



Engaging Families & Supporting Young Children

Training Tool Kit

Prepared by Mary McKernan McKay, PhD



Purpose: To support staff at all levels to develop and enhance skills that maximize family engagement and partnership across a range of provider organizations and settings targeting young children.

Rationale: Parents are critical influences on the early development of their children.

- Unlike service providers, parents have consistent presence in their children's life when they are young and are more likely able to influence their child day-to-day.
- Child engagement in intervention services can be dependent upon parental actions and follow-up.
- The impact of intervention services early in a child's development can be magnified by parental involvement and partnership.
- Childhood development, the ability to communicate, their social and emotional well-being, and school readiness are all influenced by the home environmental conditions, as well as parent-child interactions.
- Parent follow-up at home is critical for bolstering child skills, addressing delays and needs and generalizing use of new skills.

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Section One: Slides for Web-based training



Family Engagement: What Does the Evidence Suggest?

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Acknowledgements

McSilver Community Collaborative Board



Parents are key influences on childhood development

In fact, every aspect of child development, the ability to communicate, social and emotional well-being, school readiness, is influenced by home environmental conditions, as well as parent-child interactions



Why are parents so key?

- ▶ Parents have consistent presence in their children's lives
- ▶ Likely to influence their child day-to-day
- ▶ Set the foundation for opportunities to grow within and outside the home

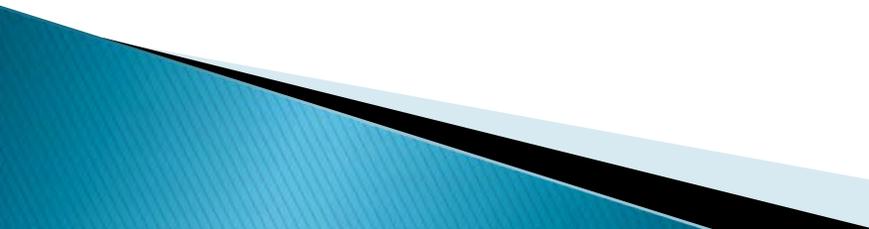


When a child develops special needs that require attention

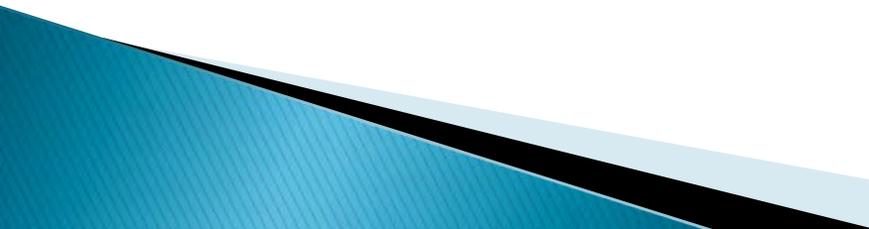
- ▶ Receipt of services is highly dependent upon parental actions and follow-up
- ▶ Impact of services can be magnified by parent involvement
- ▶ Parental follow-up at home is critical for bolstering child skills, addressing delays and generalizing use of new skills



Barriers to Engagement

- ▶ Ecological perspective locates barriers to initial and ongoing engagement within the family, the provider, and/or the system
 - ▶ Triple threat: poverty, single parent status, stress
 - ▶ Concrete obstacles: time, competing priorities, transportation, child care
 - ▶ Perceptual obstacles: attitudes about help seeking, stigma, negative experiences, parents' own stress and needs, feelings of fear, hopelessness, loss of control
- 

Research Findings on Barriers to Engagement

- ▶ Not all barriers are “equal.”
 - ▶ Perceptual barriers (e.g., stigma) and prior negative experiences have been shown to have the greatest influence on initial and ongoing engagement
 - ▶ Addressing perceptual barriers may be more important than focusing only on concrete obstacles
- 

Early experimental work aimed at increasing initial and ongoing engagement

- ▶ Brief, evidence-informed, targeted interventions focused on enhancing attendance
 - During initial telephone or first meeting (closing the gap between referral/initial contact and keeping a first appointment)
 - During first intake evaluation (closing the gap between evaluation and ongoing services)

Initial Engagement Interventions

(at point of initial contact or referral)

Goals:

1. Clarify the need
 2. Increase caregiver investment and efficacy
 3. Identify attitudes about previous experiences with services, schools and institutions
 4. **PROBLEM SOLVE! PROBLEM SOLVE!
PROBLEM SOLVE!** around concrete obstacles to care
- 

Clarify the need

- ▶ Parents definition of child need, causes of concern may differ substantially from referral source or professional provider/teacher.
- ▶ Clarification of need also includes creating a comprehensive view of parent and family strengths, resources, motivations, preferences.
- ▶ Points of agreement and divergence between perspectives on child need clarified.

Increase caregiver investment and efficacy

- ▶ Recognition of stress and strain that parents experience is critical.
- ▶ Reinforce courage and motivation to seek help for child.
- ▶ Enhance motivation and parental activation.
- ▶ Decrease perceptions of stigma and blame.
- ▶ Mobilize naturally-existing resources.

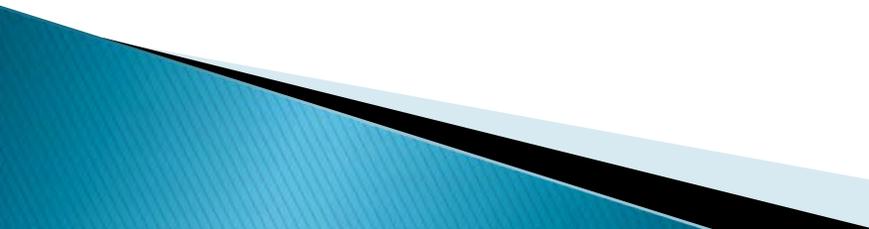
Identify attitudes about seeking help and previous service experience

- ▶ Help parents express concerns about services.
- ▶ Provide opportunities for parents to explore options for involvement.
- ▶ Ask about previous experiences with services and helpers
- ▶ Help parents convey expectations and hopes for child and relationships with helpers.

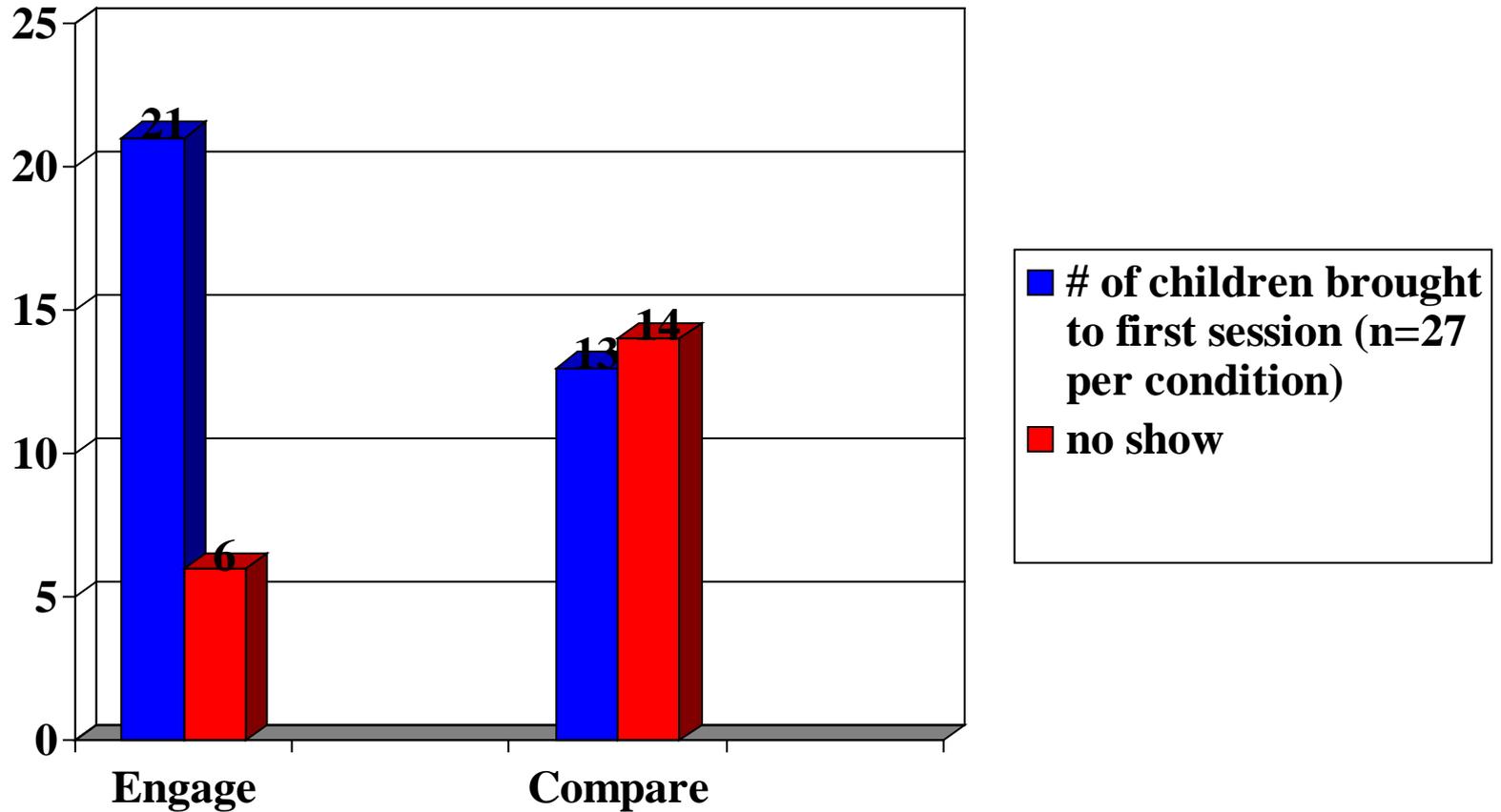
Problem–solve around concrete obstacles

- ▶ Problem–solve around concrete obstacles
- ▶ Process and discuss barriers collaboratively to find creative solutions
- ▶ Address concrete barriers and find ways to problem–solve

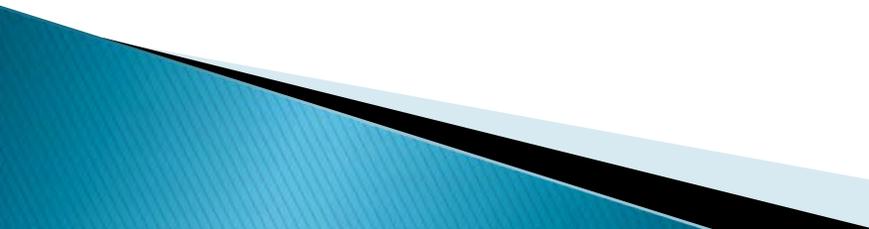
Study #1 Methods

- ▶ Outcome of interest: # of families that brought their child to an initial appointment
 - ▶ Setting: child serving center
 - ▶ Sample: $\underline{n}=54$
 - ▶ Design: Matched comparison of consecutive referrals in one month
- 

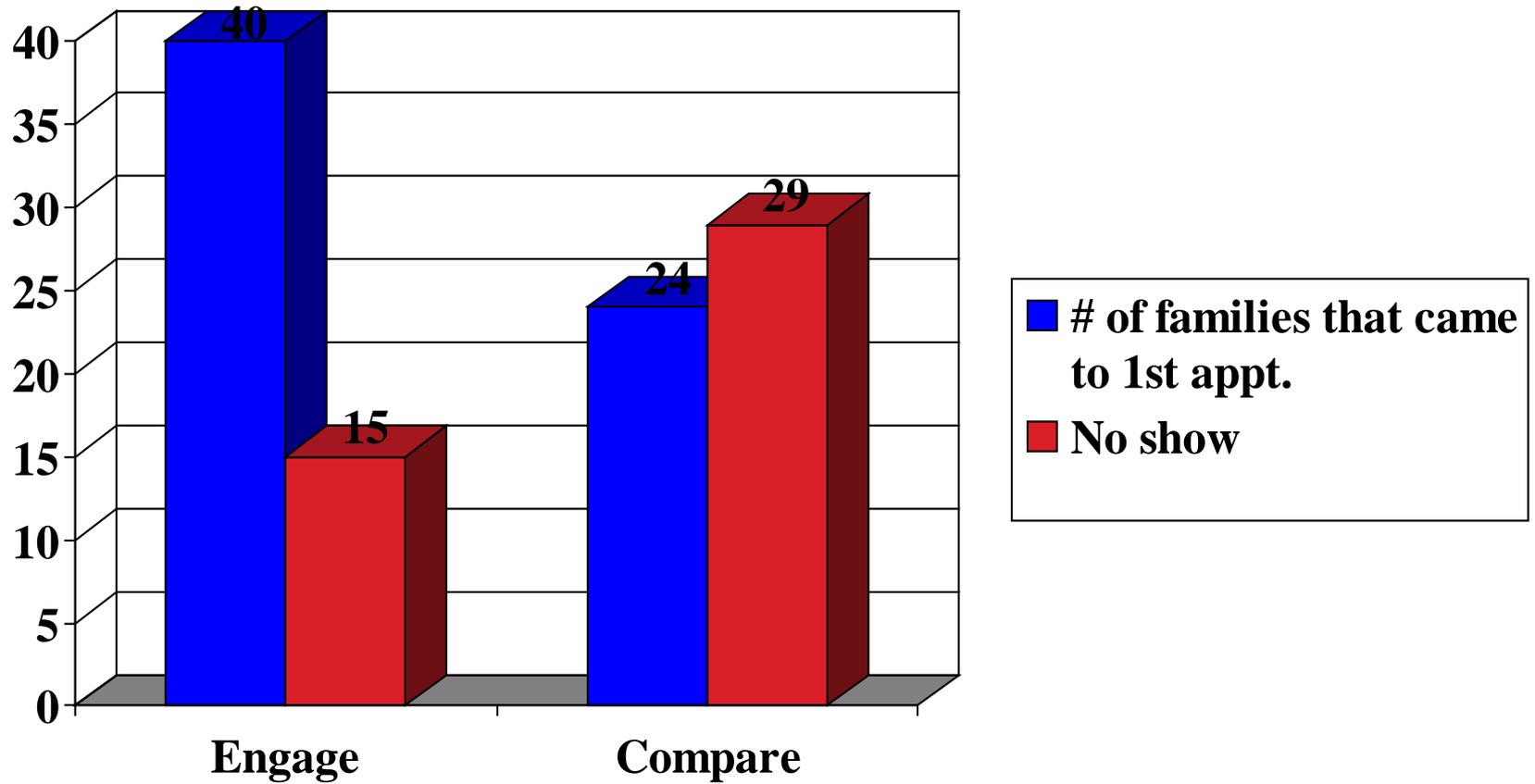
Study #1 Results



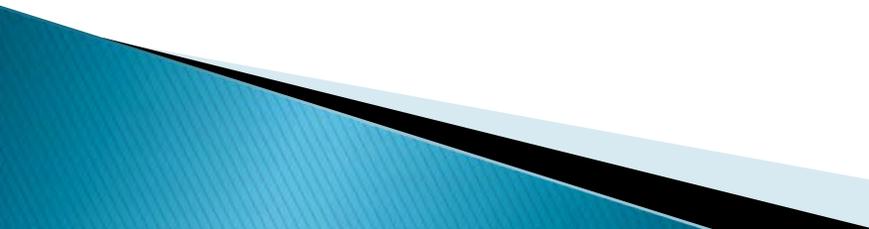
Study #2 Methods

- ▶ Outcome of interest: # of families that brought their child to an initial appointment
 - ▶ Setting: child serving center
 - ▶ Sample: $n=108$
 - ▶ Design: random assignment to condition
- 

Study #2 Results



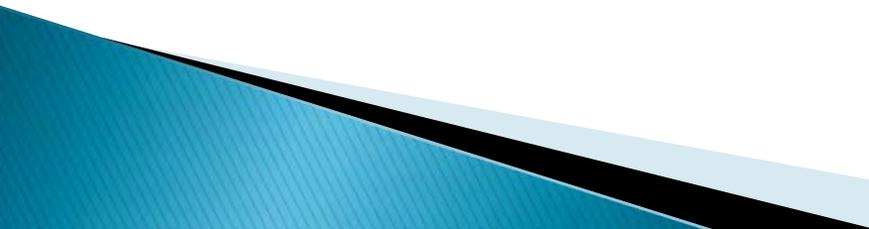
Importance of First Evaluation Interview

- ▶ Families are 49% less likely to return after a first evaluation if parents are skeptical about possible service helpfulness.
 - ▶ The first evaluation interview is the point at which many families decide if the center/service provider they are visiting is a good fit.
 - ▶ If families are leave first meeting dissatisfied or with significant questions/concern, they are not likely to return.
- 

Study #3 focused on orientating providers to the engagement purposes of the first evaluation meeting

- ▶ Two primary purposes:
 - To understand why a youth and family can benefit from involvement.
 - To engage the family in a helping process, if appropriate.
- 

Four Critical Elements of the Engagement Process

- ▶ Clarify the options for the family
 - ▶ Develop the foundation for a collaborative working relationship
 - ▶ Focus on immediate, practical concerns
 - ▶ Identify and problem solve around barriers to help seeking
- 

Clarify parent involvement options

- ▶ Carefully introduce self, role and process and setting resources.
- ▶ Explore parental knowledge about services, options, setting
- ▶ Do not assume that the parent has been given accurate information about services.
- ▶ Do not assume parents know what is expected of them.

Develop the foundation for a collaborative working relationship

- ▶ Set up the foundation for a collaborative relationship by defining expertise of professional and parent.
- ▶ Explicate roles and responsibilities of all going forward towards shared goals.
- ▶ Use “we” when talking and working together.

Focus on immediate, practical concerns

- ▶ Responding to parents concerns provides an opportunity to demonstrate commitment and potential capacity for help.
- ▶ Parents often need help negotiating with other “systems”

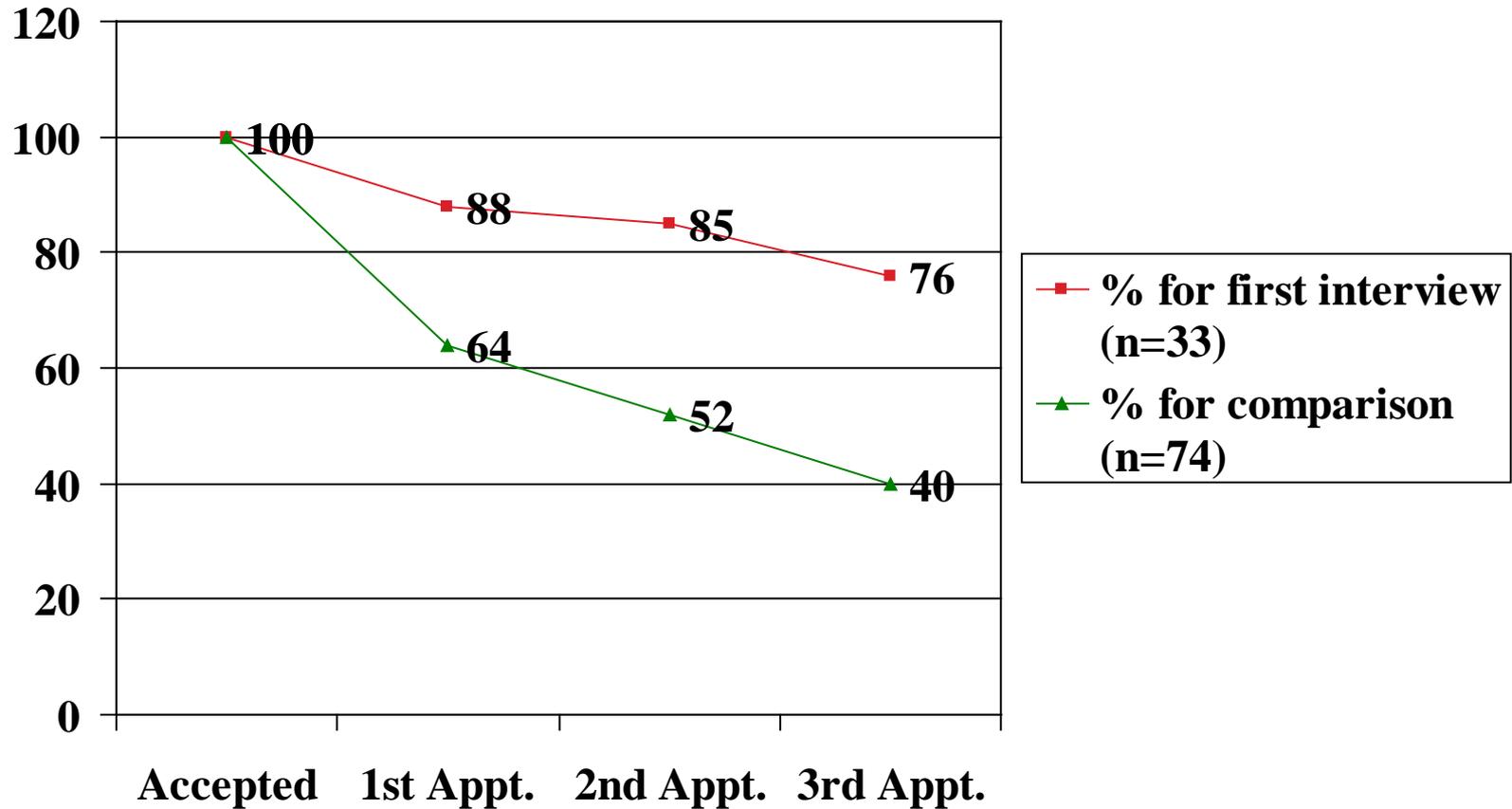
Identify and problem-solve around barriers to help-seeking

- ▶ Every contact is an opportunity to explore potential barriers to involvement
- ▶ Additional barriers to consider: discouragement by others to seek professional help; racial and cultural considerations; families' experiences with racism and its impact on their willingness to receive services from a "system" need to be carefully explored.

