



Review and Rationale for Involving Parents in Health Promotion

Rothwell (1992) examined the different forms of parental involvement. Her review indicates that properly planned programs result in greater student achievement and more support for schools. She also concluded that parental involvement can help to compensate for socioeconomic differences and that school personnel can assist parents to be more effective in supporting their child.

The research on the effectiveness and benefits of parental involvement in governance through advisory committees is mixed (Lucas & Lusthaus, 1981; McCall, 1980). However, researchers such as Fullan (1991) suggest that parent councils are effective when they have a clear focus and sound organization. Durkin & Kingdon (1995) lay out the conditions favouring a successful parent council. They include a real commitment to parent involvement, leadership from the school principal, an emphasis on trust, training for all participants, accurate information and extensive efforts for broadly-based involvement.

Valpy (1995) has suggested that one of the best recommendations of the recent Ontario Royal Commission on learning was the creation of school-community councils. He suggests that such councils could become the "village educating the child", thereby providing a variety of resources and support services. However, we did not locate any study that examined the impact of involving such councils in prevention.

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.

Parent Involvement In Prevention

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.

Williams & Kubik (1990) reported the impact of a community, parent and school effort in nutrition education. The combination of parental involvement, classroom instruction, staff wellness and community coordination.

Nader et al, (1989) reported that a family-based heart health program was able to change eating habits but not physical activity patterns.

Cohen et al, (1989) review the results of a combined peer-parent program in heart health. The combined intervention led to changes in eating habits, tobacco use and blood pressure. The evaluation was done over a three year period.

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.

Fors et al, (1989) compared the effect of a selected instructional program on heart health. It combined the same program with parent activities with their children at home and the school district's regular health education program. The approach involving parents had a more powerful effect on student blood pressure knowledge and skills.

Perry et al, (19--), assessed the impact of a home learning activity program for the parents of pre-adolescents. The program created an opportunity for parents to discuss smoking with their children.

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.

Crockett et al [246] have also tried to help us understand how parents can become involved in nutrition education. They summarize selected research about the impact of youth directed nutrition education interventions on parents. A conceptual model is proposed to guide the development and evaluation of future interventions with a parent component.

This review has identified several case studies of parents being educated or involved in nutrition and other health issues. A review done for Health Canada identifying innovative practices [247], describes an example from Waverly, Nova Scotia. A parent's committee has been leading school efforts to promote nutrition health. Perry et al [248] examine the impact of parent involvement with a children's heart health promotion Project in Minnesota. The authors conclude that the application of this behavior model places emphasis on skills and behaviors and was effective in improving the nutrition habits of the students. In another example, identified in the Health Canada review of innovative practices, students and parents helped the school improve its nutrition status. [249] This program uses community development strategies and begins with the needs identified by parents and students.

Johnson et al [250] describe another behavioral model combining parent education and nutrition counseling. In this program parents were offered eight 90 minute sessions and three counseling sessions over 12 weeks. Results indicate changes in the nutrition and eating habits of the students. Cohen et al [251] report on the combination of the efforts of parents with older peers in a school-based cardiovascular disease prevention program. These parents and this project indicates that it is more effective to ask families to undertake activities such as shared preparation of meals rather than doing homework or answering questions.

Two other examples [252, 254] examine the perceptions of adolescent girls and adolescents regarding their parent involvement and parent nutrition styles. Soldano & Markell [253] used the National Standards for Family/Parent Involvement issued by the Parents Teachers Association in the United States to involve parents in the issue of adolescent immunization.

Leitza [255] describes the process of involving parents in the design, implementation and evaluation of an eat smart educational program. Johnson et al [256] report on parent involvement for cardiovascular intervention with high-risk families as part of the Heart Smart Program. Both children and parents showed positive changes in habits and physical activity as well as significant changes in knowledge and BP levels. The children involved also halted their weight gains. Hopper et al [257] examined the effect of including parents in a school-based exercise and nutrition program for children. The results indicate that including the family was primarily effective in improving children's nutrition knowledge rather than changing diet or exercise behaviors.

References

Bangert-Drowns J. 1988. The effects of school-based substance abuse education: A meta-analysis. *Journal of Drug Education*: 18(3).

Bond LA, Wagner BM. 1988. *Families in Transition: Primary Prevention Programs That Work*. Newburg Park: Sage Publications.

Brannon.

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

Burch CW. 1985. Influencing the community and its agencies toward family health. In JC Hansen, ed. *Health Promotion in Family Therapy*. Rockville, MD: Aspen-Systems Corporation.

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

Cohen

Crockett.

Dembo MH et al. 1985. An evaluation of group parent education: Behavioural, PET and Adlerian Programs. *Review of Education Research*: 55(2):155-200.

Durkin M & Kingdon H. 1995. *Effective Beginnings: A Guide to New Partnerships in Schools*. Ottawa, ON: Canadian Home & School/Parent Teachers' Federation; Canadian Association of Principals.

Fors.

Fullan. 1991. *The New Meaning of Educational Change*. Toronto, ON: OISE Press.

Hahn EJ et al. 1996. Cues to parent involvement in drug prevention and school activities. *Journal of School Health*: 66(5):165-170.

Hearn MD et al. 1992. Involving families in cardiovascular health promotion: The CATCH Feasibility Study. *Journal of Education*: 23(1):22-31.

Hopper

Johnson

Leitza.

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

Lucas BG , Lusthaus CS. 1981. *Public Involvement in School Governance in Canada*. Oxford: Pergamon Press.

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 Canada. (unpublished).

McCall D.

Nader.

Perry

Powell DR. 1990. *Parent Education and Support Programs*. Urbana, IL: ERIC Clearinghouse on Elementary and Early Childhood Education.

Simons-Morton

Soldano & Markell

Tobler NS. 1986. Meta-analysis of 193 adolescent drug prevention programs. *Journal of Drug Issues*. Fall.

Valpy M. 1995. Drafting the village to help the schools. *The Globe and Mail*. February 2.

Werch CE et al. 1991. Effects of a take home drug prevention program on drug-related communications and beliefs of parents and children. *Journal of School Health*: 61(8):346-350.

White KR et al. 1992. Does research support claims about the benefits of involving parents in early intervention programs? *Review of Educational Research*: 62(1).

Williams & Kubik.

Woody RH. 1985. *Shaping public policy for family health*. In JC Hansen, ed. *Health Promotion in Family Therapy*. Rockville, MD: Aspen-Systems Corporation.