

Good TL, Wiley AR, Thomas RE, Stewart E, McCoy J, Kloos B, Hunt G.D, Moore T, Rappaport J. (1997). Bridging the gap between schools and community: Organizing for family involvement in a low-income neighborhood. Journal of Educational and Psychological Consultation, 8(3).

Hahn EJ et al. (1996). Cues to parent involvement in drug prevention and school activities. Journal of School Health, 66(5):165-70.

Hahn EJ, Hall LA, Simpson MR. (1998). Drug prevention with high risk families and young children. J Drug Educ. 28(4):327-45.

Hearn MD et al (1992), "Involving Families in Cardiovascular Health Promotion: The CATCH Feasibility Study", Journal of Health Education, 23(1), p.22-31.

Kumpfer KL, Alvarado R, Tait C, Turner C. (2002). Effectiveness of school-based family and children's skills training for substance abuse prevention among 6-8-year-old rural children. *Psychol Addict Behav.* Dec;16(4 Suppl):S65-71.

Kumpfer KL, Alvarado R, Whiteside HO. (2003). Family-based interventions for substance use and misuse prevention. *Subst Use Misuse.* Sep-Nov;38(11-13):1759-87.

Liontos LB. (1991). *Involving the Families of At-Risk Youth in the Educational Process.* Eugene, OR: ERIC Clearinghouse on Educational Management.

Mangham C (1992), Family Empowerment as an Approach in Substance Abuse Prevention, A paper prepared for the Alcohol and Drug Unit, Health Promotion Directorate, Health and Welfare Canada.

Meininger (2000)

Perry CL et al. (1989). Parent involvement with children's health promotion: A one year follow-up of the Minnesota Home Team. *Health Education Quarterly*, 16(2):171-180:171-180.

Perry CL et al (1990), "Parent Involvement in Cigarette Smoking Prevention: Two Pilot Evaluators of the Unpuffable Program", *Journal of School Health*, 60(9), 443-447.

Powell DR (1990), Parent Education and Support Programs, ERIC Clearinghouse on Elementary and Early Childhood Education, Urbana, ILL.

Simons-Morton et al, (1984)

Tobler NS (1986), "Meta-Analysis of 143 Adolescent Drug Prevention Programs: Quantative Outcome Results of Program Participants Compared To A Control Group or Comparison Group", *Journal of Drug Issues*, 16(4), 537-567.

Weeks K, Levy SR, Gordon AK, Handler A, Perhats C, Flay BR. (1997). Does parental involvement make a difference? The impact of parent interactive activities on students in a school-based AIDS prevention program. *AIDS Educ Prev.* Feb;9(1 Suppl):90-106.

Werch CE, Young M, Clark M, Garrett C, Hooks S, Kersten C. (1991). Effects of a take-home drug prevention program on drug-related communication and beliefs of parents and children. *J Sch Health.* Oct;61(8):346-50.

Werch CE, Owen DM, Carlson JM, DiClemente CC, Edgemon P, Moore M. (2003). One-year follow-up results of the STARS for Families alcohol prevention program. *Health Educ Res.* Feb;18(1):74-87.

White K.R. et al (1992) "Does Research Support Claims About the Benefits of Involving Parents in Early Intervention Programs", Review of Educational Research, 62(1).

Whitehead PC, Gliksman L. (1984). Parent Education: A Review and Analysis of Drug Abuse and General Programs. Ottawa, ON: Health Canada.