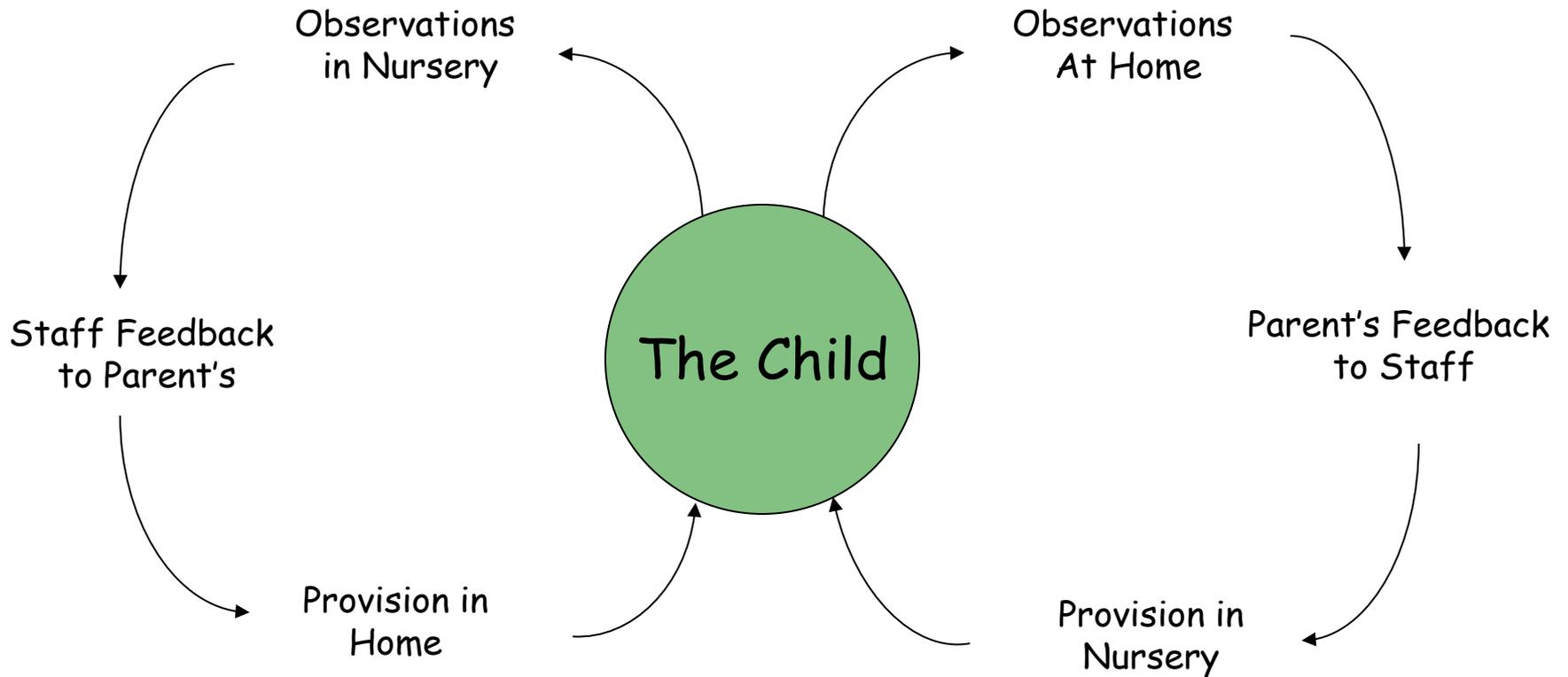
Study #3 Methods

- ▶ Outcome of interest: # of families that came to initial and ongoing appointments
 - ▶ Setting: child serving center
 - ▶ Sample: $\underline{n}=107$
 - ▶ Design: Random assignment to condition
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First Interview Results



The Pen Green Loop



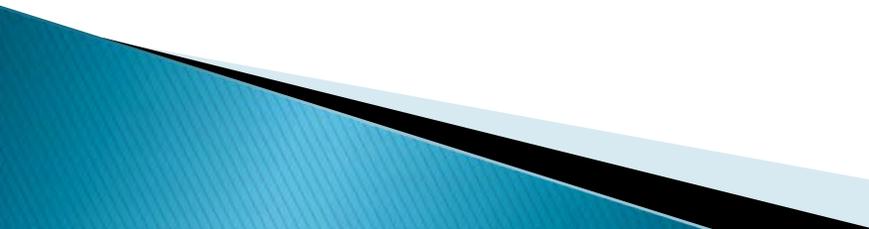
Engaging Services: Multiple Family Groups

- Multiple Family Group (MFG) is a service option meant to enhance engagement and outcomes for low-income children.
- NIMH-funded, randomized effectiveness trial of MFG vs. services as usual in 10 sites
 - Met criteria for ODD or CD
 - Majority of families with low household income and of African American and/or Latino descent
- MFG content and process was designed in collaboration with parents & providers

What is a MFG?

- A group series targeting early child conduct difficulties
 - Developed from previous research
 - Provides an opportunity for families to share information, address common concerns, and develop supportive networks
 - Involves 6 to 8 families
 - At least two generations of a family are present in each session
 - Knowledge sharing and practice activities foster both within family and between family learning/interaction
- 

MFG Evidence Informed Targets

- ▶ Strengthens parenting skills and family relationship processes
 - child management skills
 - family communication
 - within family support
 - parent/child interaction
 - ▶ Addresses factors affecting service use and outcomes
 - parental stress
 - use of emotional and parenting support
 - stigma associated with mental health care
- 

In the words of families...

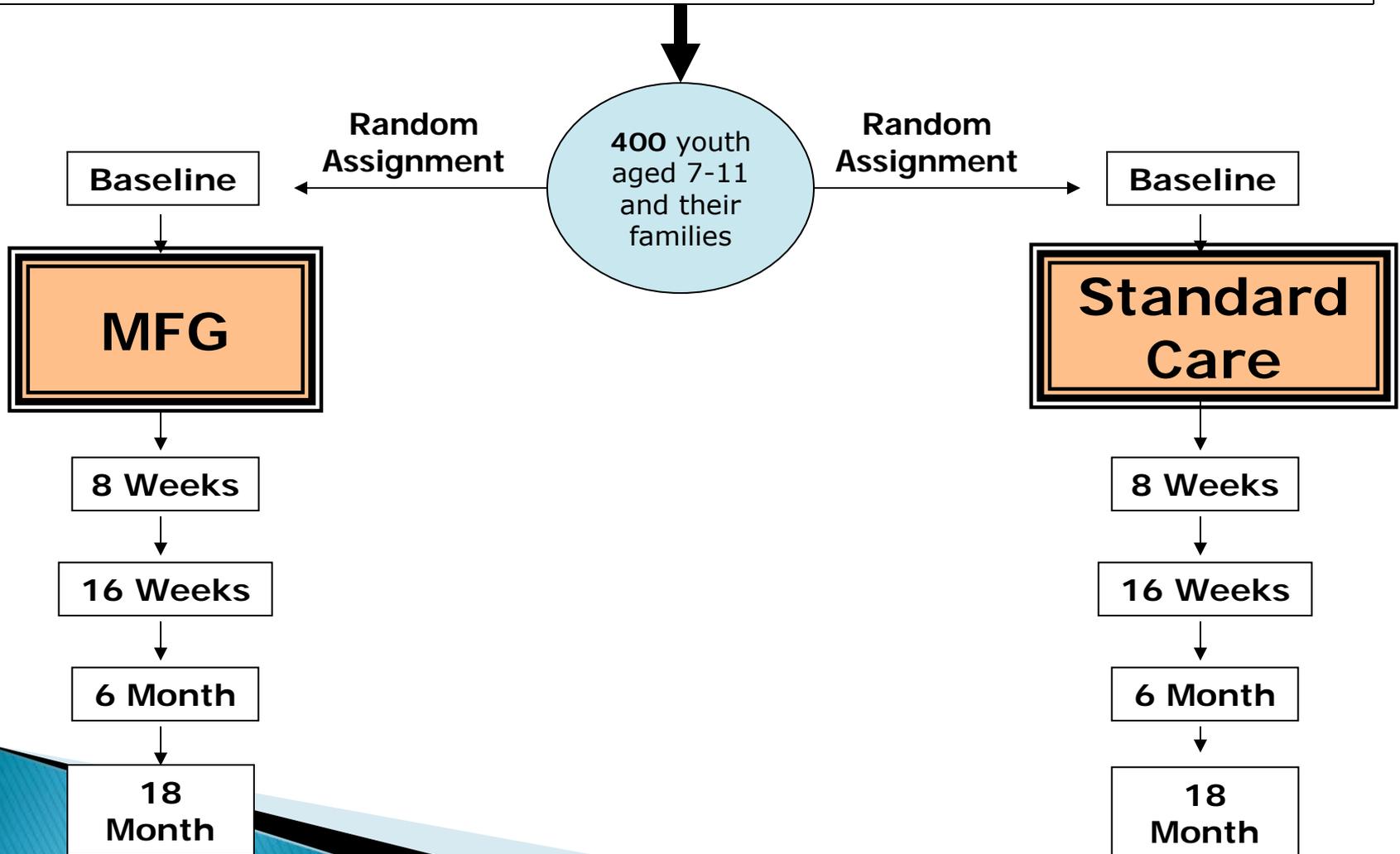
Multiple family groups should focus on: (4Rs)

- Rules
 - Roles and Responsibilities
 - Respectful communication
 - Relationships
-
- As well as the 2Ss:
 - Stress and Support

MFG Collaborative Development & Service Delivery

- ▶ Clinician and parent advocate co-facilitate
 - ▶ Clinicians provide professional expertise
 - ▶ Parent advocates provide support and practical information
 - ▶ Sessions guided by a manual characterized by flexibility, choice of activities, discussion questions
 - ▶ Parent consumers made substantive contributions to the development of the intervention guide based on their experience and existing literature (e.g., brought stress to the forefront)
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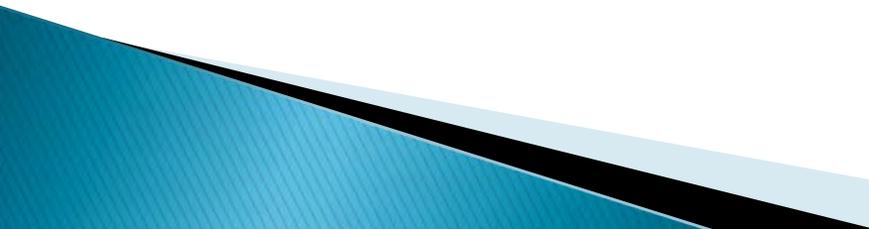
Research Design



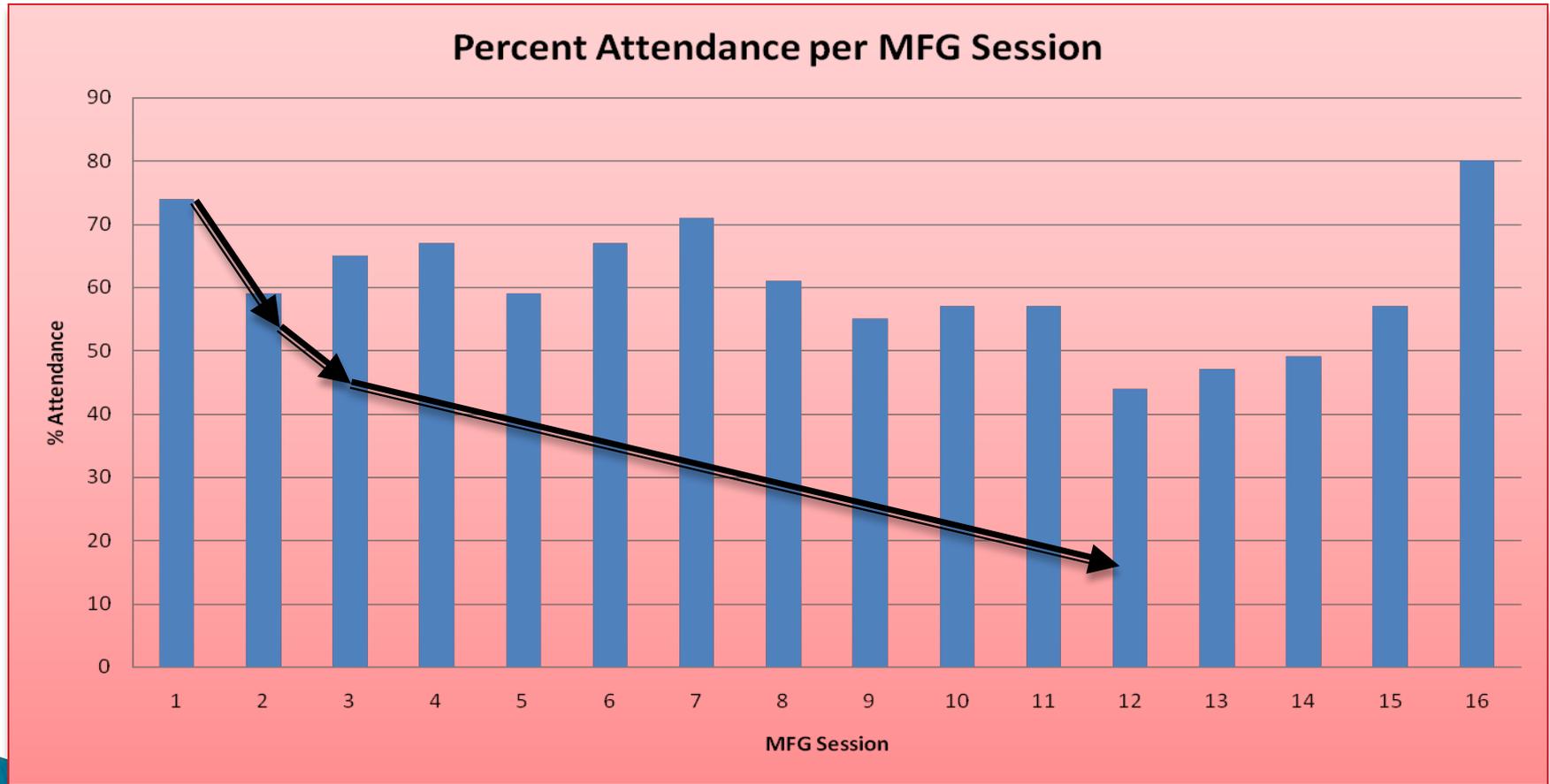
To date....

Emerging findings from 408 youth and their families involved in the study

Study Participants

- ✓ Adult caregivers were 87% female
 - ✓ A third of parents were born outside the US
 - ✓ Half of parents completed high school
 - ✓ 45% were employed
 - ✓ Racial/ethnic backgrounds were:
47% African American; 42% Latinos
 - ✓ Families had an average of 3 children living with them.
 - ✓ Youth were evenly split by gender with an average age of 9.5 years.
- 

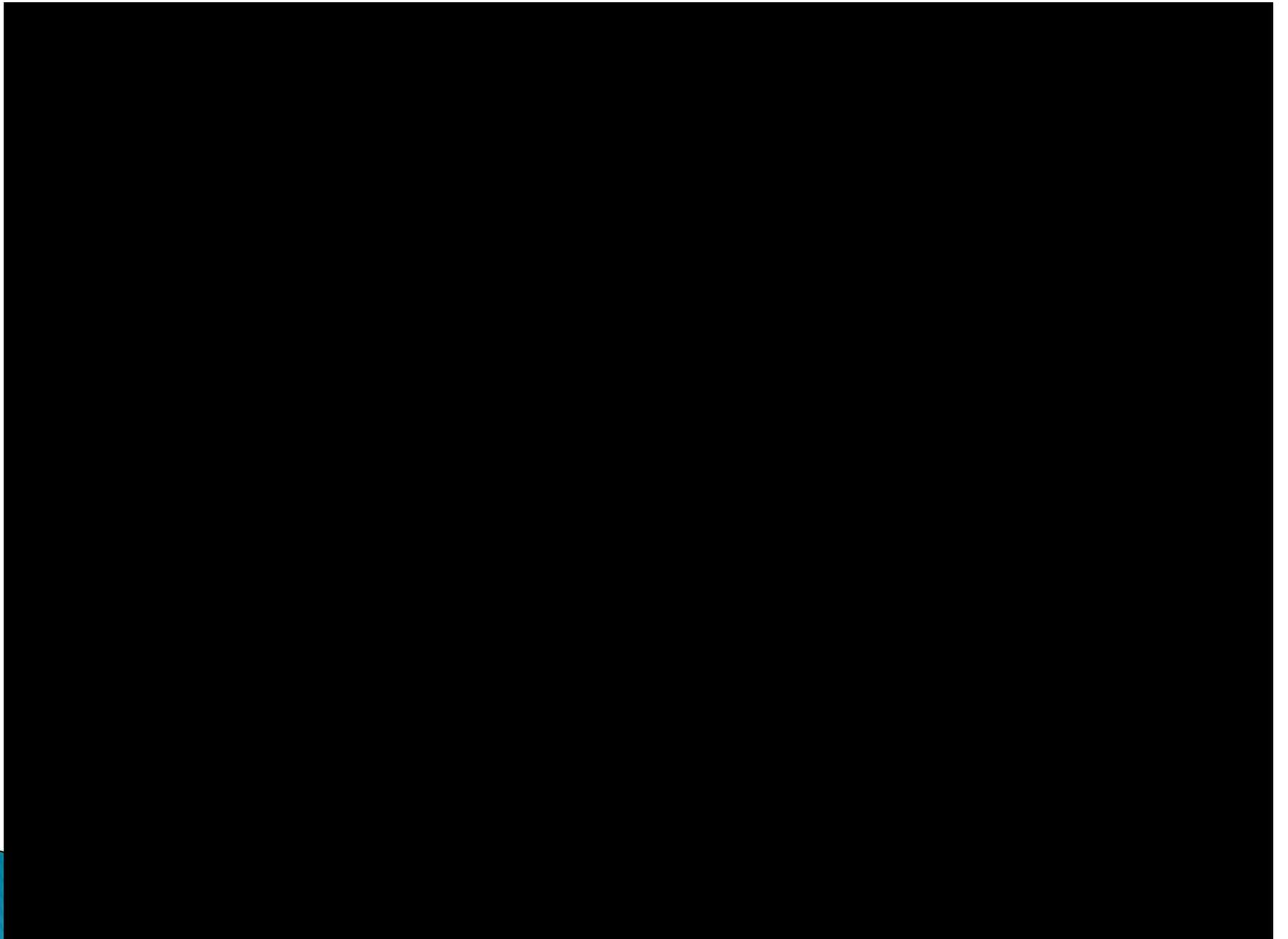
MFG Attendance (in comparison to rates of retention in comparison services)



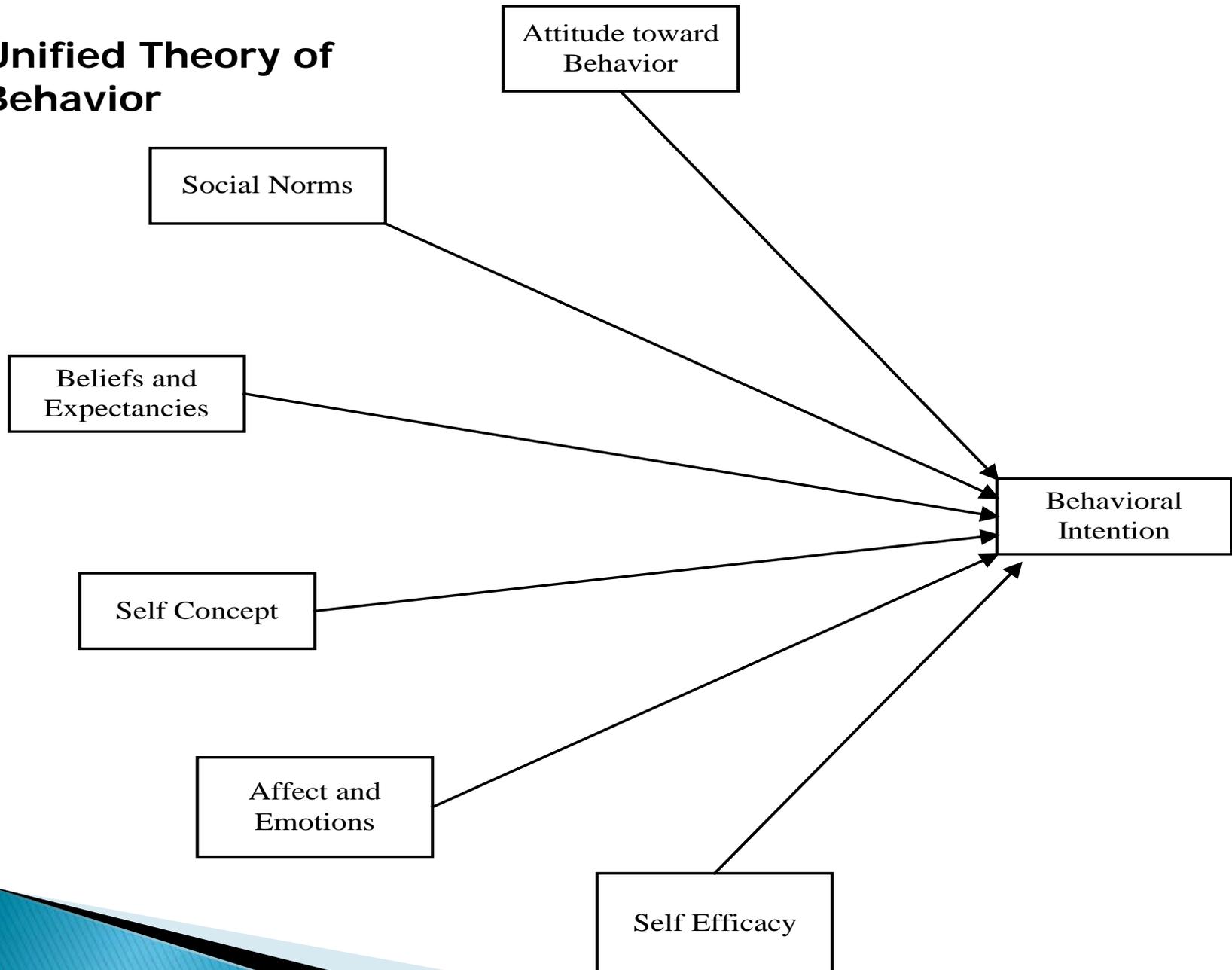
Further steps: Evidence on Family Support & Engagement

- ▶ Reduces stigma and distrust by improving communication (Linhorst & Eckert, 2003)
- ▶ Improves activation in seeking care (Alegria et al., 2008)
- ▶ Improves self-efficacy— i.e., active participation in decision-making (Heflinger & Bickman, 1997; Bickman et al., 1998)
- ▶ Improves knowledge and beliefs about children's mental health and this is associated with use of higher quality services for children (Fristad et al., 2003; 2008)

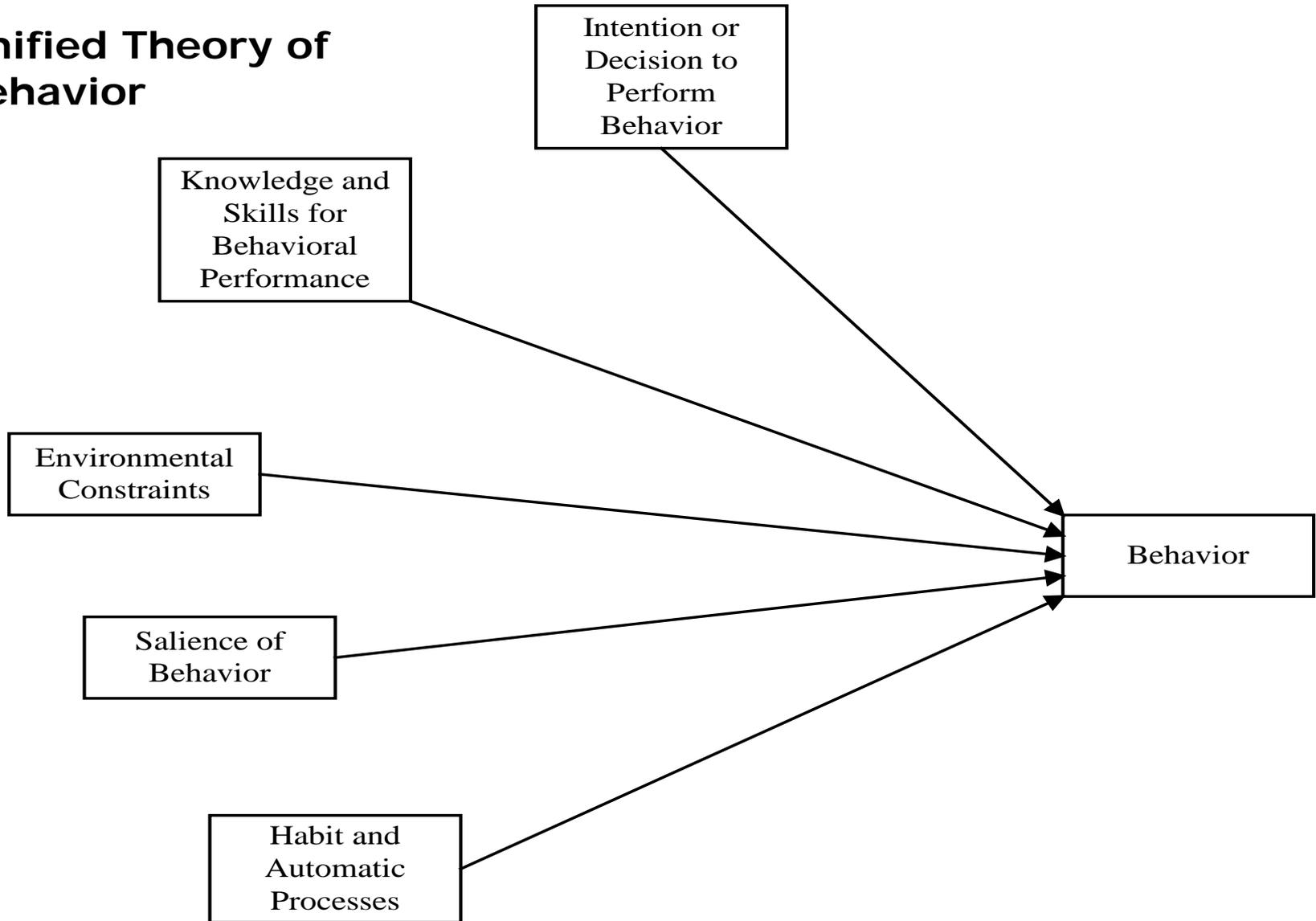




Unified Theory of Behavior



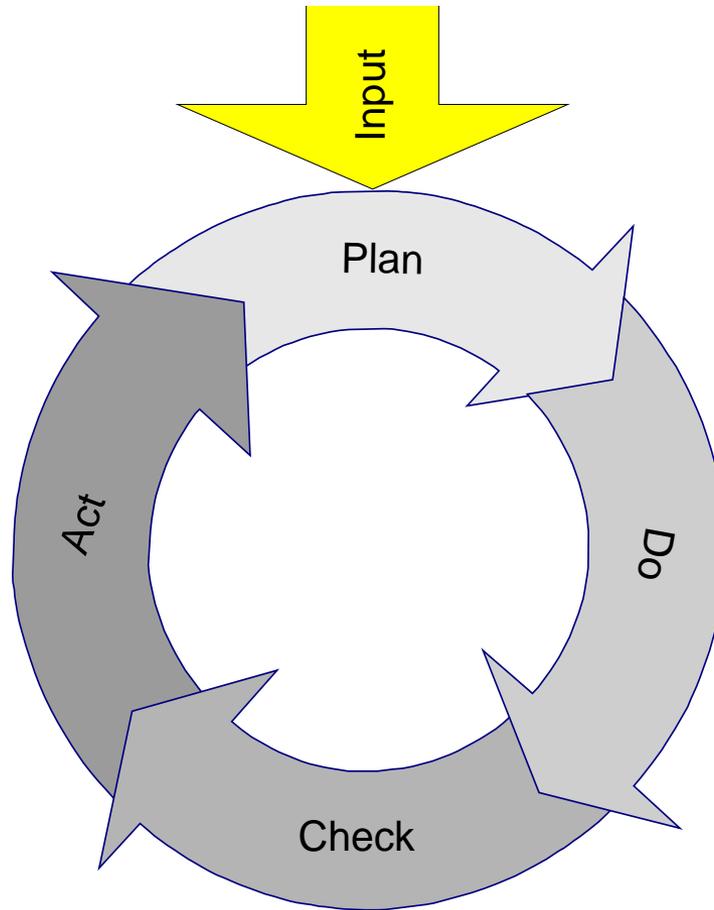
Unified Theory of Behavior





What will you do next?

The Continuous Quality Improvement Cycle



CQI cycle

- ▶ Plan – define organizational plan for quality tied to customer needs.
- ▶ Do – improve organizational performance on key indicators.
- ▶ Check – assess how well the services delivered in “DO” phase accomplished the objectives in “PLAN” phase.
- ▶ Act – evaluate and refine quality plan.

Resources

- ▶ **McSilver Institute for Poverty, Policy, & Research:** www.mcsilver.org
 - ▶ **Families Together in New York State:** www.ftnys.org
 - ▶ **Clinic Technical Assistance Center (CTAC):** www.ctac.com
- 



Section Two: Resources on Parent Engagement and Family Partnership

Principles for engaging with families

**A framework for local authorities
and national organisations
to evaluate and improve
engagement with families**



Early Learning Partnership
Parental Engagement Group



Foreword

Research going back many years has consistently told us – not surprisingly – that parents are the most important people in their children's lives, and that their support for their children's learning and development is crucial. The 1967 Plowden Report into primary education, for example, concluded that parents' attitudes towards their children's schooling had a greater impact on how they did in school than either variations in home circumstances or in schools; and Uri Bronfenbrenner's substantial 1974 evaluation of the American Head Start programme concluded that strategies which included parents were more effective in the long term than those that did not. These findings have now, of course, been replicated by the longitudinal Effective Provision of Pre-school Education (EPPE) study (Sylva and others 2004), and by Desforges and Abouchar's overview of the impact of parental involvement on pupil achievement (2003); both of which have reinforced the importance of parental interest in and support for their children's learning, while pointing out that what parents do (how they relate to their children) is actually more important than what they are (the family background).

What has changed over the past 10 years is the impact that this continuing body of research has had on both policy and practice. Supporting practitioners to engage more effectively with families is a key plank in government policy for improving cognitive and social outcomes for children, first through the Ten Year Child Care Strategy and Every Child Matters (DCSF 2003, 2004) and, more recently, in the Families and Relationships Green Paper *Support for All* (DCSF 2010). Working in partnership with parents is now an integral part of early years and children's centre services and is embedded in the Early Years Foundation Stage framework, and in guidance and inspection documents. Although this concept of partnership has been around for many years, there is now a greater understanding that this does not mean professionals dictating the terms of the relationship but rather a more equal approach based on respect, trust, empathy and integrity.

What is important is not just that engagement with families happens, but **how** it happens. As this booklet shows, partnership should be based on a 'principled' approach that recognises and builds on parents' expertise, where professionals and parents really listen to and learn from each other in ways that are valued and evaluated by parents themselves. In exploring and expressing the common principles on which engagement is a reality in their own organisations' work, the members of the Early Learning Partnership Parental Engagement Group (ELPPEG) have made a valuable contribution to the debate about the need for a broad base of evidence, and what that might look like. Demonstrated here are the importance of the processes of engagement and the importance of making explicit the beliefs and values held by those working to engage with families across the many agencies that play a part in families' lives.

Dame Gillian Pugh, Chair NCB

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Background

The Early Learning Partnership Parental Engagement Group (ELPPEG) was formed in 2009 by lead people from organisations who had come together through the Early Learning Partnership Programme (ELPP) strand 3, 2007–2008, funded by the DCSF.

The overarching aim of this strand of the project was to help create and support an early years workforce with the skills, knowledge and disposition to build respectful relationships with parents of children under three, and to help parents to support their children's innate readiness to learn. In addition, the project aimed to extend early years practitioners' continued professional development. The evaluation identified a 'huge appetite within the early years workforce for training in engaging parents' and that 'much of the training delivered within Strand 3 has the potential to positively influence practitioner–parents' relations within a short timescale'.

There was a strong feeling in the group that the principles informing their way of working with parents were very important and needed national recognition and focus. The group set out to formulate shared principles that underpin practice across all member organisations, which could be used to promote an effective way of working with families across the early years, family support, education, health, childcare and play sectors.

A consultation conference held at the Pen Green Research Base, on 9 November 2009, engaged stakeholders from a range of local authorities and national organisations in the formulation of the principles. ELPPEG members also consulted parents, through focus group discussions, and practitioners with a range of experience and backgrounds. Much consideration has been given to the language used.

The ELPPEG member organisations are:

- NCB
- Pen Green Research, Development and Training Base
- Parenting UK
- ICAN
- PEEP (Peers Early Education Partnership)
- Parents as First Teachers
- Pre-school Learning Alliance
- ContinYou
- Parents 1st.

Acknowledgements

ELPPEG would like to thank all its members who have given up their time and energy in the production of these Principles and this publication. In particular, Dwynwen Stepien from NCB and Kate Hayward from Pen Green Research who led on developments, with support from Joyce Connor and Heather Ransom from NCB, Margy Whalley and Sally Peerless from Pen Green, Helen Barrett from Birkbeck University and Sian Larrington from Bowthorpe, West Earlham and Costessey Area Sure Start Children's Centres.

We would also like to thank the National Quality Improvement Network (NQIN) Steering Group for their role in the production and dissemination of this booklet through their network.

NQIN is a specialist body that supports quality improvement managers and policy-makers working in early years and extended services (birth to eight) to improve outcomes for children and their families, by providing an extensive range of peer support, practice development, leadership and guidance.

The Network plays a central role in informing the national policy debate on quality improvement, while regional networks consider their unique concerns and challenges to ensure best practice and resources are shared locally.

In 2007, NQIN was funded by the DCSF to develop a set of quality improvement principles to support local authorities and national organisations to improve quality outcomes for children and young people. A companion guide and poster were subsequently developed.

The Principles for engaging with families complement this work and support the long-term drive to bring about learning, change and improvement in settings.

Please visit www.ncb.org.uk/qualityimprovement

Photo credits:

Cover and pages 19, 22, 27, 31 and 38: PEAL

Pages 7, 12, 15, 17, 25 and 34: Pen Green Research, Development and Training Base

Introduction

For a long time in the UK, there has been an ongoing national and local debate about how to engage families in child and adult services. Recent and current government initiatives – building on the Ten Year Child Care Strategy and Every Child Matters agenda (DCSF 2003, 2004) – for example *Think Fathers* and *Reaching Out: Think families*, set out an agenda for engaging families (DCSF 2008, Social Exclusion Task Force 2007).

A key policy driver has been to 'narrow the gap' to improve the life chances of poor children. As Feinstein (2003) has noted 'there is already a social class differential at 22 months' between the children from disadvantaged backgrounds and the children from advantaged backgrounds in the UK. This gap widens as children get older. This is not the case with our European neighbours and presents us with an immediate and very real challenge.

We know that parental involvement is key. Blanden (2006), using the same data as Feinstein from the 1970 Birth Cohort Study, found that 'parental interest in children's learning enables some children to buck the trend and do well despite disadvantage'.

We have been aware that parents play a central role in relation to outcomes for children for some considerable time. The Plowden Report (1967) acknowledged both the importance of the parent's role and the need to engage parents respectfully in services. The Start Right report (Ball 1994) shaped a new kind of partnership between parents and professionals:

Parents are the most important people in children's lives. It is from parents that children learn most, particularly in the early months and years.

(Ball 1994)

One of the clearest messages that came out of the EPPE studies (Sylva and others 2004) was that 'what parents do is more important than who parents are'. Desforges and Abouchar (2003) have also highlighted the importance of the home learning environment, emphasising the fact that:

at-home good parenting has a significant positive effect on children's achievement and adjustment even after all other factors shaping attainment have been taken out of the equation.

(Desforges and Abouchar 2003)

But how do we best encourage and support successful and sustained engagement with families to support them in their parenting role?

Over the past few years there has been a growing interest in parenting programmes. The adoption of the 'programme approach' can give the impression that parents can be processed and easily changed as a result of a limited number of sessions delivered over a short space of time, provided that a set formula is followed. The use of randomised controlled trials to evaluate programmes, and a concomitant reliance on

narrow, easily quantifiable behavioural outcomes, has also given the impression that parenting programmes can be viewed as akin to a medical 'cure'.

The organisations, workers and parents who have come together to create the Principles outlined here advocate a different approach. Their focus is not only on 'what' but also on 'how' workers engage with families. They stress the importance of the underpinning principles and beliefs that guide work with families on a day-to-day basis. This approach is more about challenging practice and building relationships than simply about 'teaching parents new skills'.

When working within multidisciplinary, multi-agency teams, the dialogue and debate about beliefs and values is crucial for achieving a 'joined up' approach. The focus is on building and sustaining relationships with families so that knowledge can be shared, both ways, between workers and parents in a respectful dialogue. There is therefore a need for the stability of services and for the support of staff to maintain their connections with a given community over time.

Parents' views and voice in the development of services and their evaluation of 'what works' is central. We need a broad evidence base looking carefully at the processes of engagement as well as the outcomes for children and adults. We need to develop ways to evaluate outcomes that are meaningful, within each local context.

We also need to ensure that the evidence of effectiveness is drawn from a range of sources across a number of dimensions and from different perspectives. The development of these principles gives us a focus for these investigations. They have been developed in line with the National Occupational Standards for working with parents (Lifelong Learning UK 2005). It is hoped that funders, commissioners and practitioners will be able to use them to identify, celebrate and support the development and quality improvement of practice in relation to engaging families within local community services.



Key definitions

parent	The term 'parent' refers to mothers and fathers as well as carers or key adults who have the responsibility for, and loving relationship with, children in their care. We have not emphasised the issues around the diverse nature of adult carers for children but want to make it clear that we have used the term 'parent' to represent all key adults. These include working mothers and fathers, parents with a special right, parents who speak English as an additional language and parents not living in the family home.
family	Refers to the network of important people around a child, in whatever form the family is constituted. This could involve parents, partners of parents, step parents, grandparents, carers and key adults in a child's life, siblings, step siblings and extended family members who have a close relationship with the child.
service users	Any adult or child accessing services either in settings or children's centres, or through services offered in their own home such as family visiting.
practitioner	Any worker in child and adult services, including workers in early years, health, family support or those working in the voluntary and community sector with children and families.
family support	Work carried out by practitioners who offer support for the whole family in many different ways including home visiting, one to one support and liaising with other professionals in addition to enabling families to access other services.
safeguarding	Keeping children safe and protected from physical, emotional and sexual abuse and neglect.
local authorities	Public sector activity at a local level in specified geographical areas.
group leader	Practitioners who run groups for children and/or families/parents, such as drop-in groups.

1 Successful and sustained engagement with families is maintained when practitioners work alongside families in a valued working relationship

Recognising parents' expertise in their own children and lives, doing things with families rather than to them is crucial.

(Moran and others 2004)

Parents need to feel that they are active participants in partnership with practitioners.

We know that parents want to remain in control of their family lives [and to] be listened to ... Relationships are at the heart of this process. For a parent lacking in confidence and trust to access services, forming a warm and positive relationship with a practitioner can be a bridge to available help and information.

(Roberts 2009)

Davis and others (2002) suggest a partnership model with the following key elements: a common aim; working together; complementary expertise; mutual respect; open communication; sharing power; and negotiation.

Roberts (2009) in *Early Home Learning Matters* describes how Braun and others (2006) set out the following list of qualities that underpin what they call 'a helping relationship and partnership'.

- Respect:** valuing parents as individuals, believing in their fundamental ability to cope and make a difference in their family lives, and working within an ethos of partnership.
- Empathy:** showing an understanding of the challenges a parent is facing in their lives, and being able to see the situation from their point of view.
- Genuineness:** being sensitive, honest, undefensive and trustworthy.
- Humility:** working in the context of an equal relationship and using parents' strengths, views and knowledge alongside your own at every stage of the process.

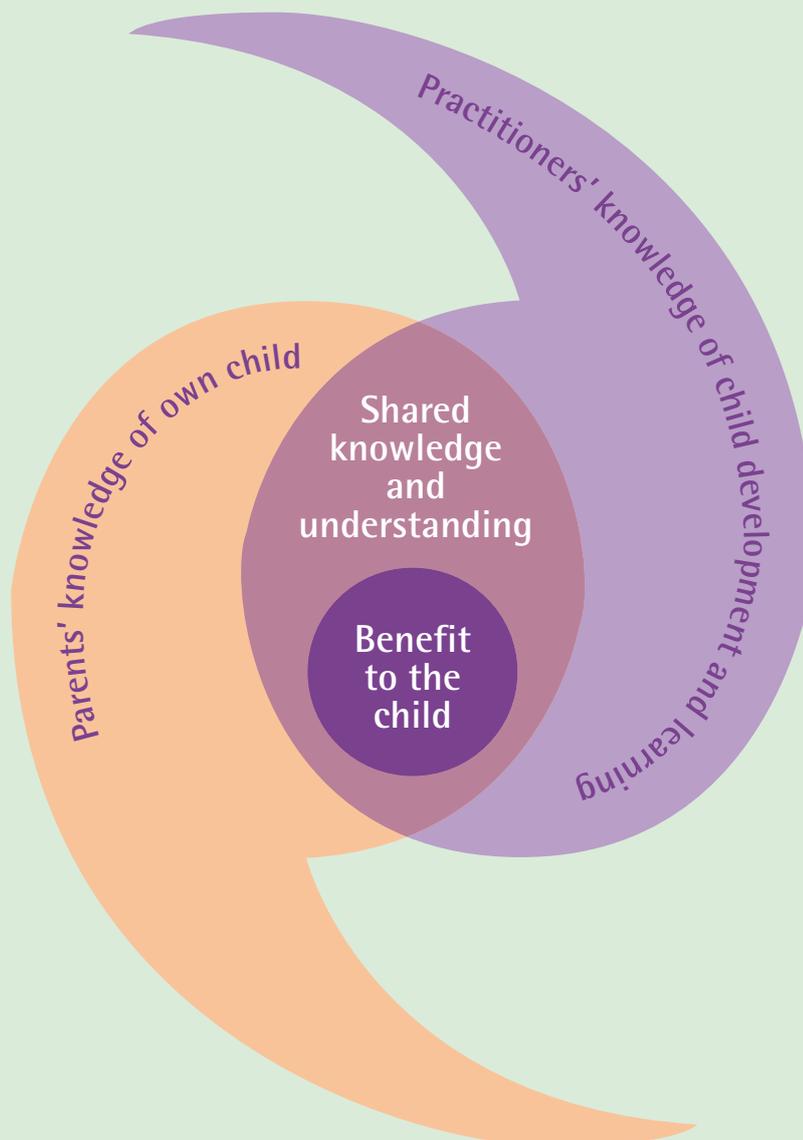
Quiet enthusiasm: bringing a friendly, positive energy to the relationship and a consistently calm, steady and warm approach.

Personal integrity: in addition to empathising with the parent, being able to hold alternative views and offer these when appropriate.

Expertise: the knowledge and experience that the helper [practitioner] brings to the work to complement the parent's existing knowledge and skills, both in building the relationship and in providing information and support.

Key to all successful engagement of families is working in partnership, acknowledging what families bring and what practitioners contribute. In all interactions with families, effective communication is key to building real relationships. This depends on making time to talk one to one, and giving individuals attention either in the home environment or in a welcoming environment outside the home and at appropriate and convenient times for parents.

Balanced relationships



Wheeler, H and Connor, J (2006) *Parents, Early Years and Learning: Reader*. London: NCB.

Easen and others (1992) talk about a '**developmental partnership**' in which both parent and practitioner contribute their expertise. Parents have their own specific knowledge of their child and their family. Practitioners have a more general knowledge of child development and learning. Through sharing both sets of equally important expertise, the provision and outcomes for the child are improved.

What would this Principle look like in practice?

Parents As First Teachers: An approach to personal visits that is based firmly on the belief that the parent is the child's first and most influential teacher.

When the project worker first visited my house, she was the only one to accept a cup of tea and sit down with me and listen to what I had to say. All the others, my social worker, drug support worker, just stand in the middle of the room and tell me what I'm doing wrong. Pam really helped me to realise I can be a good mum not only to my baby but to my other two children. I really look forward to her visits.

(Annette)

I was a little apprehensive going to my first meeting with Annette but having accepted the cup of tea I moved into the first part of the visit programme, building rapport with the parent. I visited weekly at first, working with her to increase observational skills of her baby's development, asking open-ended questions and listening carefully to her concerns. Annette enjoyed the parent-baby play activities I modelled, and increasingly asked questions about child development. As she grew in confidence the visits became fortnightly and then monthly. Her increased parenting skills impacted on her two older children who now regularly attend school and are making good progress – and to think the children were heading for being taken into care.

Annette and her partner increasingly offer to help in any voluntary work needed at school and are involved in our pilot study of assessing successful ways to engage families who do not traditionally access services.

(Pam)

Pre-school Learning Alliance: A discussion between parents and a practitioner, at the Charlton Family Centre, where they comment on their partnership.

Probably the most important thing is communication. Just talking one on one; you ask how they've been, they give you a rundown on what they've been doing.

Communication is not one way, it's flowing both ways.

(Russell)

We try to involve the whole family and build a relationship over time. Parents tell us what their child has been doing at home and the staff incorporate it into their planning.

Recently we asked parents if they would be interested in celebrating the diversity of the families in the centre and asked how they would like to contribute. Twenty out of thirty parents took part in the Language and Culture Week and decided what they wanted to do. Some read stories and sang songs in their own language, while others talked about their clothes or their food. One of the mums, Naya, led a music and dance session in Igbo for different age groups.

Parents are now asking for courses on child development and are keen to give feedback on book bags and puppets that they take home.

(Mona Naqvi, Charlton Family Centre, Greenwich)

Points for reflection

- What professional development opportunities are you offering in your setting or local authority to support practitioners in working with adults in families as well as with children?
- Do your policies and practice reflect the importance of valued working relationships (partnerships) with parents, through the processes of induction and recruitment and in the running of your organisation?



2 Successful and sustained engagement with families involves practitioners and parents being willing to listen to and learn from each other

We know that young children achieve more and are happier when early years educators work together with parents and share ideas about how to support and extend children's learning.

(Meade and Cubey 1995)

Knowing families well is the key to really listening and responding to what families want from services and how and when they want to engage. Brazilian educator, Paulo Freire (1970), challenges us by stating that being willing to listen and learn from each other requires an approach where practitioners are able to:

identify with others and recognise the fact that 'naming the world' is not the task of an elite. Value the contribution of others and listen to them with humility, respecting the particular view of the world held by different people.

(Freire 1970)

Recognising the complexities of families, and the knowledge within them about the child and their daily life, is vital if those working with families are **really** to create an approach that has families at its heart. It takes time to know families well, and to be able to share their 'funds of knowledge' (González and others 2005).

Easen and others (1992) acknowledge 'the parents' own learning process' in the dialogue with practitioners, and emphasise the importance of:

taking what children do now as the starting point for observation and reflection [as this] allows for a positive and non-judgemental dialogue to develop between parents and educators [practitioners].

(Easen and others 1992)

In this process the practitioner is also open to new learning and the sharing of knowledge about a child, which can be transformational for the practitioner.

Mezirow (1994) talks about how we can begin to see things very differently through a process of dialogue and reflection in what he calls 'perspective transformation'. If practitioners and parents are willing to listen and learn from each other they are both able to be transformed by their interaction.

What would this Principle look like in practice?

PEEP: A practitioner's review of a PEEP home programme.

Today we talked about a language issue with her three-year-old boy. Ranie is worried and surprised that the school has suggested he has this problem, because he is a good communicator in the house. We also talked about which languages they are using in the house. She told me that she and her husband speak Punjabi with each other and Urdu with their children.

I asked Ranie why they speak Urdu with the children if their own language is Punjabi? She replied: 'I suffer through my mother tongue and we don't want them to suffer or be embarrassed because they speak Punjabi.' I also discovered that her own language is not Punjabi but Pothowari. She explained that when she got married the first thing she experienced was everybody laughing at her dialect.

I encouraged her and let her say what she wanted to say, which she might never have said before: that she hardly speaks her mother tongue with anybody but Pothowari is the only language she knows by heart. She described her mother tongue beautifully like this: 'A Mother's language is mixed with breast milk and I heard her 20 years before coming to another area of other language, so I still think in it and can't forget for a minute no matter how much I try...' I used her words and reassured her that children will learn any other language easily if she will give them language mixed with her breast milk.

Points for reflection

- What opportunities do practitioners create to enable them to listen and learn from parents and for parents to learn from them?
- Does your organisation create time for practitioners to reflect upon their own learning?
- How does this process apply to **all parents and carers**; for example, working parents, parents of children who access services via local authority transport, parents with additional needs, parents who speak English as an additional language, and parents who do not live in the family home?

3 Successful and sustained engagement with families happens when practitioners respect what families know and already do

...early years educators need to recognise parents' roles as their child's first and most consistent educators.

(Whalley 2007)

It is very easy to describe parents as their children's main educators – but do practitioners work with families in a way that connects with and honours this knowledge? Practitioners can never know children as well as those who live with them and have had loving relationships with them over time, in many cases from birth. In the words of Paulo Freire, practitioners need to 'give up the idea that we are the exclusive owners of truth and knowledge' (Freire 1970).

Respecting what families know and already do with their child to support their learning and development enables workers to engage positively with families. This way of working recognises that the home learning environment is key. It is a way of working that respects the nurturing and supportive experiences that happen day to day within the home and with family members and friends outside the setting or group contact experienced by the practitioner.

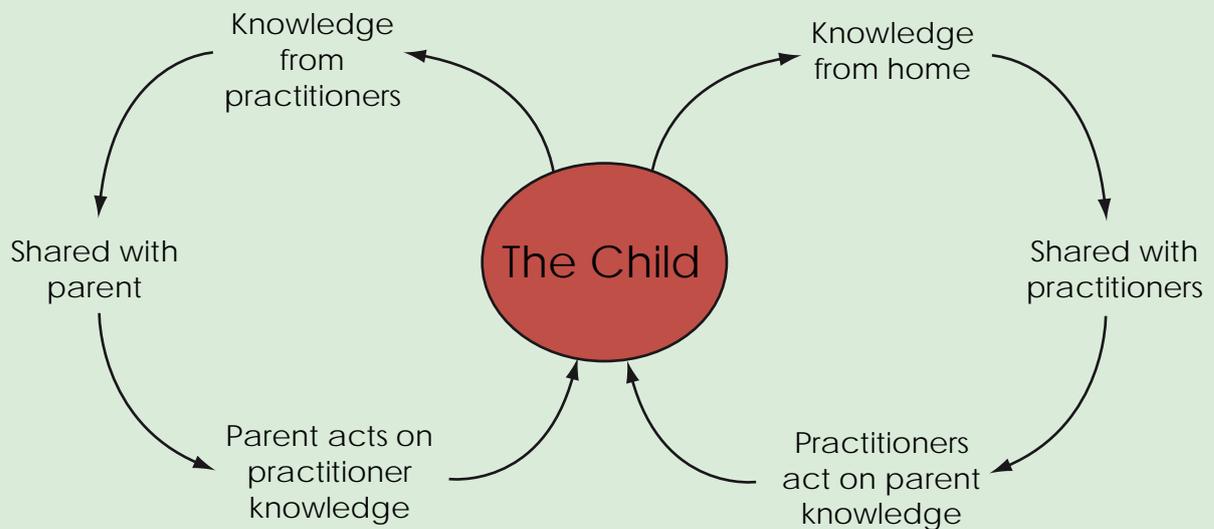
Making connections with children's experiences across all the environments they encounter day-to-day enables children to make sense of their world and build on what they know and can do.

(Pen Green Research, Development and Training Base 2007)



The Pen Green Loop

Knowledge-sharing between parents and practitioners, to enable all adults to work most effectively in supporting the child.



Adapted from Whalley, M (ed) (2007) *Involving Parents in their Children's Learning*. (second edition)
London: Paul Chapman.

What would this Principle look like in practice?

Parents Involved in their Children's Learning (PICL): Parent's and worker's reflections following the sharing of knowledge about a child through using video.

I was a bit shocked seeing the video of Marie. I was blown away. I didn't understand that making a mess was learning. I liked watching the DVD, it's like being a fly on the wall. My house is Marie's little art box now. I also take videos, it's so exciting to show the workers. I really enjoy it. I lived with my mum and dad for the first two years of Marie's life – they have a big impact. There's always been a strong bond between me and my daughter, being a single mum, but understanding her a bit more has made us unbreakable.

(Nicola)

I did a home visit and met grandma and great grandma. It shifted me to go and talk about why Marie was doing things. They related what she was doing at home and how she was learning. It helped me to put all we know about Marie into context. I asked Nicola what she wanted for Marie and she told me she wanted her to be Prime Minister! PICL has helped Nicola to gain confidence and be an advocate for her own child and also other parents within the centre.

(Anne, Crescent Children's Centre Meir, Stoke-on-Trent)

Points for reflection

- Do parents and practitioners regularly share knowledge about children's learning and development?
- Does the information from home feed into the planning for that individual child in the setting or home-based project plan?
- Does the information from the setting or practitioner working in the home feed into what the parents provide for their children at home?



4 Successful and sustained engagement with families needs practitioners to find ways to actively engage those who do not traditionally access services

The sheer diversity of family life now means that 'one size fits all' approaches are unlikely to be successful and that instead, giving families access to information, advice and support of various kinds that they can make use of as and when they think best, is much more likely to be effective.

(DCSF 2010)

The phrase 'hard to reach' is often used to describe parents who do not access services. This rather loaded phrase puts the emphasis on the inaccessibility of parents but in reality it is the services that are hard to reach for some parents. There can be both organisational barriers to overcome, such as times of opening and distance to travel, and barriers connected to personal feelings and attitudes. Staff and parents in any setting can be inclined to treat some adults differently or to 'other' those who appear to have different family contexts to themselves (Muhr 2008).

Children's centres are now required to be accountable for the learning and development of children in their area, irrespective of their attendance at the centre; it is not acceptable to simply engage with those who choose to come through the door. Practitioners need to find ways to actively engage parents, particularly those parents who have not accessed services in the past. This could involve reflecting with parents on how they became engaged in services, and finding out what worked and what did not work for adults in a range of family contexts and with a variety of life experiences (Hayward 2010).

In the recent publication from the Family and Parenting Institute, *Early Home Learning Matters* (2009), Roberts reviews the learning from the DCSF-funded programmes, Early Learning Partnership Programme (ELPP) and Parents as Partners in Early Learning (PPEL):

A major shift in focus for many services that participated in the ELPP and PPEL projects was to see vulnerable adults primarily as parents rather than clients and to bring them into a partnership that recognised the importance of their involvement in their children's learning.

(Roberts 2009)

The important key messages from the projects were that, if sessions are to engage parents who traditionally do not access services, practitioners needed:

- **time** – enough to develop relationships with families in a way that was acceptable
- **support** – and supervision for themselves
- **flexibility** – the ability for workers to make flexible and responsive decisions about how best to support families, involving other agencies where necessary, such as housing and debt relief.

And services needed:

- **fine-tuning** – to support specific needs and circumstances, including services for particular members of the family who do not traditionally access services, such as dads
- **outreach** – as it was important, in some cases, to 'take the service to the parent' rather than wait for the parent to come to the setting
- **to be complementary and networked** – as a raft of services are needed to address multiple needs, and different needs at different times.



What would this principle look like in practice?

The Pen Green Centre for Children and their Families: reflections from a children's centre outreach worker and parent.

I got to know Christine through her visiting my partner and she eventually persuaded me to take the kids to Dads Club on a Sunday.

The very first time I went it was a proper nightmare – I couldn't get in to the place! But Christine 'persuaded' me to try again and it worked out better after that. When I first went I had all sorts of stuff going on in my life and I found it very hard to speak to people or to go out of the house but gradually, as the time went on, I started to feel better in myself.

My kids Heather, Bobby and now Penny, won't let me miss a single Sunday! They have to be at Dads Club every week and it has definitely brought us closer as a family. It started with Christine hounding me – and I mean hounding! – to get involved with my kids and take them to Dads Club and after two years of asking I said I would give it a try and see if my kids liked the club.

(Jimmy)

I home-visited Jimmy's partner, Claire, on a regular basis and also began supporting Jimmy. Jimmy had very low self-esteem and lacked confidence. He had hardly left his house for the best part of two years and his continuing use of alcohol and drugs maintained his low self-esteem. I felt that it was really important to support Jimmy in taking his children to one of the weekend groups at Pen Green for dads and their children.

(Christine, family visitor, Pen Green Centre for Children and their Families)

Points for reflection

- Do all practitioners know their community, and the families within them, well?
- Do all practitioners know which sectors or social groups of the community they are not working with effectively?
- What systems are in place to monitor the level and quality of engagement with families from different family contexts and life experiences?
- Do practitioners involve parents in analysing what works and what does not work in terms of engaging families?
- Do practitioners find ways of talking to parents who are not engaged in services to understand their views?

5 Successful and sustained engagement with families happens when parents are decision-makers in organisations and services

The building was here, but we have created together the space for parents, children and staff to work, play and grow. Parents and staff have jointly defined the use of the space and consistently challenge and evaluate the centre's 'development'.

(Pen Green 1985)

Successful and sustained engagement with families is supported when there is a community development approach to developing services and they are co-constructed with families. Moss (1992) advocates for settings to develop:

from a perspective which regards early-childhood services as a need and a right of all communities and families, and as an expression of social solidarity with children and parents.

(Moss 1992)

Developing services is a joint venture between all stakeholders, and the involvement of families in making decisions about how services operate is crucial if the services are going to meet the needs of a particular community. Parent representation needs to be more than a sounding board for decisions made by setting leaders. If parents are working in true partnership with organisations they need to be part of the decision-making processes that shape and build the services they access.

Encouraging community members to be decision-makers in organisations requires an active approach to community education. Workers can support adults in the community to be self-directing, to have the self-confidence and belief that they can change things (Whalley 2007, p.4). Organisations need to open pathways for adult engagement to enable parents and family members to take on different roles within the organisation, building community capacity and enriching the learning community created by the setting.

Much better are approaches that invite parents to participate and choose the elements that they would like to try for themselves. That is, they fitted the programme to the parents' needs rather than fit the parents' 'problems' to the prescriptions of the service.

(Quinton 2004)

What would this principle look like in practice?

Parents 1st: Reflections from a community parent volunteer working in the community to support others.

I first heard about the Community Parents Programme from a friend of mine, who had been attending a weekday session at the children's centre with her son. She had picked up a leaflet ... which she dropped off at mine suggesting I might be interested ... What attracted me to the idea was the fact that I could use the skills and experiences I had as a mother to help better other parents' lives and use my skills and knowledge to help promote healthy living. It also made me feel a great sense of pride in being involved ... [I am now a community parent volunteer myself and] I believe the support the local families get from the community parent volunteer works well because parents find the visits to be more relaxing and less stressful knowing that another parent is helping and supporting them and not a professional.

(Tracy, community parent volunteer, NSPCC, Liverpool)

Points for reflection

- Does your organisation have an active parent forum or parent group?
- Does your organisation take into account the views of parents who do not attend the parent forum or group?
- Do parents jointly make decisions with workers about how services are shaped and developed?
- Do parents play active roles in your setting?
- How are parents involved in evaluating your services (for example, through a parent-led needs assessment)?
- Do parents have a voice in what is evaluated and how evaluations are conducted?



6 Successful and sustained engagement with families happens when families' views, opinions and expectations of services are raised and their confidence increases as service users

Approaches to families should be personalised and tailored to their self-defined needs, help parents and carers raise and realise aspirations for their children, enable them to feel in control and engage them as partners in tackling local problems and planning services.

(Sure Start 2010)

The initial and sustained experiences that families have of services will obviously affect their confidence in using them. Workers need to reflect on families' initial engagement with their settings. Who are the people that make this first contact: family workers, receptionists or outreach staff? How positive is this experience for families?

A consistent welcoming environment, with workers who build positive relationships with families, will boost parents' confidence in becoming service users. They will be supported in accessing a wider range of services according to their needs and preferences and good services will raise expectations, giving parents a key role in quality assurance. Engaging parents as decision-makers in organisations (Principle 5) will also support parents' confidence as service users, giving them a voice in the development of services.

At the Pen Green Centre for Children and their Families, engaging families effectively:

was not about compensating for disadvantage. Instead it was about acknowledging the impact of poverty on the lives of local children and their families and encouraging families to take an equal and active role in developing responsive services.

(Whalley 2007)

Practitioners need to be supported in developing the skills to enable parents to become advocates for their children and their families. Strong practitioners can help parents to have a voice in shaping services so that they meet their needs more effectively.

Holman (1983) talks about the qualities and skills he found in community social workers who successfully engaged families in family centre services and community projects. These workers brought the resources of their own personal strengths and sensitivities to the relationship with families, together with the resources they offered from the connection they had with agencies and services. He describes these workers as '**resourceful friends**'. Families were able to raise their expectations of being heard and of gaining access to resources through these workers.

What would this principle look like in practice?

Room to Play: comments on a PEEP drop-in based in a community shopping centre, taken from an evaluation of Room to Play.

This parent had three children: two of school age as well as a baby ... Initially she was only able to come in for short periods of time to change her baby's nappy, and over a period of around six months she gradually stayed longer each time, eventually accepting a cup of tea from staff, although she was only able to interact with staff through her children and avoided eye contact. She had no qualifications and had difficulties with literacy. In her own time she began to share information about herself and her family, and staff noticed that she became more confident and more able to interact with other users, although she only stayed for short periods of time. It emerged that her children were having difficulties at school in relation to behavioural problems and anger management issues, but she did not feel confident addressing this with the school. However, as she began to share this information, staff were able to suggest strategies for dealing with the children.

Staff also advised her how to raise her concerns with the school, making suggestions as to who she could contact, and trying to take a proactive approach – for example, helping her to identify triggers or key problem areas. Eventually she was able to access more support for her children at school. She had initially been reluctant to allow her children to participate in activities outside school, such as play schemes, commenting: 'I like to keep my kids with me ... they won't go anywhere without me.' However, staff noticed that as her own self-esteem increased she became more open to new experiences, allowing them to take part in outings and excursions.

(Adapted from Evangelou, M and others (2008) 'An evaluation of PEEP provision for "excluded" families: Room to play', Sutton Trust Evaluation Project (STEP) Phase 3 research report)

Points for reflection

- Do parents access services over an extended period?
- Do parents access multiple services?
- Do all parents tell you (by whatever means appropriate but non–returned questionnaires do not count!) that the services on offer meet their expectations and needs?
- Do you have a parent forum; how are the views of parents acknowledged and are they acted upon?



7 Successful and sustained engagement with families happens where there is support for the whole family

Good parenting happens in all sorts of families and policy needs to reflect this diversity, helping children to have the best. Policies and services also need to respond sensitively to the needs of all family members as it's not only parents who are important to children.

(DCSF 2010)

Children thrive when they grow up in families where they receive what Desforges and Abouchaar (2003) refers to as 'at home good parenting'!

Positive relationships between parents and children are fundamental to good outcomes for children.

(C4EO 2009)

Parent's lives are complicated and at times all parents can find they are under pressure. For some parents, their circumstances and unmet needs can severely impact on what they can offer their child at that time. What affects the family affects the child, so the focus needs to be on the whole family rather than any one individual within it.

By being inclusive of fathers and mothers (or carers where appropriate) and taking the whole-family approach, services can secure better outcomes for families at risk of poor outcomes by identifying support needs at the earliest opportunity.

(Sure Start 2010)

There has been a recent government focus on the importance of understanding the issues affecting the family as a whole and the strengths and challenges within families:

When parents experience difficulties in their own lives, the impact can be severe and enduring for both themselves and their children. The consequences can cast a shadow that spans whole lifetimes and may carry significant costs for public services and the wider community.

(Social Exclusion Task Force 2007)

Reaching Out: Think families (Social Exclusion Task Force 2007) goes on to highlight the learning from the Families at Risk Review, stressing that in order to engage effectively with all families, practitioners need to be aware that:

- 'one size does not fit all' and families need a personalised approach that works for them
- an integrated approach is required where families are supported by a range of integrated services
- early intervention is important, so practitioners need to build relationships with families effectively so that the best support can be offered as quickly as possible.

The whole-family approach stresses the importance of looking at the family as a unit and focusing on positive interdependency and supportive relationships. This approach takes the family's resilience and social capital as the foundations for achieving positive outcomes.

(Social Exclusion Task Force 2007)

We need to move to away from a long-standing concern with risk factors and towards a focus on protective factors, where families are viewed as active and knowledgeable participants (Council of Europe 2007).

If we are to reach out to families at risk, we need to identify and exploit opportunities to build the capacity of systems and services to 'think family'. This means a shift in the mindset to focus on the strengths and difficulties of the whole family rather than those of the parent or child in isolation.

(Social Exclusion Task Force 2007)



What would this principle look like in practice?

The Pen Green Centre for Children and their Families: reflections from a social worker and parent.

Karen was referred to me at the children's centre through her community mental health worker. Karen began to use many different parts of the centre with her children including crèche, nurture group, nursery and after school club. We set up meetings between all the professionals involved to give Karen continuity of support as there were difficulties in providing a consistent approach to her care.

After Karen was admitted to hospital last year, other family members became involved and supported at the centre. Karen's husband, Craig became actively involved with the children in the nursery and accompanied them on trips. Karen's mum, Mary, and her dad, John, regularly attend group support sessions and come in to bring and collect the children from the different groups that they attend. Enabling all family members to get to know the workers at the centre and receive support for themselves in caring for Karen and the children has been really important in maintaining Karen's support network.

(Sarah, adult mental health worker)

Without the Centre I don't know where I'd have been. One of the main reasons I came to the Centre was for breast feeding support because no one in my family had ever breast fed. I joined the breast feeding support group and went on to Sarah from there. Then I got referred to a Sure Start Family Visitor and Sarah who came to my home to help me with the family and my post natal depression at the time. The family started to become involved when I joined the GAP (Getting Ahead of Post Natal Depression) group and they found it supportive because Sarah made some home visits and she became a point of contact if they had concerns as well. Then the children moved from nursery and Sarah got some funding for after school club for us so that I could concentrate on my health issues and have continued one to one care and support.

(Karen, parent Pen Green Centre for Children and their Families)

Points for reflection

- How is support offered for all family members?
- How is information about families shared between different services offering support? How is the family involved in the sharing of this information?
- If families leave your service, is there a common approach and shared information regarding support?
- How do you involve extended family members?

8

Successful and sustained engagement with families is through universal services but with opportunities for more intensive support where most needed

*Trust is key to success: staff in universal services such as teachers, doctors and health visitors [practitioners in children's centres] can be important sources of support where families have built **strong and sustained personal relationships**. This can be crucial in achieving positive outcomes.*

(Social Exclusion Task Force 2007)

Providing flexible non-stigmatising universal services, where families are already known and have established relationships with practitioners, means that families have access to support as and when they need it. It is important that 'families are not pushed into action by professionals but are allowed to go at their own pace' (Council of Europe 2007, p.122).

Sometimes families need help to access specialised services, which is easier if support is offered by well-known and trusted practitioners or 'key workers' who have developed a relationship with both the children and the adults in the family. Building such relationships takes time. The development of trust between parent and this 'key worker' practitioner allows for this more specialised support to be offered, ideally by the same worker. This continuity of care is important in maintaining the trusting relationship with families. If further specialised services are required, it is important that the key worker is alongside to offer support to the family in engaging with other professionals. Parents may attend an 'open to all' drop-in group or experience a home visit from a health visitor or family nurse during which the practitioner-parent relationship builds.

As Siraj-Blatchford and Siraj-Blatchford argue:

services are more effective when ... they provide intensive support to vulnerable parents in the first three years to enable them to meet their children's needs, and they avoid labelling 'problem families'.

(Siraj-Blatchford and Siraj-Blatchford 2009)

In a review of the literature on ways of working with parents, the Council of Europe report (2007) *Parenting in Contemporary Europe: A positive approach*, suggests that programmes and services should be guided by certain principles. These are:

- *Non-judgemental and non-stigmatising attitudes*
- *A bottom-up approach*
- *Multi-focused and flexible services*
- *Integrated community-based services*
- *Inclusivity towards the experience of minority and ethnic groups.*
(Council Of Europe 2007)

Recent research has argued that services which offer specialised support within universal services are particularly effective and need to be inclusive of all families challenged by complexities, including disability. The Marmot Review says that:

actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage.

(Department of Health 2010)

What would this principle look like in practice?

The Pen Green Centre for Children and their Families: reflections from a Growing Together group, a universal drop-in for parents and children aged 0–3, where there is access to specialised support through known workers at the Centre.

I got to know Alison through her health visitor as she had post-natal depression. She attended the Growing Together drop-in group, where she was able to develop relationships with practitioners in a non-stigmatised environment and engage in reflection about her relationship with her child. Because of the way the group is set up, she was able to do this in her own time and in her own way. She accessed other services for her post-natal depression through the centre, while maintaining her connection through the Growing Together group.

(Tina)

Growing Together was an important group for me and my child. The room was always set up in the same way every week, this made it predictable. The staff were always the same; and knowing I would always see the same people helped me to make relationships with them. I knew each week who would be there and I would know if someone was going to be off on annual leave. This helped me to feel safe.

(Alison, Pen Green Centre for Children and their Families)

Points for reflection

- How well do you know your families and how do you identify their needs? Do you do home visits?
- What professional development do you offer to universal service providers in assessing levels of need with families?
- How do statutory, voluntary and community services collaborate to support families?
- How is support offered to families with a range of complex issues and needs?



9

Successful and sustained engagement with families requires effective support and supervision for staff, encouraging evaluation and self-reflection

If staff members are to provide the kind of encouragement and support necessary for the support and development of children and families, they need to be encouraged and supported themselves.

(Mezirow 1994)

One of the many benefits from working in multidisciplinary teams is the opportunity to learn from the working practices derived in different disciplines.

Within the professions of psychotherapy, counselling and social work, it is generally accepted that those who work with distress and discouragement are at risk of becoming distressed and discouraged as well.

(John 2008)

Those practitioners are required to take part in regular formal supervision, which helps them to look at how their work is affecting them and to maintain, or regain, a healthier perspective and helpful distance from the distress of others.

(John 2009)

There is growing recognition that regular mentoring of staff, as well as support and supervision, are essential to the well-being of staff and their ability to work effectively with children and families. Effective supervision is different from performance management. Performance management tends to be guided by a narrow focus on designated outcomes. The supervision process is much more about the person and their personal and professional development.

Effective support and supervision has three elements:

- reflection and dialogue about your self and any personal issues that are affecting you and are impacting on your work
- reflection and dialogue about your work with children and families
- reflection and dialogue about your professional development and the opportunities that are available to you to improve and reflect on your practice.

Where support and supervision works best is when a lead person in a setting is responsible for the supervision of named staff and the supervision session takes place on a regular basis, generally lasting for an hour once a month. The supervision session takes place in an agreed confidential space where the supervisee will be at ease. There is an element of stimulation, challenge and emotional containment (Formishino and Oliveira-Formishino 2005). Regular designated time with a lead person in the setting enables practitioners to take stock and 'offload' before underlying issues become insurmountable. The space created for these discussions also enables workers to bring issues to supervision and to develop trust in the leadership of others that these issues will be discussed and addressed.

In some situations, for example for group leaders working with children and families, group supervision is required. This enables group members to reflect on difficult practice issues and to challenge, support and encourage colleagues and share knowledge, skills and insights with them in a non-threatening, safe and confidential environment.

Professional self-reflection and evaluation leads to reflective practitioners who constantly respond to feedback on their practice and strive to improve what they offer on a day-to-day basis. Supporting practitioners professionally in this way is an investment in their future and leads to a deeper commitment by staff and much better relationships within staff teams as practitioners feel nurtured and cared for.

What would this principle look like in practice?

The Pen Green Centre for Children and their Families: reflections from crèche workers at the Centre.

In Sarah's supervision we explored the challenges she was facing supporting Lesley, a parent of a 2½ year old boy attending crèche. The discussions we had during supervision helped Sarah to work through her feelings and anxieties. We were able to put a professional development plan into place that helped her to build on and enhance her practice within the crèche.

(Jenny)

I discussed my work with Lesley and her child in my supervision. This gave me the opportunity to explore my feelings and worries about my ability to support this family successfully. I had suffered post-natal depression many years ago and was feeling anxious. My supervisor suggested that I became a group leader within the GAP (Getting Ahead of Post-natal depression) group within the Centre. This enabled me to understand the support that was available to parents, and how I could enhance my practice in the crèche.

(Sarah)

Points for reflection

- Do practitioners have regular support and supervision sessions?
- How are practitioners encouraged to evaluate their practice?
- Are practitioners given time for self-reflection and review?



10 Successful and sustained engagement with families requires an understanding and honest sharing of issues around safeguarding

The separation between children's and adult services has resulted in a fragmented approach to work with families and different views about whether the focus of support is on child protection or on supporting people with their parenting role

(Commission for Social Care Inspection 2009; Roberts 2009)

Working hard to build positive initial relationships with families makes it easier later on if difficult issues need to be discussed. Parents need to know, and internalise, the feeling that they are important, that they are known to those working with them and that their difficulties are understood and acknowledged.

Many aspects of the wider environment impact on children's outcomes but the greatest influence, within a child's first years of life, are the experiences within the family, including the parental relationship, family environment, social and economic environment and culture. It needs to be recognised that it is parents' experiences of being parented in their turn, the history of their own relationships with family, peers, partners, professionals and the community, coupled with their current life stressors, that will affect the way they understand and interpret the needs and behaviours of their own children.

Early identification of parenting difficulties is crucial and it is important to recognise the value and significance of the role of universal services, such as midwifery, health visiting and education within this. But it is equally important to acknowledge the need for **clear pathways to targeted and individualised support**. Work with vulnerable families needs to be considered as long term, and this can best be done through organisations with a stable workforce who are well supported to remain curious about the families they work with and committed to the work they do.

It is apparent that practitioners' individual knowledge, experience and confidence about their own ability, as well as their own experience of being contained through effective supervisory provision, are significant in enabling them to consider their own emotions and therefore how they manage their work within challenging situations.

Those working with parents may not always find conversations about their safeguarding concerns easy, and all workers will need support through regular management and safeguarding supervision to cope with the complex emotional

demands of such work. In the same way that 'parents need to know that staff care about them as well as their children' (Whalley 2007), practitioners need to be cared for and supported within their staff team.

Although many factors influence the way in which families engage with services, the way that professionals respond to parents can be a key factor. As families are actively engaged in a two-way process through the common assessment framework (CAF), it is particularly important to follow a transparent approach that is underpinned by the above principles, throughout all levels of safeguarding work. Only then will there be a real commitment to building and sustaining relationships so that knowledge can be shared two ways in a respectful dialogue, with the focus remaining upon the needs of the child.

What would this principle look like in practice?

Sure Start children's centres: reflections from practitioners at Bowthorpe, West Earlham and Costessey.

The children's centre health visitor had previously worked with parents Sarah and Rick, both aged 17. Sarah had previously given birth to a daughter, Ebony, alone at 36 weeks, after a concealed pregnancy. Both parents have learning difficulties. Sarah's home life was chaotic and Rick had a history of abuse throughout his own childhood, and for two years had been on the Schedule 1 Offenders register. Aged 18 months, Ebony had been removed from the care of her parents to her grandmother's care following ongoing safeguarding concerns around neglect and Ebony's ambivalent attachment.

In 2009, Sarah presented to the GP with another unplanned pregnancy but this time at just eight weeks gestation. The health visitor immediately re-engaged with the family, instigating a planned package of intensive antenatal support and attachment work from the wider multi-disciplinary team, all of whom had met with the family while they were caring for Ebony. In the light of the previous history, a referral was also made to children's services. In February 2010, baby Callum was born. Rick and grandmother were both present at this birth, and the family returned home with a multi-agency package of support.

When I first met Sarah she was difficult to engage with, she didn't make eye contact and did not easily communicate with professionals. Due to his own past experiences, Rick was resentful of the need for any professionals in the family's lives. I visited regularly at home to develop a relationship with the extended family and gradually introduced the wider team, all of whom I knew would use a consistent approach. Although Ebony was removed from their care, Sarah and Rick developed a trusting relationship with the whole team

and, when Sarah became pregnant for the second time, she was able to ask for support at a much earlier stage. Most significantly, this gave an opportunity for the Centre to work alongside the family throughout the entire antenatal period; Sarah and Rick were visited by workers they were familiar with and, knowing individuals within the team, the family have been able to identify and ask for the support that they need, planning themselves for the care of their new baby son. I believe the trusting relationships that had previously been established enabled shared conversations with Sarah and Rick even during the most difficult and challenging times.

(Bowthorpe, West Earlham and Costessey Area Sure Start Children's Centres)

Points for reflection

- Do all staff have training not just in child protection but also in how to share issues around safeguarding with parents?
- Do all staff know how the common assessment framework operates and how to support and engage parents through the process?



How might the Principles be used in practice?

It is hoped that these Principles will be used to promote reflection at all levels within a local area – including children's trusts, local authority teams and settings.

They could be used, for example, to:

- identify the most effective practice, so that there is a consistent understanding and vision of quality
- contribute to local authorities' strategies to meet their statutory duties to improve outcomes for children and reduce inequalities
- shape training and staff development strategies for practitioners and managers of settings and for quality improvement mentors and verifiers
- enable local authorities to work together within a common framework.

But beyond this, the Principles have a wider use in informing and supporting any consultations, practice and policy developments and commissioning frameworks.

How might the Principles be used by parents?

A father speaking about his experiences with his child's school:

There should be some sort of way they [the school and the children's centre] can liaise together locally to be on the same par of how they run things.

The Principles could be used by parents to demonstrate their expectations of services and to point out when these expectations are not met.

How might the Principles be used by local services?

A parent speaking about children moving from nursery to reception:

The staff all work together in a way that you feel you can speak to anyone.

The Principles could be used to support communication and partnership between organisations, so that there is transparency about the approaches used and the values supporting them.

How might the Principles be used by national organisations?

A development manager used these at a stakeholders' meeting to reflect on a new model of support for pregnancy, birth and beyond.

The Principles helped reflect on the proposed new model for delivering a universal service and gave me confidence to raise points in the small multi-agency focus group. I really wanted to see the celebration of parents as experts in their children's lives, and the Principles supported discussions around partnership and learning from parents. This was especially useful as this was a multi-agency meeting.

The Principles can introduce debate about commonly held views, and challenge assumptions about so-called 'hard to reach' parents.

How might the Principles be used by commissioners?

A head of early years and extended services hopes to use the new Principles to provide a vehicle for debate, discussion and evidence-gathering for all their services, and to help their children's trust partners to engage successfully with all parents and families across the borough.

We recognise that it is parents who bring up children and that some parents need information, advice and support at different times as their children grow up. And that it is crucial that all services work with parents in a way that is consistent. In delivering our Family and Parenting Support Strategy we will be considering the principles which underpin all services' work with families, from housing to early years to schools and health as well as specific family support services.

The Principles could be used to ensure the development of a way of working with families and parents throughout a borough. They could help with commissioning family and parent support services, by ensuring they meet the ethos of the children's trust.

How might the principles be used by managers of settings?

A centre manager speaking about the importance of supervision, training and support for staff:

We know that how we work in partnership with parents really makes a difference, and we need to make sure all our staff are supported and trained. We can't assume they will all find this easy, or will see this as part of their role. Good supervision is vital. We encourage staff to develop their skills and seek accreditation, and have supported and celebrated their achievements.

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PARENTAL INVOLVEMENT IN EARLY LEARNING

A review of research, policy and good practice

ICDI
International Child Development Initiatives


**Bernard
van Leer**
FOUNDATION

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GLOSSARY AND ACRONYMS

BKK	Bureau Kwaliteit Kinderopvang/Centre for Childcare Quality
BOINK	Belangenvereniging Ouders in de Kinderopvang/Parents representative organization for childcare
BvLF	Bernard van Leer Foundation
CPB	Dutch Bureau for Economic Policy Analysis
CBS	Central Bureau for Statistics
CDA	Christian Democratic Appeal
CJG	Centrum voor Jeugd en Gezin/Centre for Children and Families
DDJGZ	Digitaal Dossier Jeugdgezondheidszorg
DECET	Diversity in Early Childhood Education and Training – a European Network
EACEA	The Education, Audiovisual and Culture Executive Agency of the European Union
ECEC	Early Childhood Education and Care
ENSAC	European Network for School-Age Childcare
EPPSE 3-16	Effective Provision of Pre-school, Primary and Secondary Education
EU	European Union
FSW	Faculty of Social and Behavioural Sciences, University of Leiden
G4	Four largest cities Amsterdam, Rotterdam, The Hague, Utrecht
G37	37 largest municipalities in the Netherlands
GGD	Gemeentelijke of Gemeenschappelijke Gezondheidsdienst/ Public Health Services
HBO	Hoger Beroep Onderwijs/Professional level education
IB'er	Interne Begeleider/Staff Mentor
ICDI	International Child Development Initiatives
LEA	Lokale Educatieve Agenda/Municipal education cooperation
MEE	State supported organization for people with disabilities
MIM	Moeders Informeren Moeders/Mothers Inform Mothers
Min. OCW	Ministry for Education, Culture and Science
Min. VWS	Ministry Health Welfare and Sport
NGO	Non governmental organisation
MR	Medezeggenschapsraad/Parent advisory board
NJi	Nederlands Jeugd Instituut/
OECD	Organisation for Economic Co-operation and Development
O&O	Opvoedingsondersteuning en Ontwikkelingstimulering/Childrearing Support and Stimulating Development
PAOO	Platform Allochtone Ouders en Onderwijs/Platform for non-Native Parents and Education

PvdA	Labour Party
PSZ	Peuterspeelzaal/Pre-school playgroup for 2 to 4-year-olds
ROC	Regionaal Opleidingcentrum/Lower vocational training and adult education institutes
SCP	Sociaal en Cultureel Planbureau/Bureau for social policy analysis
SES	Socio Economic Status
SPIL	Speel, Integreeren, Leren/Play, integration and learning initiative, Eindhoven
UNCRC	United Nations Convention on the Rights of the Child
UU	University of Utrecht
UvA	University of Amsterdam
VBJK	Resource and research centre for early childhood education and care, Ghent, Belgium
VHL	Vroeghulp Loker/Early help service
VNG	Vereniging Nederlandse Gemeenten/Umbrella organisation for municipalities in the Netherlands
VVD	People's Party for Freedom and Democracy
VVE	Voor-en-Vroegschoolse Educatie/early childhood education
VVI	Vroeg, Voortdurend, Integraal/Early diagnosis and integrated support initiative for families where there is a concern about young children's development
VU	Free University of Amsterdam
Wet OKE	Wet Ontwikkelingskansen door Kwaliteit en Educatie/Act for Development Opportunities through Quality and Education
WMO	Wet Maatschappelijke Ondersteuning/Support for Social Participation Act
WMS	Wet Medezeggenschap op Scholen/Participation in Schools Act
ZAT	Zorg en Advies Team/Care and Advice Team

EXECUTIVE SUMMARY AND CONCLUSIONS

This study has been carried out on behalf of the Bernard van Leer Foundation in order to gain more insight into the current theories and practices in relation to parental involvement in early learning in the Netherlands. It is based on national and international research literature, policy reports, as well as discussions with key informants which took place between September 2011 and January 2012.

The study has been carried out around a number of key questions: Why involve parents in early learning? What factors need to be taken into account?; What are the current policies and provision for parental involvement in early learning in the Netherlands? What do we learn about parental involvement from case studies of good practice?

Why involve parents in early learning?

The main arguments proposed in the literature for engaging parents in young children's learning are:

Parents are children's first and most enduring educators International bodies such as OECD and UNICEF characterise the involvement of parents in young children's education as a fundamental right and obligation.

Parents and what they do have a powerful effect on children's learning

There is robust evidence which links the home learning environment, including parenting behaviours and attitudes, to children's learning outcomes. Key factors are a literacy rich home environment, quantity and quality of cognitive stimulation, parental sensitivity and child-centred emotional support and emphasis on the value of learning.

Parents and professionals working in partnership benefit children The essence of partnership is respectful listening and sharing of information between parents and practitioners about children's learning and development at home, and at an early childhood education and care (ECEC)¹ service. Partnership involves responsibility on both sides.

Enhancing quality in ECEC Engaging families and community is one of five policy levers, which OECD Starting Strong III has identified that are likely to enhance quality in ECEC.

ECEC offers parenting support As well as providing learning and development opportunities for children, good quality ECEC offers child rearing advice and peer support to parents, referrals to more specialised services if necessary, and it frees parents to engage in training, lifelong learning and employment. This is important for all children, but particularly so for children growing up in disadvantaged circumstances.

What factors need to be taken into account?

The extent and form of parental engagement in early learning is strongly influenced by a family's social class, mothers' level of education and psychosocial health, single parent status, and, to a lesser degree, family ethnicity Research also indicates that there is a very strong correlation between the cognitive development of parents during their own childhood and that of their children.

¹ Throughout this report we use the term Early Childhood Education and Care (ECEC) to match the most common international terminology, which is being used by the OECD and the European Commission.

When the topic of working in partnership with parents in ECEC is discussed, it is often tacitly understood that parents mean mothers. **Fathers and male practitioners have tended to be invisible in services for young children.**

Children, mothers and fathers and practitioners all have a role to play in early learning. Attention therefore needs to be paid to parent-child relationships; practitioner-child relationships; child-child relationships and parent-practitioner relationships. It is recognised that **parents and practitioners may need support to make these learning partnerships work.** Families dealing with stressful circumstances such as poverty, unemployment, family breakdown or addiction need particular support.

National and international research indicates that relations between practitioners and parents are often strained. Factors accounting for this include:

- » **Lack of confidence** on part of both parents and practitioners regarding mutual communication
- » **Different understandings and expectations** of each other's contribution to children's early learning
- » **Differences in views** between parents and practitioners regarding respective responsibilities for child-rearing and education
- » **Lack of attention to skills necessary** to work with parents and families in pre-service and in-service training of practitioners.

What are the current policies and provisions for parental involvement in early learning in the Netherlands?

There is a wide variety of child-rearing support and early learning advice which parents of young children can potentially tap into. However, **not all forms of support and advice are accessible to all groups of parents**, due to costs involved, unevenness of coverage, gaps in provision, waiting times and a lack of awareness amongst parents regarding support.

Attention to parenting and child-rearing support via home-visiting parenting support and early learning programmes and parenting classes has primarily focussed on disadvantaged groups. With some exceptions, these are typically part-financed by national government administered via municipalities and outsourced to welfare organisations for implementation. **Parents themselves report that they are more likely to seek child-rearing support and advice from their child's daycare centre, pre-school and school, than from the Centre for Children and Family (Centra voor Jeugd En Gezin) and Baby and Child Health Clinic (Consultatie Bureau), school doctor or social work services.** **Low educated parents and unemployed parents receive relatively little informal support from family and friends compared to middle and higher educated and working parents.**

The degree to which parents and/or schools are 'responsible' for children's learning outcomes is a topical issue in educational and social policy in the Netherlands. The **current government policy emphasises joint responsibility between formal educational institutions and parents for learning outcomes.** **Language and literacy development are emphasised.** The government tone on this issue is experienced by many parents as 'finger-wagging' and unsupportive.

Research has pointed to the **lack of harmonisation** between child-rearing and education at home and in ECEC and school settings, and the **need to improve communication between parents and practitioners**.

In recent years there have been a number of initiatives - printed and online guidelines, handbooks, in-service workshops, film material, online discussion fora - to support ECEC services and schools to enhance parental involvement, and to develop conditions for and improve learning partnerships between parents and ECEC services and schools. Despite these initiatives, **some academic researchers speak about worsening relations and little meaningful participation between parents and schools**, to the detriment of children.

Up to recently, most government attention has been paid to parental involvement in formal primary school settings. However, new agreements between government and municipalities which, in theory provide parents with easily accessible child-rearing advice and referrals to more specialised support via Centres for Children and Families, and which promote parental involvement in early learning mark a policy shift in this regard. However, important to note is the **huge variation across 430 municipalities regarding how these measures work/will work in practice**. Furthermore, many child and family focussed initiatives and financial supports to families with young children are under threat because of local and national government cuts.

Internationally, **a combination and comprehensive approach to ECEC is advocated, particularly when tackling the needs of families and young children living in disadvantaged circumstances. This includes: intensive, early starting, child-focussed, centre-based education together with strong parental involvement, parent education, programmed educational home activities and measures of family support**. Furthermore, ECEC must be linked to initiatives in other policy areas such as employment, housing, health, etc in a comprehensive strategy (European Commission, 2011).

What do we learn from case studies of good practice?

The study includes seven case studies of good practice, national and international, in relation to parental involvement in early learning. Key points of interest and learning are:

- » The benefits of **a continuum or joined-up services for young children and their families**. This entails making sure services are physically close to where families with young children live; effective communication and sharing between home and ECEC settings; taking the whole child-rearing, family and relational context in account when supporting children's early learning and development; working collaboratively with home based services, social and health services and adult education.
- » **Political commitment and a longterm vision** has been a key success factor for sustainability of policies and practice, ensuring coherence and continuity even when government changes. Governments also depend on sound information and research data from practice to inform policies. The most effective initiatives are those which demonstrate strong links and cooperation between practice, research and policy.
- » Importance of **engaging fathers as well as mothers in supporting their children's learning** and development.
- » Viewing **parents, practitioners and children all as active learners**,

ensuring a greater balance of power and respectful relations between parents and practitioners.

- » Attention to ensuring that **practitioners are skilled in responding to a diversity of families and parents** (different countries of origin and cultural background, social class, educational level, fathers and mothers) and to families' changing needs and circumstances. As noted by one interviewee "the starting point should be that parents have questions, not problems".

Conclusions

ECEC services are assuming an increasingly important role in supporting families and promoting the wellbeing of young boys and girls and giving them – in co-operation with their parents – a good start to life-long learning. Therefore, **ECEC is not just about working with children it should also about working with and supporting families**, and ultimately about how societies function.

A review of the forms of parental involvement in early learning in informal, non-formal and formal settings in the Netherlands indicates that there is a wide range of initiatives, programmes and information resources designed to support parents. However, because of uncertainties about the respective role of parents and institutions in children's childrearing and education, decentralisation of social services and education policy to the 430 municipalities, changing government priorities, and looming budget cuts, coverage of these supports is uneven and there are gaps in provision.

An important conclusion of this study is that ECEC as a parenting support measure needs to be embedded in training, practice and policy at national and local (municipal level) in the Netherlands. This applies to all types of ECEC (day care, pre-school play groups, first years of primary school) and all population groups – fathers and mothers, all SES groups, native and non-native Dutch population, recognising that low SES groups, including lone parents families can particularly benefit from the parenting support ECEC can offer.

In this regard, **greater recognition in pre-service and in-service training, in practice and policy needs to be given to the fact that good quality ECEC can reduce stress in families' lives and enhance outcomes for children.** Most attention on parent-school partnership relations to date has focussed on formal education (primary and secondary school). The benefits of ECEC services engaging with parents has received lesser attention, despite the fact that it is in earliest years of children's learning and development, that parents have most need for information and support.

It is important to **always keep in mind the multiple functions of and possibilities inherent in ECEC** such as: offering **stimulating learning, development and socialising opportunities** for young children; providing **information to parents on children's learning and development** and stimulating **sharing of information about learning and development at home and ECEC**; **enhancing parents self-esteem as parents**; providing **information to parents on systems of education** particularly at **important transitions**, such as from home to ECEC setting, and from ECEC setting to school; helping parents **reconcile family and work responsibilities**; **linking parents to other support systems in the community**, such as health, housing, training and employment; **linking parents to other informal learning, cultural and leisure amenities in the community** (playground,

library, parks, swimming pool, cultural centres).

This is important for all families but particularly for families living in disadvantaged circumstances, who due to stress and low education, have diminished energy, motivation and or capacities to enjoy and sensitively respond to their children, and stimulate positive attitudes to learning. Given its family support dimension and the fact that ECEC can reduce burdens in parents' lives, **indirectly ECEC has an important preventative function in relation to reducing violence in young children's home lives.**

In this respect, **ECEC should be accessible and affordable for all families with young children.** Additionally, given that parents are young children's primary educators and **most learning takes place in informal settings such as home and neighbourhood, attention needs to be paid to ensuring these learning environments for young children and their parents are also safe and secure, free from discrimination and attractive spaces for families to be with young children.**

With these conclusions in mind, it becomes clear that **working with parents and families needs to be an essential topic of professional development for all early childhood practitioners.** Increased attention needs to be paid to **communicating with parents and working with diverse families.** Knowledge about children's wider family context is important, keeping in mind that young children can learn from brothers and sisters, grandparents and other extended family members as well as parents. One size does not fit all – rather practitioners need to be flexible in how they engage with parents and families and the kind of outreach provided.

In addition, to being in tune with young children's family lives, **ECEC practitioners also need to be knowledgeable about community resources so as to best support parents in stimulating their children's informal learning at home and in the neighbourhood.** Good co-operation between all those involved in these learning spaces, whether at home, in ECEC or in the neighbourhood, will support young children fulfil their potential.

Young children's learning and development takes place in a range of contexts: at home with the family, in non-formal settings in the community, and in formal early childhood education and settings (ECEC). In all of these settings parents have an important contribution to make. The aim of the study is to review recent and current research, policies, strategies and initiatives relating to parental involvement in early learning in the Netherlands. The review is supported with reference to key European developments in this area.

A number of arenas are considered: parental involvement in early learning of their children (0 to 6 years) in the home and neighbourhood context (otherwise described as informal and non-formal learning contexts); parental involvement in early learning of children of 0 – 6 years in institutionalized or formal settings such as day care, pre-school playgroups and the first two years of primary school. Also considered are the interrelationships among and between parents and professionals in support of children's early learning whether at home or in school.

Data and background information for the study has been collected from a number of sources including national and international research literature, national and European policy reports and reviews, informal and formal discussions with experts and key informants at national and international conferences and seminars and specifically arranged face to face meetings. During the period of the study (September 2011 to January 2012) attention has also been paid to how the topic of parental engagement in early learning has been treated in the media.

The report of the study is organised in two parts. Firstly, we provide an overview of the research and policy context nationally and internationally regarding parental involvement in early learning. We will discuss 1) the rationale and aims for parental involvement, 2) definitions and typologies for describing parental involvement in early learning, 3) key research which tell us about the impact of family factors and parental involvement on learning outcomes, 4) the legal and policy basis for parental involvement in the Netherlands, 5) describe the main forms of parental involvement and support for early learning in the Netherlands, their prevalence and key related research, evaluations and effect studies.

In the second part of the study we highlight good practice in the form of case studies of successful and innovative parental involvement programmes and initiatives including programmes and initiatives targeted at disadvantaged families and/or fathers. Here we draw firstly on current and previous Bernard van Leer Foundation supported projects in Flanders and in the Netherlands, paying attention to the outcomes of these projects. Secondly, we include the Pen Green Children and Families Centre in England as an international good practice example. Finally, three current Dutch innovative ECEC initiatives with regard to parental involvement in early learning are described and analysed.

PART 1: RESEARCH AND POLICY CONTEXT ON PARENTS, FAMILIES AND EARLY LEARNING

1.1 Why involve parents in early learning?

Parents are children's primary educators

There is a notable consensus across education policy statements and practice guidelines in many countries that parents are children's first and most enduring educators (OECD, 2012). In recent decades this 'truth' is frequently accompanied with recommendations firstly, about the need to support parents in their parenting, including their role in supporting their children's learning and development. A second focus in policy recommendations concerns strengthening the relationship between the home and the ECEC setting and school in order to enhance children's learning and development. In fact, throughout the international field of ECEC, good communication and co-ordinated partnership between parents and staff is seen as essential to high-quality care and education of young children (Mac Naughton and Hughes, 2008; OECD, 2012; Urban, 2009).

Parents and professionals working in partnership benefit children

Invariably the term 'partnership' is used to describe the relationship between parents and ECEC professionals. The principle of 'working in partnership' with parents is now firmly established within national educational policies, including in the Netherlands. Often, the notion of *equal* or coordinated partnership is emphasized, with each party recognizing and valuing the contribution of the other to children's wellbeing. Within such a vision, parents and practitioners are both viewed as experts: parents as experts on their own children and practitioners as experts in caring and educating children in the context of an institution or group setting. Respectful sharing of information between parents and practitioners about children's learning and development at home and at school is viewed as being in children's best interests. Also, partnership involves responsibility on both sides.

In the past decade the notion of *educational partnership* has been prominent in discussions and publications at policy level in the Netherlands. This is defined as the process whereby schools, parents and other services support each other in stimulating children's curiosity, motivation and development (de Wit, 2005). It is up to each children's centre or school to decide their particular aim, motivation and approach to educational partnership (Kalthoff, 2011) once basic legal requirements are fulfilled.

Four general aims or motives for educational partnership have been proposed in the Dutch context: pedagogical, organizational, democratic and enabling (Smit et al. 2006 cited in Kalthoff, 2011). The **Pedagogical aim** involves harmonisation of childrearing and educational approach at home and at school, whereby parents and practitioners/teachers listen respectfully to each other and are open to share knowledge about children. The **Organisational aim** entails parents providing practical help in the organization and implementation of activities in and outside school: such as listening to children read, accompanying classes to swimming pool, library or a museum. It could also involve parents sharing their own talents in school. The **Democratic partnership aim** focuses on giving parents a voice in education whereby parents are active formally and informally in decision-making processes about the school's aims and developments. This also

presupposes respectful listening between school and parents, whereby each other's areas of expertise is acknowledged. The **'Enablement' aim** involves enabling both parents and practitioners to enhance the quality of their mutual relationship for the benefit of children's learning.

ECEC as a parenting support measure

It is recognized internationally that ECEC has an important function in providing parents and care takers with educational and social support in meeting their responsibilities in bringing up their children. ECEC can also contribute to engaging parents with related measures to improve employment, job-related training, parent education and leisure time activities (European Commission, 2011). This is viewed as particularly important in disadvantaged areas (Eurofound, 2010; Council of Europe, 2006). It is therefore not surprising that there is huge overlap between good practice in ECEC and parenting support measures. However, according to the 2009 Eurofound report on developing support to parents through early childhood services, although all European countries provide some form of support to families through services, cash transfers, tax incentives or other benefits, "in most countries there is little organized outreach to parents from early childhood centres or services" (Eurofound, 2010, 1). The OECD has identified that a current challenge for ECEC services is to embrace the crucial role of parents in young children's development and involve them in services as much as possible (OECD, 2012). Engaging families and community is one of five policy levers, which OECD Starting Strong III has identified that are likely to enhance quality in ECEC.

Current policy discourse on parents and early learning

International policy documents, such as the OECD Starting Strong reports (2006; 2012) and UNICEF Innocenti Report Card 8, describe the involvement of parents in young children's education as a fundamental right and obligation. Nevertheless patterns of parental and family engagement in ECEC differ from country to country. The following statements, the first from the UK, the second, third and fourth from the Netherlands, are typical of the current policy discourse in these countries:

Cited in Connor and Wheeler, 2009 p.36

"Working with parents as partners is critical for young children's development and learning, which is why highly effective settings and schools work hard to put partnership with parents in practice"

Trouw (15 december 2008) cited in Hogeboom (2009) (Source: Hogeboom (2009) Oogst; School en ouders, partnerschap voor leerling-succes)

"Een kind kan zich niet optimaal ontwikkelen, ook niet op school, als ouders daar niet aan meewerken. Ouders moeten hun verantwoordelijkheid nemen en betrokken zijn bij de school. Een school is gebaat bij betrokken ouders. Je moet als school eisen durven stellen en verwachten dat ouders taken op zich nemen." ("A child does not develop optimally, also not at school if parents are not co-operating. Parents must take their responsibility and be involved in the school. A school benefits if parents are involved. As a school you must dare to demand and expect that parents take on tasks")

Staatssecretaris M. van Bijsterveld

Concept Regeerakkoord, 2010 p.31

"Ouders zijn mede verantwoordelijk (ook financieel) voor de taalontwikkeling van hun kinderen" (Parents are co-responsible (also financially) for the language development of their children)

"Kinderen met een grote taalachterstand gaan met dwang en drang deelnemen aan voor- en vroegschoolse educatie"
(Children who are very much lagging behind in language development will, by force and pressure, participate in pre-school education)

Brief aan Tweede Kamer (Letter to the Second Chamber) cited in interview with the Minister, De Volkskrant 30 November 2011

'Besteed meer tijd aan kinderen, desnoods ten koste van werk'... 'Ouders moeten zoveel doen dat ze het idee hebben dat ze voor de volle honderd procent betrokken zijn bij de school' (Spend more time on children, even though this takes time from your work. Parents need to do as much so that they have the idea that they are 100% involved in the school).

Marja van Bijsterveldt, Minister van Onderwijs (Minister of Education)

One of the reasons explaining the strength of these statements is the research evidence from recent longitudinal research studies which link home learning environment, including parenting behaviours and attitudes to children's learning outcomes (Desforges and Abouchaar, 2003; Siraj-Blatchford et al. 2011; Sheridan et al. 2010). Key factors are a literacy rich home environment, quantity and quality of cognitive stimulation, parental sensitivity and child-centred emotional support and an emphasis on the value of learning.

In other words, parents and what they do have a powerful effect on children's learning. This effect is stronger than ECEC setting or school effects (Desforges et al. 2003).

1.2 Definitions and frameworks for understanding parental involvement

1.2.1 Defining parental involvement

While there appears to be universal support (in principle) for the *notion* of parental involvement in young children's early learning and the inherent value of ECEC services working in partnership with parents, the concepts of parental involvement and partnership can be hazy.

Different definitions, models and traditions underpin practice (Share, Kerrins and Greene, 2011). Adding to the confusion is that fact that the term 'involvement' can be used synonymously with 'participation', 'partnership', 'collaboration' or 'cooperation'. Furthermore, there is no common understanding of its meaning among educators (Whitmarsh, 2009).

Forms of parental involvement, identified by Desforges and Abouchaar (2003) in a review of the English language research literature on parental involvement (relating mostly in primary and secondary schools), included the following:

- » good parenting in the home, including: the provision of a secure and stable environment; intellectual stimulation; parent-child discussion; good models of constructive social and educational values; high aspirations relating to personal fulfilment and good citizenship;
- » contact with schools to share information;
- » participation in school events;
- » participation in the work of the school;

» participation in school governance.

These forms of parental involvement also apply in many ECEC services.

Most recently, the all-embracing term *parental engagement* has been used in international literature, although this too is used differently depending on the source. Goodall and Vorhaus (2011) use the term to capture learning at home, school-home and home-school communication, in-school activities, decision-making and collaborating with the community. In a project focussing on enhancing the school readiness of disadvantaged preschool children in the US, parental engagement is defined as comprising 1) parental warmth and sensitivity, 2) support for a child's emerging autonomy, and 3) active participation in learning (Sheridan et al, 2010).²

Finally, it is important to note the model of partnership, focussing on involvement in school life and supporting children's learning and education as home has been critiqued as classed, gendered and racialised representing a dominant discourse of white, middle-class motherhood (Crozier and Davies, 2007 cited in Whitmarsh, 2007).

1.2.2 Parents and professionals and the balance of power

A number of commentators have pointed to the gap between (national) policy or stakeholder agreements on professionals and parents working in partnership, and the reality at individual setting level (Broekhof, personal communication Sept. 2011; EACEA, 2009; Share et al. 2011; Smit, Driessen and Doesborgh, 2005). There are a number of reasons accounting for this. In the relationships and interactions between parents and professionals, questions of power and the balance of power and the degree of openness to each other's perspective arise. In the 1994 European Network for School-age Childcare (ENSAC) conference on 'Empowering the Parents', Prof. Remi Baekelmans referred to approaches to parental participation as being related to the democratic functioning of society. It's about "openness to defend one's own interests but at the same time show consideration for other people" (Baekelmans, 1994, p. 58). However, clearly this is easier said than done. Ten years later Prott and Hautumm (2004) argued a case for 'co-operation' rather than, or a stepping stone to 'partnership' between parents and services given that in the everyday practice of both groups, parents and practitioners, "mutual contacts may bring about insecurity, anxiety, disappointment and fear, but also delight, appreciation and success" (p.8). Micha de Winter, Professor of Childrearing Issues, University Utrecht, in an interview in de Volkskrant, 10 December 2011, referred to the worsening relations between parents and schools in the Netherlands and the negative impact this has on children (Gerrits, 2011).

International research cited by Mac Naughton and Hughes (2008) has consistently reported that relationships between practitioners and parents are often strained and not always meaningful. Professionals struggle in knowing how best to communicate with parents, are often anxious about it and reluctant to do it. Parents too, are often unsure of their role, both at home and in school, in relation to children's learning (Menheere and Hooge, 2010).

What are the origins of these difficulties? Some authors have referred to the unequal knowledge-power relationship between parents and educators (MacNaughton and Hughes, 2008), especially in contexts of poverty and large immigrant populations. Parents and practitioners may also have

² These three dimensions of parental behaviours have been demonstrated to be highly predictive of children's social-emotional learning and cognitive development (Sheridan et al. 2010).

different understandings and expectations of each other's contribution to children's early learning (Share et al. 2011; Smit et al. 2005). The notion of practitioner as 'expert' invests teacher with power, and thus inhibits partnership relations (Whitmarsh, 2009). Often the voices of parents are not included in the elaboration of ECEC curricula (Vandenbroeck, 2009), including the forms of parental involvement.

A research study by Smit (2005) focussing on the expectations and wishes of non-native and native Dutch parents with respect to primary education in Rotterdam illustrate some of these issues. The findings point on the one hand to satisfaction amongst parents with contacts with teachers and school principals and the extent to which they are kept up to date with school happenings, but on the other hand to parental dissatisfaction regarding the extent to which their views are taken on board. Non-native parents in particular feel that communication is one-sided. A further finding was that topics of discussion and information given by teachers to parents at parent evenings or informal meetings with parents have little influence on child-rearing behaviours at home. The authors conclude that mutual sharing of information regarding children's learning and development between parents and practitioners is not happening (Smit et al. 2005).

Factors accounting for these findings included: a clear separation in the minds of parents between child-rearing at home and education at school; differences in norms and values regarding childrearing and education between (non-native) parents and teachers; cultural differences in communication styles, differences in views regarding respective responsibilities for child-rearing and education and limited abilities in the Dutch language amongst non-native parents.

A further important contributing factor to strained relations between parents and practitioners is the lack of attention given to the skills necessary to work with parents and families in pre-service and in-service training of professionals. An important finding of the EU CORE study about professional competencies and training in ECEC was that many formal professional competence profiles and training profiles focus mainly on knowledge and competences about working with children "neglecting the essential work with parents and local communities" (Vandenbroeck, Urban et al. 2012).

What kinds of solutions have been proposed to improve working relations between parents and educational settings? Some authors point to the necessity of clarifying the overall responsibilities of parents versus schools. According to Epstein, parents ultimately have the responsibility for their children's upbringing and schools remain ultimately responsible for the organisation and the quality of education (Epstein 2001 cited in Menheere et al. 2010). Additionally, according to Smit et al. (2005) authors of the Rotterdam study referred to above, both parents and educators need to acknowledge that they 'need' each other – in order to be better able to communicate about the pedagogical climate at home and at school, so that they can better complement each other's contribution to children's learning and development, and can develop respect for each other's contribution to the childrearing and education of children (Smit et al. 2005).

De Graaff et al (2008) place the emphasis on improving communication and mutual understanding. "For educators, listening to parents more, dealing with language barriers, improving communication, counteracting stereotypes, taking concrete action and learning about family situations seem to be the key aspects for overcoming problems." (De Graaff et al, 2008, 21). Here the responsibility for action is placed squarely on practitioners' shoulders.

In relation to immigrant parents explicitly, Vandenbroeck, Roets and Snoek (2009) make the point that a welcoming early years setting in which staff 'recognise and respect the difference of immigrant mothers explicitly' can support the development of a hybrid or dual identity whereby mothers can draw on values and practices from their culture or origin as well as those from the host country (212, cited in Whitmarsh, 2009).

Between 2010 and 2011 the parent's organisation Boink, and the authors of the early childhood pedagogical framework in the Netherlands (Pedagogisch Kader Kindercentra 0-4 jaar) collaborated in a project, "Pedagogisch Kader voor Ouders" which aimed to make the framework accessible to parents, to explain to parents what they can expect from daycare settings in terms of young children's learning and development, and to provide advice regarding good communication between parents and practitioners. The outcome has been two illustrated publications, one intended for Parent Commissions (Boink, 2011) and one intended for parents of young children (Singer, 2011).

Debate on relationship between home and schools in the Netherlands during 2011 pointed towards the need to formalising an agreement between parents and professionals with respect to responsibilities for supporting learning at the point of enrolment of a child in an ECEC service or school. In such a 'contract', expectations of settings regarding parental engagement could be clearly laid out and parents commit to these as a condition of enrolment.³

³ The notion of written contract between parents and settings with respect to parental responsibilities in supporting children's learning at home and in ECEC setting was proposed by Gjalit Jellesma, director of BOINK at the launch of the research study Diversiteit in Oudercommissies on 26th September 2011, which was conducted by e-Quality and Boink. Similarly, in the workshop on parental involvement het Jonge Kind congress on 1st November 2011, Frederik Smit proposed an 'engagementverklaring' which parents would sign on registration of their child in a service, although he acknowledged that it probably could not have a legal standing. It could include for example a commitment from parents to ensure that children are in bed in time, and have a good breakfast before school. The positive experiences with such a contract from the perspective of the school principal of one school in Utrecht was reported in De Volkskrant 3 Dec 2011 (Stoffelen, 2011).

1.2.3 Using frameworks to critically reflect on and improve parental involvement policies and practice

There have been a number of attempts nationally and internationally to give further structure and meaning to the concept of parental involvement in children's learning, through the development of typologies or frameworks. These serve to critically reflect on and improve parental involvement policies and practice in ECEC. Some examples from the Netherlands are briefly outlined here.

Smit et al. (2008) analytical framework for VVE settings in the Netherlands, which builds on earlier work by De Wit (2005) draws a distinction between three different 'directions' of involvement and four different forms of involvement. The framework consists of 11 cells, the final 12th cell remaining blank, as it would not be expected (nor considered appropriate) for a VVE service to help parents make decisions with regard to the upbringing or education of their child.

'Mutual involvement: empathizing, helping, thinking along with and helping in decision making'

	Empathising (meeleven)	Helping (meehelpen)	Thinking along with (meedenken)	Joint decision making (meebeslissen)
Parents vis-à-vis offspring				
Parents vis-à-vis group or VVE				
VVE vis-à-vis parents				

Smit, Driessen, van Kuijk, de Wit (2008)

This framework has subsequently been used on the Ouder bij de Les website <http://www.oudersbijdeles.nl/> as a means to provide guidelines and ideas to services in each of the identified categories. A variation of the framework in a pyramid format has also been developed to stimulate involvement of parents in daycare services (De Laat et al, 2011). Here the base of the pyramid is envisaged to involve as many parents as possible in 'Thinking along with/Meedenken', the middle section, includes parents who from time to time help with activities (Meehelpen) and the top of the pyramid (Joint decision making) refers to the few parents who sit on the Oudercommissie.

Pyramid of involvement, in *Diversiteit in de Oudercommissies van de Kinderopvang: Handleiding voor Trainers*, de Laat, van Egten, Duesmann-Oosterlaan (2011) p. 19



The Bernard van Leer Foundation supported 'Parents and Diversity' project also adapted De Wit's framework to assess the awareness of diversity in parental participation in ECEC in the Netherlands (De Graaff and van Keulen, 2008). In the course of this action research project, the same four dimensions, 'living together', 'working together', 'thinking together' and 'taking decisions together' were crossed in a matrix form against six diversity objectives (which were based on DECET's objectives).⁴ The outcome was a completed matrix, containing 30 actions judged most important by participating practitioners, for promoting parental participation and respect for diversity (see also Parents and Diversity Case Study Part 2).

In concluding this section it is worth reiterating the importance of good communication in building learning relationships. Both parents and practitioners may need support to make these learning partnerships work. As MacNaughton and Hughes (2008) advise, "Building partnerships with parents doesn't just happen – it needs to be actively worked on over time" (p.94). The frameworks described have been designed specifically, to stimulate services to critically reflect on how they can go about building respectful relationships with parents. (See also Appendix 1 for summary of *Pre-requisites and success factors for optimal partnership between parents and ECEC services* drawn from a range of national and international projects and initiatives; Smit et al's *Stappenplan optimaliseren ouderbetrokkenheid in de Voor- en Vroegschoolse Educatie*, 2009 and YouTube animation film 'Ouders en School: hoe werk je samen' <http://www.youtube.com/watch?v=MbOoRPG-rkA>).

⁴ ECEC services and communities where everyone: 1) feels that he/she belongs; 2) is empowered to develop the diverse aspects of his/her identity; 3) can learn from each other across cultural and other boundaries; 4) can participate as active citizens; 5) actively addresses bias through open communication and willingness to grow; 6) works together to challenge institutional forms of prejudice and discrimination (DECET, 2007).

1.3 What does research tell us about parents' and families' role in learning outcomes?

1.3.1 Background to the literature review

Given the increased attention in educational and social policy to research-based evidence of success, a number of comprehensive research reviews of impact of parental involvement and parent support in early learning have been published in the past decade. Much of this research is based on longitudinal cohort studies where attempts have been made to isolate factors which positively or negatively affect children's outcomes. It is noteworthy that cognitive outcomes (especially language and literacy), and social emotional outcomes (especially behaviours and attitudes) are given priority in this research. Also the vast majority of research refers to child outcomes from aged 3 years onwards, with most attention on the primary school years (typically 5 years and upwards). While there are many clear trends and consistent findings, there are also a number of conflicting pieces of evidence. Additionally, there is some disagreement on how research findings should be translated into policy and practice. In this section we draw in particular on the evidence cited in the following research reports, meta-analyses and briefs:

Desforges and Abouchaar (2003); Carpentieri et al. (2011); Goodman and Gregg (2010); Hartas (2010, 2011; Menheere and Hooze (2010); Siraj-Blatchford, I., Mayo, A., Melhuish, E., Taggart, B., Sammons, P. and Sylva, K (2011).

1.3.2 Impact of family factors, and 'at home good parenting' on learning outcomes

One of the most frequently cited literature reviews on parental involvement is the 2003 review prepared by Desforges et al. (2003). The review concludes that the extent and form of parental involvement is strongly influenced by family social class, maternal level of education, material deprivation, maternal psycho-social health and single parent status and, to a lesser degree, by family ethnicity. Parents' perception of their role and their levels of confidence in fulfilling it, is also influential.

The most important finding of this review is that parental involvement in the form of 'at-home good parenting' has a significant positive effect on children's achievement and adjustment. Furthermore, in the primary school age range the impact caused by different levels of parental involvement is much bigger than differences associated with variations in the quality of schools.

Desforges et al. conclude that parental involvement 'works' through the indirect influence of parenting in shaping the child's self concept as a learner and through setting high aspirations. Other researchers have similarly focussed on identifying the key capabilities that parents bring to supporting their children's learning and education. Lee and Bowen identify three forms of parental capabilities: 1. personal dispositions (sensitivity, warmth, attitudes towards learning); 2: access to education resources and services and 3: access to education-related institutions (Lee and Bowen, 2006 cited in Hartas, 2010).

Parents attitudes to learning was also one of the key factors found in the case studies of the *Effective Provision of Pre-school, Primary and Secondary*

Education (EPPSE 3-16) study (Blatchford et al. 2011), which explored why certain children 'succeed against the odds' (i.e. low SES families) while others fall further behind. In the homes of children 'succeeding against the odds':

- » Parents engaged their young children in learning processes, reading with them, providing them with educational (computer) games and materials, talking to them about school and learning and engaged in other joint activities (e.g. cooking together).
- » They valued these activities as opportunities to develop cognitive skills that prepared the child for school; and believed experiences helped them develop positive attitude to, and interest for, school related activities
- » Child-centred emotional support was also found to be important and parents reinforced high standards for behavior and academic aspirations for children and explicitly expressed their high esteem for education.

The significance for child outcomes, of what parents 'do' at home, as well as their background was also highlighted in the Millenium Cohort Study in the UK. This study showed that aspects of the early childhood caring environment explain around one quarter of the cognitive gap between the poorest and richest children at the age of 3, with differences in the home learning environment (HLE) playing the biggest role. In this study HLE was measured by parents reading to child; taking child to library, help child learning abc, teaching child numbers, counting, songs, rhymes; child painting, drawing at home.

Important to note, however, is that differences in family background factors, such as mother's age, parental education and family size together explained a much bigger proportion of the gap in cognitive outcomes at age 3. Furthermore, a third of the cognitive gap remains unexplained by any of the observable characteristics measured in this study (Dearden, Sibieta and Sylva, 2010).

1.3.3 Intergenerational perspectives on learning outcomes

Another cohort study, the British Cohort Study, which tracked families over two generations provides further light on this reasons for the unexplained gap. The main finding is that there is a very strong correlation between the cognitive development of parents during their own childhood (in this case parents born in April 1970) and that of their children (aged about 6 in 2004). This connection remains, even after taking environmental factors into account suggesting an inherited genetic component to cognitive abilities. Other factors identified by the study as showing particularly strong intergenerational transmission include:

- » Attitudes to education: the child thinks that good marks in school are very important, and the parent thinks that university is likely;
- » Home learning/reading: the parent reads stories to the child every day (pre-school) (p.44)

1.3.4 Parents engagement in children's language and literacy

One area of development which research has consistently found a positive

link between parenting behaviours and involvement is verbal language and reading (Dearing et al. 2006; Patall et al. 2007 and Merlo et al. 2007 cited in Menheere et al. 2010). Hartas' (2010) analysis of data from Millenium Cohort Study to assess the impact of family social background factors on social adjustment and on language and literacy at 7 years revealed that family income and mother's educational qualifications had a modest to moderate effect on social adjustment and moderate to strong effects on language and literacy. Interestingly, the frequency of parental engagement with home learning activities was not found to contribute to teacher ratings of children's language and literacy at age 7. However, mother-child emotional closeness and mother's (own) reading made substantive contributions to teacher-rated language and literacy (Hartas, 2011). This study, like others (Dearing et al. 2004; Patall et al. 2007) showed that homework support given by parents is not a significant factor in terms of child outcomes in language and mathematics.

1.3.5 Implications for policy

One of the outcomes of these findings have been the promotion of policy approaches which focus on improving home learning environment, noting that this does not just entail transmitting reading and numeracy skills but rather creating literacy-rich home environments where the value of learning is emphasised. A second policy approach focuses on helping children and parents from poor families believe that their own actions and efforts can lead to higher educational outcomes.

Given the complexity of the issue, particularly in relation to reducing the educational gap between disadvantaged and non-disadvantaged children Hartas writes (with respect to UK policy on parental involvement), "to approach parental involvement as the panacea for making up for the effects of socio-economic inequality is overly simplistic and potentially misleading. Offering an idealized construction of parenthood in which what parents do with their children, regardless of their socio-economic circumstances, is a key determinant to their educational advancement and social-emotional wellbeing shifts the debate from supporting parents accessing genuine educational and training opportunities to moralizing about them by holding them responsible for their children's academic and social difficulties". (Hartas, 2010, p. 17)

A multi-dimensional systemic approach offers a promising solution particularly when addressing the needs of children and families living in disadvantaged circumstances. An EACEA review of the literature regarding ECEC and tackling social and cultural inequalities in Europe concluded that the **most effective programmes are the so called 'combination' approaches, which involve intensive, early starting, child-focussed, centre-based education together with strong parental involvement, parent education, programmed educational home activities and measures of family support** (Leseman in EACEA, 2009).

The OECD Research Brief "Parental and Community Engagement Matters" similarly highlights the benefits of a combination approach: "since ECEC settings provide services for a range of people with different backgrounds, not every strategy or type of engagement meets all needs or is suitable for each child, family or community" (OECD, 2012: 9).

In this regard, the recommendations of the European Economic and Social Committee on ECEC (January 2010) are also relevant:

1.8 The needs of families and children living in disadvantaged, remote areas and regions should be addressed better and in a more complex way, including community involvement and public support. The different forms of services – integrated, home based, parent support etc. – can respond to differences in the needs of children and their families.

1.4 Current national policy in the Netherlands

As stated earlier the notion of an educational partnership between schools, parents and other services is a topical policy issue in the Netherlands. The government policy in 2011 emphasised joint responsibility between formal educational institutions and parents for language and literacy development. The focus on improved performance in language and literacy reflects the priorities which have been set out in the government's Quality Agenda for Primary Education (Opiniepeiling Kwaliteitsagenda eindrapport).

In 2010 the *Education Council*, an independent advisory body that advises government (ministers and ministries) and parliament ('Eerste & Tweede Kamer'), published the report 'Parents as partners' in response to a parliamentary request for advice on improving parental involvement in education (Onderwijsraad, 2010). The council draws a distinction between three kinds of relationships between parents and schools: 1) the individual, legal relation (parents as rights bearers and duty holders), 2) parents as 'cooperation partners' in terms of upbringing and education of their children, and 3) parents as part of a (informal) parent community. In its report, the council advised that greater emphasis be placed on the second and third type of relationship, arguing that the legal position of parents is already sufficiently solid (see Box 1 below for more details).

Drawing on previous studies, the council concludes that **there is little meaningful partnership between schools and parents**, despite schools generally having met all the legal requirements such as setting up participation councils. To establish 'real' partnership, the council advises greater attention be paid to developing the *conditions* for meaningful partnership, namely structure, culture, willingness and skills. The council places responsibility for this 'developmental work' largely with schools and parents, and not with government or municipalities.⁵

A strong parent community is viewed as a means to support not only the upbringing and education of children but also social cohesion. In relation to stimulating the (informal) parent community, the Council advises that responsibility for parent-to-parent initiatives remain with parents, but that schools can be stimulated to play a supportive role in the set up and ensuring sustainability of networks/ groups etc.

⁵One example of an initiative to support such development work is the guidelines developed by Smit, Driessen and de Wit (2009) for VVE services to optimise parental involvement. The step by step plan is designed to guide practitioners through a 6-phase process encompassing a needs analysis, the development of a vision, elaboration of an action plan, implementation, and evaluate activities and skills and attitudes of practitioners are intended to inspire and give concrete suggestions to practitioners.

Box 1: The legal position of parents with respect to formal primary education

The **Wet Medezeggenschap op Scholen (WMS)/Act on Participation⁶ in Schools** provides the framework for - compulsory - 'representative advisory councils' (*medezeggenschapsraden*) in primary and secondary education schools. The Act was designed to ensure democratic involvement of (secondary) learners, staff and parents in policy development and governance at primary and secondary level. Practitioner members are elected from and by practitioners, whilst caregiver members are elected from and by caregivers. The Act furthermore states (article 7.1, 7.2) that the representative advisory council should strive to promote openness and consultation in the school, guard against discrimination and support equal treatment (of women, ethnic minorities and disabled people in particular). The representative advisory council receives a budget to carry out its work. The council has the right to approval (*instemmingsrecht*) and the right to advise on a range of issues (respectively, articles 10 and 11). With regard to its 'approval right', a school needs to gain approval of the participation council in relation to among other issues, changes in educational goals of the school, changes in school regulations, and changes to rules with regard to for instance, health and safety in the school. With regard to the right to advise, a council is given the opportunity to advise the school on matters such as changes to school time tables, modifications of overall long term (multi-year) financial policy, appointment or dismissal of school management, and changes to policy with regard to accepting and removing of learners. In addition to parents' rights (and duty) to partake in the advisory council, under the act they are also obliged to ensure their children attend school regularly (*leerplicht*); as well as having the right to information about their children's progress at school (*recht op informatie*), the right to be informed about school's policies and programmes and policy on quality, and the right to participate in the schools' parent representation group (*ouderraad*). This generally deals with less formal school issues, such as celebrations and parent information evenings.

The rights and responsibilities of parents of children attending ECEC services such as daycare centres, pre-schools and playgroups have a weaker legal basis (personal communication, Jellesma, 2011 – Boink-eQuality seminar). Nevertheless, amongst the provisions of the **Wet Kinderopvang** (2005), or **Childcare Law**, is the obligation on all childcare organizations to have in place a parents' representative group (in Dutch: *Oudercommissies*) for each location.⁷ Parent representative groups have the right to advise on issues such as the quality of care, opening times and prices charged by organizations.⁸ It is up to each parent organization to agree with the childcare organization on their way of working (the number of members, how they are chosen, length of time they sit on the group). A central parent representative group is recommended in the case of larger childcare organizations. On 11 November 2011, Minister Henk Kamp (Social Affairs) announced the establishment of a complaints body for parents of children attending day care settings. He also noted by the end of 2012 parents should be able to access information about prices and quality in all daycare services via the digital *Kinderopvangkaart* an initiative of the parents' organisation BOINK.

The two pieces of legislation which are significant for educational policy at municipal level are Lokale Educatieve Agenda (LEA) (Local Educational Agenda) and *Wet OKE Ontwikkelingskansen door Kwaliteit en Educatie*⁹ (see box 2 below for summary). Neither elaborate parental involvement in any detail. However, in a letter to parliament on 29th November 2011, Minister for Education, Marja Bijsterveld announced extra financial support

⁶ N.b. the term *medezeggenschap* refers to having a say, having a voice (in decision-making processes). Although the notion of participation does as such not fully cover the meaning of *medezeggenschap*, it is used here as a form of shorthand.

⁷ Provisions regarding the role and setting up of Parental Representative Groups are set out in Section 3, Paragraph 3, Articles 1.58 to 1.60a of the Childcare Act 2005.

⁸ Provisions regarding the role and setting up of Parental Representative Groups are set out in Section 3, Paragraph 3, Articles 1.58 to 1.60a of the Childcare Act 2005.

to improve quality for VVE for the 37 largest municipalities. Included in the announcement were measures to strengthen parental involvement, acknowledging the contribution parents make to children's learning within the home context.

Box 2: Lokale Educatieve Agenda (LEA) Local Educational Agenda

The Local Educational Agenda was introduced at municipality level to give form and content to the changes introduced to the *Onderwijsachterstandenbeleid* (Educational Disadvantage Policy) in 2006. It is an instrument for municipalities, school managements and other partners to work collaboratively together at local level in respect of education policies and policies relating to children and youth. One of the topics on the LEA is parental involvement (in education).

The **Wet OKE (Ontwikkelingskansen door Kwaliteit en Educatie'** /Act for development opportunities through quality and education), in force since August 2010, stipulates that municipalities are responsible for ensuring that all children and particularly those who 'need' it have access to good quality ECEC (understood as VVE programmes). It harmonizes the inspection/regulatory and quality requirements for daycare and pre-school playgrounds and the costs to parents for VVE (whatever the type of service VVE is delivered in). Areas of co-operation include: pedagogical policy and quality, use of space and materials, personnel and in-service training, co-operation with schools, Centres for youth and family (Centra voor Jeugd en Gezin), Care and Advice Teams (Zorg en Advies Teams, ZATs), and neighbourhood. It is viewed by many as a first step towards a more integrated provision for all young children in integrated Children's Centres (Kindcentra).

What about policy and legislation relating to supporting informal and non-formal learning?

Wet Maatschappelijke Ondersteuning (Wmo) (2007) (Support for Social Participation Act) ensures that everyone in the community, particularly those most vulnerable have the possibility of services such as social work, pre-school playgroups, community centres and women's refuge centres. Each municipality is responsible for devising and implementing services and actions under Wet MO. With regard to support to parents, the Act defines 'maatschappelijke ondersteuning' as including preventive support to parents experiencing difficulties with the upbringing of their children (article 1.1.g.2). Municipalities are not responsible for delivering support services directly but outsource to welfare organizations.

The arguably, up to now, minimal support to parental involvement in informal and non-formal parenting and learning can be understood in the broader context of the withdrawal of national government from the informal/non-formal to the formal sphere (Carpentieri, 2011). According to some commentators, this shift is underpinned by a belief that government can exert greater control over learning outcomes in formalized education settings, such as schools and day care centres (personal communication, Kees Broekhof, Sept 2011). The additional support to municipalities, announced November 2011, to promote parental involvement in early learning may mark a shift in this regard (see Appendix 2 for full text of letter from Minister for Education, Culture and Science).

Furthermore, Centres for Children and Family (Centra voor Jeugd en Gezin,

CJG), which by the end of 2011 should exist in all municipalities, are intended to provide easily accessible child-rearing and ECEC information and referrals to more specialized and targeted support and services where needed. However, there is huge variety across 431 municipalities in how Centres for Children and Family operate in practice and the extent to which they engage all parents in the community (see Case Studies in the Netherlands for further information, Part 2). Also of note is the announcement in November 2011, by Minister for Education, Marja van Bijsterveld of a Special Professorship on parental involvement.

In closing this section on government policy on parental involvement it is worth referring to the emotive response, early December 2011, to the Minister's call to (working) parents to invest more time in the learning of their children including their involvement in school. Below is the final paragraph of a piece posted by the editors of the Ouders.nl website which captures the tone of the public response:

Borgdorff (2011)

Ouders en school - Dossier ouderbetrokkenheid

2 december 2011

De oproep van minister van Bijsterveldt voor meer betrokkenheid is veel ouders in het verkeerde keelgat geschoten. Martine Borgdorff analyseert de volkswaede. Juf Marja hoef je toch niet serieus te nemen?

Ouderbetrokkenheid volgens juf Marja

...Dat de brief van juf Marja zo'n open zenuw blootlegt, is wél interessant. Ouders, en dan vooral de werkende, voelen zich miskend. En dat laten ze horen. Ze buffelen, balanceren en multitasken zich suf, ze laveren tussen reorganisaties, files en ouderavonden, en krijgen als dank te horen dat ze niet betrokken zijn bij hun kind. En of ze verplicht ook nog even willen letten op het voorlezen en rekenen.

Na andere betuttelende, belerende en wantrouwende beleidsmaatregelen – zoals het DDJGZ (voorheen EKD), de CJG's, en de vragenlijsten Stevig Ouderschap – én een reeks aan bezuinigingen op kinderopvang en onderwijs die het ouders en kinderen alleen maar lastiger maken, is dit het zoveelste bewijs dat je als gezin van onze overheid niets hoeft te verwachten.

1.5 Forms of parental involvement in the Netherlands

One of the aims of this study was find out more about the range of parental involvement in early learning in the Netherlands. Specifically: What are the predominant forms?; Who is doing what?; How are parents supported in their childrearing and educating role?; What programmes, initiatives and interventions exist? And What does research tell us about these?

This scoping exercise was conducted primarily through desk based research and discussions with key informants. Unlike much research on this area which tends to focus either on parental involvement in ECEC and school settings, or child-rearing behaviours and parenting support – we kept the parameters wide and included both parenting support structures, and mechanisms and parental involvement in:

» informal learning and non-formal learning *at home* and *in the community*

- » *formal centre-based ECEC settings* (day care, pre-school playgroups (PSZ), pre-schools)
- » *in primary school settings*

The data collected are organised in tabular format and are to be found in Appendix 3. Here we summarise the main trends and findings.

1.5.1 What parenting support services are available to parents of young children?

An overall finding is that there is a wide variety of child-rearing support and early learning advice which parents of young children can potentially tap into. This could be informal advice and sharing of experiences with extended family, friends, or in informal parent networks linked to preschool, school or playgrounds. Another possibility available to parents is to discuss issues with staff in their local Centre for Children and Family (Centra voor Jeugd En Gezin) and Baby and Child Health Clinic (Consultatie Bureau), or with staff in the daycare centre, pre-school playgroup or school, which their child attends.

A further source of information and support is attendance at organised parenting classes, such as *Triple P* or *Opvoeden & Zo* or the *Gordon Training* for parents on effective communication with children. Parenting advice websites or discussion fora such as Ouders online provide yet another possibility.

Whilst it is acknowledged that parents differ greatly regarding the kind of interaction and support they need (van de Hoek and Pels, 2008), closer analysis of the data indicates that not all the forms of support or advice referred to above are accessible all groups of parents. According to Gezinsrapport 2011, parents report that they are more likely to seek child-rearing support and advice from their child's daycare centre, pre-school and school, than from the Centre for Children and Family (Centra voor Jeugd En Gezin) and Baby and Baby and Child Health Clinic (Consultatie Bureau), school doctor or social work services. These latter services typically involve telephone calls, waiting times, appointments in contrast with the more immediate, personal face to face contact parents can have with ECEC practitioners in daycare settings, pre-schools or playgroups.

In general, low educated parents and unemployed parents receive relatively little informal support from family and friends, compared to middle and higher educated and working parents. Research indicates that it is these groups of parents who are in most need of support if their young children are to thrive.

1.5.2 Reaching families most in need of parenting and early learning support

The quantity and quality of cognitive stimulation and parental sensitivity, is related to positive child development. These parenting behaviours are generally lower in ethnic minority families and lower educated parents. This is due to family stress, linked in turn to socio-economic disadvantage (Mesman, 2010).

On ongoing challenge for local authorities is to reach families of young children experiencing most stress and who have diminished energy and

motivation and confidence in their parenting capacities. Typically, attention to parenting and child-rearing support via home visiting parenting support programmes, mothers groups or parent and toddler groups and parenting classes has primarily focussed on disadvantaged or at risk groups, including low educated parents, ethnic minority groups lone parents and young mothers.

These initiatives are financed by national government who allocate funds to municipalities (primarily under Wet WMO), who in turn outsource to welfare organisations for implementation. However, coverage is very uneven and in 2012 such initiatives are under-pressure due to budgetary cuts at national and local government level.

Examples of targeted home-visiting parenting support programmes, which aim at enhancing knowledge, skills and confidence of parents of young children include: *Voorzorg*, which is intended for young, low educated women pregnant with first child; *Stevig Ouderschap*, a primary prevention programme against maltreatment for parents of children up to 1.5 years; *Moeders Informeren Moeders (MIM)*, for first time mothers of children 0-18 months and *Home Start*, in families where at least one child is under 6 years. Home based programmes with a specific attention on language and literacy development and stimulation of play and interaction between parents and young children include *Instapje* (1 year olds); *Opstap* (2 – 4 year-olds); *VVE Thuis*; *Jij Bent Belangrijk* and *Boekenpret*. Some of these work as combination home-based and centre based programmes. However, coverage of these programmes is also uneven. In 2012, NJi estimate that 58 municipalities support Opstap, 11 Instapje and 15 VVE Thuis. An estimated 4,000 to 5,000 families currently access these programmes.

1.5.3 What do we know about parental involvement in early learning in ECEC and school settings?

As noted in Section 1.1 four motives or goals for parental involvement in education have been identified for the Dutch context. Briefly, 1) *Pedagogical*: the harmonisation of childrearing and education at home and at school; 2) *Organisational*: parents providing practical help; 3) *Democratic*: giving parents a voice in decision-making practices; 4) *enablement*: enhancing the quality of mutual relationships between parents and practitioners.

There is no national monitoring data regarding parental involvement in centre-based ECEC settings such as pre-school playgroups, daycare settings or pre-schools. Any data available is based on small-scale localised research. Dutch research already cited in Section 1.2.2 has pointed to the lack of harmonisation between child-rearing and education at home and in ECEC and school settings, and the need to improve communication between parents and practitioners. Research conducted by eQuality and Boink regarding parental involvement in daycare settings focussed specifically on organisational and democratic aims of parental involvement. Recommendations arising from this research included the need to approach parents personally about becoming involved in daycare centres and secondly, subdividing oudercommissies into an activity and events group and governance group (De Laat et al. 2011).

The most recent parental involvement monitor relating to primary schools indicates high parental involvement in some aspects of learning. For example, 75% of parents report that they are active at least one year in

helping out in school events, 96% of parents report that schools inform them about learning progress of their children and 84% of primary schools have an ouderraad. Involvement in other areas would seem to be much less common: 32% of primary schools have consultation groups made up of parents and 50% of parents report reading aloud at least once per week to their child (Kans et al. 2009).

In recent years there have been a number of initiatives - printed and online guidelines, handbooks, in-service workshops, film material, online discussion fora - to support ECEC services and schools to enhance parental involvement, and to develop conditions for and improve learning partnerships between parents and ECEC services and schools. These have been developed by knowledge and advice centres such as Sardes, Expertise Centre Ouders, School en Buurt/ITS, and Mutant.

Despite these initiatives, some academic researchers speak about worsening relations and little meaningful participation between parents and schools, to the detriment of children.

The case studies of good practice which follow in Part 2 of the report provide further insight into the dynamics of parental involvement in early learning and what works.

PART 2: CASE STUDIES OF GOOD PRACTICE

Community involvement in ECEC facilitates the provision of comprehensive services for children and families i.e. expanded services and possibilities for referrals, and a space for partnership and participation of parents, responding to what children actually need in terms of their overall development (OECD, 2012). In the selection of case studies that are described in this part of the report, attention was paid to including examples which illustrated a 'continuum of services' for young children and their families, whereby formal and non-formal centre based ECEC services worked collaboratively with home based services, social and health services and adult education and other local stakeholders.

2.1 Outcomes and learning about parental involvement in Early Learning from Bernard van Leer Foundation supported projects and initiatives

Bernard van Leer Foundation has a long history of supporting partners and initiatives in the Netherlands who work to enable parents' engagement in the early learning of their children. Parent focussed programmes and interventions which the Foundation supported in 1980s, and 1990s include: *Moeders informeren Moeders* (MIM) (Mothers inform Mothers), *Samen Starten* (Starting Together), and *Samenspel*. In 2011, these programmes are still in operation (see Section 1.5).

More recent BvLF supported partners' projects and initiatives in Flanders and the Netherlands, which focus on parents' engagement in early learning are described below.

VBJK, Flanders

VBJK, the Training, Resource and Research Centre for Early Childhood Care and Education in Ghent, has a long history of working innovatively with parents. VBJK is a good example of an NGO, which has successfully forged strong links with practitioners, parents, community services, government agencies and university research departments. Since its establishment in 1979, the Bernard van Leer Foundation has funded or co-funded a number of VBJK's projects and initiatives. Fostering openness and partnership with parents, within the context of improving quality of ECEC has been a focus from the outset. In 1986, the Flemish governmental agency Kind en Gezin (Child and Family) recognised this strength and requested VBJK to give priority to improving contact between services and parents. Over the years this has been achieved, with support of VBJK's sister organisation the VCOK (Training Centre for ECEC) through: developing training and organising hundreds of training events emphasising the importance of involving parents in the pedagogy of day-care centres all around Flanders; stimulating parent meetings and social events with parents in services; researching and producing a substantial amount of visual and written documentation – books, handbooks, articles, brochures, the magazine KIDDO and video films many of which have been translated or subtitled; collaborating internationally and participating in networks such as ENSAC (European Network for School-Age Childcare), IFDCO (International Family Day Care Organisation), DECET, Children in Europe, Men in Childcare, and in European projects such as NOW (New Opportunities for Women). In all of these activities, VBJK has given particular attention to disadvantaged families and immigrant families.

The position of fathers in child-rearing and education has been a particular interest and area of expertise. In 2006 in collaboration with the Pedagogische Begeleidingsdienst, in the city of Ghent and Flora, Gender Consulting and Training, Brussels, VBJK produced guidelines and a monitoring instrument to support ECEC services to critically reflect on the level of fathers' involvement in ECEC. Key moments and activities in ECEC in which parents, including fathers have an important role to play were identified. One set of activities focus on the individual family-ECEC service contact such as: Intake meetings, settling in periods, daily contacts at arrival and going home time, custom satisfaction discussions, advice and support meetings. The second set focuses on how to more actively involve parents as a group to enhance connections and sharing between two worlds of young children: home and ECEC setting. Suggested initiatives are: occasional informal activities such as open door days, breakfasts for parents and children, theme evenings as well as involving parents in leading and supporting daily group activities: singing, reading, dancing, cooking with children, accompanying group on a walk in the neighbourhood, providing introductory tours to new parents, translating or interpreting for parents. The actions and projects on parents have had an important impact on the policy of the Flemish government. New legislation has been developed to strengthen the parents who live in difficult situations: 20% of the childcare place are reserved for those parents. The governmental organisation Kind en Gezin has also emphasised the important role of men in ECEC and the number of male workers has increased from 1.1% to 3.4%.

<http://www.vbjk.be>

Bureau Mutant: Parents and Diversity

Bureau Mutant, a partner of the Bernard van Leer Foundation since early 2000s supports ECEC professionals and institutions through innovative methods, action research and training. One of Mutant's focus areas has been in improving quality of care and education through working positively with parents, particularly in the context of services meeting the needs of an increasingly diverse population of parents and children. The BvLF supported project *Parents and Diversity Research and Training Project* (2003 to 2006) gave concrete form to the theoretical framework, 'experiencing together, acting together, reflecting together and deciding together' with reference to six diversity objectives, which were based on DECET's objectives.⁹ The outcome was a completed matrix, containing 30 actions judged most important by the participating practitioners, for promoting parental participation and respect for diversity.

The project also analysed the perspectives of practitioners and parents in five childcare organizations regarding the partnership between them. Findings show that contact between parents and practitioners were generally positive although discussions about difficulties children were having, were often experienced as problematic. Furthermore, concerns of parents and practitioners were sometimes diametrically opposed. For example, when it was practitioners aim to get information from parents to help explain why a child's development was delayed, parents' priorities were to find out things from the practitioner to enable them to entrust their children to their care. The most frequent topics of discussion between parents and practitioners were: centres' daily programmes, dealing with sick children, nappy changing, playing outside and the balance between stimulating development and offering children a safe environment. In this and the subsequent phase of the project, *Diversity and Parental Involvement* (2004-2006), training and methodologies for practitioners and managers of ECEC services were developed

⁹ECEC services and communities where everyone: feels that he/she belongs; is empowered to develop the diverse aspects of his/her identity; can learn from each other across cultural and other boundaries; can participate as active citizens; actively addresses bias through open communication and willingness to grow; works together to challenge institutional forms of prejudice and discrimination (DECET, 2007).

to improve pedagogical quality on the basis of respect for diversity and parental involvement.

A number of supporting publications, handbooks and training courses have been developed as a result of this project. The training course 'Open doors for parents' has been provided to all childcare workers, coordinators and managers in the Municipality of the Hague. A related output is an arts based training methodology for equal opportunities in the cooperation with parents 'De Kunstkar' (The Art Cart). This training has been nationally accredited and has been provided to all 150 childcare centres of Child Care Humanitas. Unresolved questions in the *Parents and Diversity* projects were a starting point for the *Sustainable Change Project* (2007 – 2009) which addressed: How to anchor the insights and methods of cooperation with parents within childcare provider organizations? And how to create a sustainable learning process with professionals? Outputs of this project include instruments and learning approaches, publications and handbooks which support practitioners to be critically reflective with colleagues regarding their daily work with children and families. BKK views the methodology as a framework for ECEC services in the Netherlands as 'Learning Organisations' and the methodology was presented at 5 regional conferences organized by BKK for (5 x 100) 5000 participants in 2010, and in 5 conferences during October and November 2011.

<http://www.mutant.nl>

Stichting Pedagogiekontwikkeling 0-7 (P0-7) – SPOREN

The original aim of Stichting Pedagogiekontwikkeling 0-7 (P0-7), which was established in 1995 in Amsterdam, was to develop a new pedagogy for children 0 to 7 years in the Netherlands, in which young children and their parents had a strong voice. In time, P0-7 became the means by which the internationally recognised Reggio Emilia approach to ECEC could be translated and interpreted for the Dutch context. The outcome has been SPOREN (Stichting Pedagogiekontwikkeling Reggio Emilia Netherlands), translated in English as 'Traces'. Sporen is now officially accredited as VVE Programme.

Within the SPOREN approach equal attention is given to working with teachers, children and parents – in fact parents are viewed as vital and not to be missed contributors to the education of young children. All three participants, teachers, children and parents are stimulated to develop an explorative attitude. The pedagogical development work in the schools incorporates research, environmental design, practice, documentation, and reflection. Parents are drawn into the everyday happenings in the children's centres on a daily basis – here the pedagogical documentation is vital. Practitioners connect everything with the parents, so they can follow it, add something to it or co-operate. Importantly, the content is open and is led by what is relevant for the children and their immediate social context. In this way the children's centres are viewed as learning communities for parents as well as children and practitioners .

Currently Sporen is implemented in Childcare Centre De Platanen in Amsterdam. BvLF is currently financially supporting the piloting of SPOREN in 4 different settings in different regions in the Netherlands. P0-7 has also developed in-service training programmes which prepares and supports practitioners to work with the SPOREN. Other activities include membership of the International Reggio Emilia Network, organization of study tours from the Netherlands to Reggio Emilia, writing of articles and conference presentations.

2.2 International good practice

Pen Green Centre for Children and their Families

Pen Green Centre for Children and their Families (Pen Green) attracts national and international attention for its innovative ways of working with parents and families. The Centre, located in Corby, a working class district in the English midlands with high unemployment and a large number of multi-problem families, was established as a community service for families with young children in 1983. Today it comprises a Baby Nest (for children up to 2 years), a Nursery and Creche (for children 2 to 5 years) and after-school and holiday play scheme for children 4 to 11 years and applied research and training programmes in the Pen Green *Integrated Research, Development and Training Base and Leadership Centre*.

At the heart of Pen Green's programming is a community development approach which recognises the need for a balance of power in respectful relationships with parents. Critically parents, practitioners, referred to as *family workers*, and children are all considered as active learners. Pen Green's parental involvement framework known as *Parental Involvement in Children's Learning* or *PICL*, was developed through a research project in 1997 – 2000 during which parents and family workers worked together to find a range of successful models of engagement. The approach combines action for the parent (helping parents to reclaim their own education and build up their self-esteem) and action for children (encouraging parents to child-watch, to be involved in and respectful of their children's learning process and development). It's a way of working which involves respecting the knowledge of parents about their own children and working with parents in a 'knowledge sharing approach'. The roles of professional knowledge and parents' experience are seen as complementary and equally important. There is a basic understanding that all parents care for their children and are deeply committed if given the opportunity.

In practice this means lots of contact and communication between children's home and the Centre. Parents learn about the key theoretical frameworks which influence Pen Green's daily work such as *Wellbeing; Involvement and Schemas*. The approach also involves sharing pedagogical strategies that adults use to help children learn both at home and in the Centre. Examples of these strategies include, affirmation of the child through facial expression and physical closeness or encouraging children to make choices and decisions or adults encouraging children to go beyond the adults' own knowledge base and accompany them into new experience.

Family workers visit children at home, and parents are actively encouraged to visit the Centre - to share information and learning about their own children with the Key Family Worker or to participate in the many workgroups, courses and activities which are organised for fathers and mothers. Parents are also encouraged to work as volunteers in the messy play area – and some parent volunteers go on to become family workers themselves.

A portfolio of documentation about each child: notes, observations, children's drawings, photographs, is built up over time, to which both parents and key family workers contribute to. The analysis of videos recorded family workers in the Centre and by parents at home is also an important catalyst for knowledge sharing and research. A more formal sharing and

analysing of information takes place three times a year during which staff and parents come together to discuss the child's learning and development in all areas. The children's portfolio are key in these discussions.

Many of the groups, which focus on a wide range of parenting and personal development topics are open to all families in the neighbourhood – meaning that Pen Green is a hive of activity during the day, at evenings and even at weekends, when the Dads Group and Father Infant Massage group meet.

Sources: <http://www.pengreen.org/>; Whalley (2007); Discussions with Ass. Prof. Elly Singer regarding her study visits to Pen Green Children's Centre during 2011.

2.3 Three case studies in the Netherlands

The following more indepth case studies describe three current initiatives illustrating different challenges and opportunities when engaging parents in early learning in the Netherlands. The first case study, based on a project in Rotterdam focuses on the role of the parent counsellor in engaging parents of toddlers and primary school going children in the learning of their children in order to combat educational disadvantage. The second case study describes a city wide initiative in Eindhoven which aims to strengthen the pedagogical infrastructure of the city through establishing integrated education and care centres in each neighbourhood. A multi-disciplinary early intervention initiative supporting children 0 to 7 years in Tilburg provides the focus of the third case study. Data for the case studies were collected via face-to-face interviews with key personnel and reviewing relevant documentation. Key discussion points during the interview were: the origin and rationale for the initiatives; which organisations and co-operating parties are involved; how the initiative works in practice; how all parents are reached; pre-conditions for parental involvement in early learning; assuring quality and evaluating the impact of the initiative and future plans.

2.3.1 Ouderconsulenten, Rotterdam

Background

The municipality of Rotterdam has been supporting neighbourhood based home-school liaison actions for more than 15 years. Initiatives included a *Neighbourhood Mothers* (Buurtmoeders) programme in disadvantaged neighbourhoods and recruitment of Parental Involvement Assistants under a social employment programme. In 2005 the Ouderconsulenten (Parent Counsellor) initiative was established.

What distinguished the Ouderconsulenten initiative from the earlier projects was its requirement that ouderconsulenten had a minimum qualification (MBO3) and ongoing monitoring and coaching support of ouderconsulenten would take place. In 2011-2012 two kinds of parent counselors exist: those who visit families of 2 year-olds at home: known as Neighbourhood Welcome parent counselors (Wijkfeliciteit Ouderconsulenten) and Primary school based parent counselors. In total there are 50 of the former and 150 of the latter, who are spread across neighbourhoods with higher proportion of low ses families and migrant families and where there is perceived most need for intervention. Important to note that the structure and organization of ouderconsulenten initiative will change for school year 2012-2013. The description below relates how it operates in January 2012.

Which organizations are involved?

The Ouderconsulenten initiative is fully financed by the municipality, specifically the department *Jeugd, Onderwijs en Samenleving* or JOS (Children and Youth, Education and Community). Werkgeversinstituut, a non-for profit employment agency is responsible for the administration of contracts, salaries and sick leave for the parent counselors and Stichting de Meeuw is responsible for monitoring and guiding parent counselors and the further development of their role. The two other important partners in the Ouderconsulenten initiative are the school and school management and, in the case of the home visiting ouderconsulenten linked to the neighbourhood welcome service, the relevant welfare organization in the neighbourhood.

What are the aims of the ouderconsulenten initiative?

The central idea behind the initiative is that in order to increase the educational opportunities for children from disadvantaged families (i.e. low SES and/or migrant background), it is necessary to increase parents' capacities to stimulate their children's learning development at home. It is also important that they understand how they need to be involved at pre-school and school to support their child's educational opportunities.

The project leader summarises the approach as follows: 'Weten, willen, kunnen' ('Know, wish to, being able to') i.e. parents first need to know what is expected of them, they need to be motivated to be involved and need to have the capacity to stimulate and be involved in their children's development. The ouderconsulenten address all three aspects. This is a supportive relationship whereby the starting point of ouderconsulenten is the strengths of the parent. The example used to illustrate is that whilst a parent may not read aloud from a book to their child they may frequently tell stories. By recognizing that parents are able to tell a story, parents can be supported to realize that this is one way they can expand their children's vocabulary.

How does the ouderconsulenten initiative work in practice?

Neighbourhood welcome ouderconsulenten

The main aim of neighbourhood welcome service has been to increase participation of children from low SES families in pre-school playgroups and pre-schools following a recognized VVE programme. This is achieved via a visit to the family home when a child turns two years. In addition to bringing a welcome gift from the municipality, the ouderconsulenten informs the parent(s) about the importance of pre-school education for their children's learning and development and future opportunities. As well as being given information about the neighbourhood ECEC services with VVE component, parents are also introduced to other young child and family focused activities and services in the neighborhood. A further aim and opportunity in this home visiting approach is the early identification of problems, needs or risk factors in young children's lives and the possibility of informing parents about other services in the area which can offer more specialized help.

School based ouderconsulenten

Rotterdam is not the only city in the Netherlands where so called home-school liaison personnel or variants of neighbourhood mothers are in place. But what seems to distinguish the Rotterdam initiative from others is firstly, the physical location of the ouderconsulenten in the school or

community centre and secondly, the attention paid to ongoing support and development of the role to meet changing needs of neighbourhoods and families. Discussions with three ouderconsulenten, who are located in three different neighbourhoods, revealed both commonalities and differences in their daily work and the relationships they have with parents, children, school staff and other professionals. All three work hard to come in direct contact with parents, by for example being present at the school entrance at arrival and going home time. They specifically look out for new parents and children, helping them find 'their way' within the school system. All three mentioned that no two days were the same – some days they could have no discussions, contacts with parents, other days 15 parents might come with questions. One had her own fixed office space in one school, another was based in the neighbourhood centre, and the third worked across three different schools. In two of the three neighbourhoods, the population was very diverse – countries of origin of families mentioned were Turkey, Cape Verde, Suriname, China, Yugoslavia and the Netherlands in the case of one neighbourhood, and in another: Afghanistan, Morocco, China, Somalia. The third neighbourhood was more homogeneous where 80% of the families were of Moroccan origin.

Group events for parents which the ouderconsulenten are actively involved in organizing include coffee mornings, theme evenings – and in the case of one ouderconsulent- language support group once a week over 10 weeks. The ouderconsulenten also spoke with pride with regard to being invited to liaise with teachers, social workers, and IB's when more insight into a particular family context is necessary. The precise nature of working relations with other professionals within the school depended on the work culture within the school but also how the ouderconsulent profiles herself in the team.

The specific benefits to parents of the informal support and group events organized by the ouderconsulenten was the opportunity for parents to share common concerns and experiences amongst each other. Sometimes parents suggest a solution, or ways forward to a school related issue raised by another. Also noted was that parents often look for reassurance from the ouderconsulenten, especially with first child, about how to deal with school issues, how their children are developing, what they should be able to do at certain age.

When asked about what they felt were the pre-conditions for parental involvement, the ouderconsulenten mentioned the importance of parents feeling secure in their environment, feeling valued, respected, and supported. In a very practical way the ouderconsulenten pay attention to providing accessible information about the education and school system. Sometimes, this might mean helping parents interpret the school guide including for example the pedagogical methods and approaches described. It was also mentioned that when mothers have own personal development opportunities – by for example participating in a cycling course, or attend a theme evening, they feel better about themselves and this positively effects how they deal with own children. Another direct effect on children mentioned was that children feel a sense of pride when their parents are present and involved in school.

To what extent are fathers involved?

Experiences varied regarding the extent to which fathers were involved. The project leader noted that division of responsibilities between mothers and fathers in most of low SES families which the ouderconsulenten have

contact with still very much on traditional lines (mothers responsible for young children, father only involved with older children, and when decisions being made about next stage of education). At the same time it was acknowledged there are differences between groups – especially amongst families where both parents working. Thus the experience in one school was that fathers were equally involved in bringing children to school, attending coffee mornings and helping out with activities. However, the experience of the other two ouderconsulenten was that fathers were less likely than mothers to engage in informal chat or to volunteer, and less likely to respond to written requests for help or to attend events. They felt that the best approach with fathers was a direct one-to-one approach, with requests for help with particular concrete tasks, such as helping on school trips, or cleaning up jobs, especially if older children were involved. It was pointed out that 9 out of 10 fathers will respond positively to such direct requests. Ouderconsulenten used these opportunities to explain how important it is for children that they also get attention from their father.

Since 2005, the project has been running a Fathers' Week, on an annual basis in April, to stimulate father's involvement in a variety of activities in school – such as sport, and art - and to illustrate to them that their role is also important.

Success stories, what is going well?

Individual setting based success stories include the way in which Moroccan mothers have become involved, been trained and have developed in their role as lunchtime supervisors; the weekly Dutch courses which parents are attending, during which childcare is offered for their young children; and the growth in number of parents who make contact with and in the school, ask questions and seek information. All three ouderconsulenten referred to the job satisfaction they experience in their daily work in being part of improving home-school relations, bringing parents closer to school and school to parents and seeing what is possible when there is more open communication. Finally, parents and parental involvement is also prioritized, at least on paper, in the educational policy for the Municipality 'Beter Presteren' (Achieve More), alongside language, mathematics and the professionalization of educators.

Assuring quality and evaluating the impact of the initiative

One means of supporting the quality of the initiative is the mentoring of the individual ouderconsulenten and their professional development in the role using as a guide the comprehensive list of competencies for ouderconsulenten. Whilst it is recognized that the quality of ouderconsulenten has an impact on the quality of the service, this hasn't been measured in this specific project.

The impact of the initiative on child outcomes has never been scientifically measured. A number of qualitative studies, or discussions with teachers have reported a positive impact in terms of increase in activities such as reading aloud to children, sending children to ECEC. In 2009, Oberon, on request from the Municipality conducted an evaluation of the initiative which involved a questionnaire survey of participants and 43 interviews with parents, ouderconsulenten, school directors and welfare organization staff. Key findings of this evaluation with respect to school based ouderconsulenten were: the large diversity between schools regarding the level of interest amongst the parents in activities organized, the degree to which activities are lead or directed by the ouderconsulenten and the

awareness of the school directors of the initiatives. Factors identified in this evaluation which limited the contact between ouderconsulenten and the parents and parental involvement were:

- » Working parents have no time to participate in school activities
- » Parents of older children let them go to school by themselves
- » Lack of interest amongst parents in taking part in activities in parent room
- » Parents not sufficiently competent in Dutch language
- » Suriname, Antillian and Cape Verde parents identified as particularly difficult to reach
- » Assumption on part of native Dutch parents that the ouderconsulent was not intended for them
- » In a few cases groups of parents had preference for a ouderconsulent who had same cultural background as themselves.

Three key factors were identified with regard to the effectiveness of the position: whether or not the ouderconsulent had a 'parent room' available; the extent to which she was part of the school team; skills and competencies – school directors were more critical than ouderconsulenten themselves identifying in particular, presentation skills and talking to a group as an area that needed more attention.

With regard to the home-visiting ouderconsulenten, the study concluded that they were succeeding in making parents aware of the pre-school playgroup services in the area but it was not possible to say whether or not they were having an impact on parents' child-rearing practices or skills. Groups of parents identified as being difficult to reach in home visits were: isolated parents; non-native women who were forbidden by their husbands to speak to outsiders; working parents; parents who said they had no need of information. Being able to assume a professional approach in contact with parents was an area identified as requiring further attention for the neighbourhood ouderconsulenten (Oberon, 2009).

Future?

In 2012, the ouderconsulenten initiative is in transition. Rotterdam's education policy 2011-2014 (ROB) consists of two programmes, Aanval op Uitval (focusing on decreasing school drop-out) and Beter Presenteren (better performance). On 10th January 2012 the municipal government set out revised policies and arrangements for subsidies under these programmes for the school year 2012-2013. The ouderconsulenten initiative is being revised as follows. Firstly, provision will be made for 25 Peuterconsulenten VVE (0.8fte) who will be based in the Centres for Children and Families (in essence replacing home-visiting ouderconsulenten). Parents of all target children will be referred by staff of the Consultatie Bureau (Baby and Child Health clinic) to the Peuterconsulenten at least once and maximum three times. Provision has also been made for 130 Medewerker Ouderbetrokkenheid (parental involvement workers) in primary schools, who will also be involved in the implementation of parent component of Group 0 initiative (Beleidsregel Rotterdam Onderwijs 2012-2013).

2.3.2 SPIL Eindhoven

Background



SPIL, meaning Play, Integration, Learning, is the city of Eindhoven's concept of a Brede School or Broad School. A SPIL centre consists of a primary school, a pre-school playgroup, daycare service and child-rearing support, all under the same roof. In 2000 the municipality took the decision that all neighbourhoods in Eindhoven would have their own SPIL centre. By 2012, there were 45 SPIL centres, of which 20 are fully integrated under the same roof. The aim is to have 57 by 2015 i.e. one for each neighbourhood.

The overall aim of SPIL is to strengthen the pedagogical infrastructure across the city and its neighbourhoods by providing a continuous and integrated learning and development track for children 0 to 12 years and providing child-rearing support to parents which is adapted to their particular needs. SPIL centres are physically close to where families with young children live. In this respect they can be understood as the Eindhoven version of a Centre for Children and Families¹⁰ i.e. easy accessible, low threshold, one-stop shop for neighbourhood support for parents and children. Seven of the 45 SPIL centres also include a Consultatie Bureau (Baby and Child Health Clinic for 0-4 year-olds) on site. Importantly, all municipal funds earmarked for policies relating to children, whether for child-rearing support, 0-4 year olds, VVE, Centres for Children and Families, buildings, go into the central SPIL 'pot'.

In order to get a better insight into what SPIL means in practice for children, parents and professionals, and in particular the place of parents in children's learning and development within the SPIL 'construction', an informal interview was held with the SPIL Process Manager, and a pedagogical advisor, who works as an outreach support worker with primarily non-native families in three SPIL centres. The interview took place in one of the 45 SPIL centres, where it was also possible to meet with the staff of the preschool playgroup and the primary school director. This report is based on these discussions in addition to the information gleaned from a range of supporting written documentation.

How does SPIL work in practice

All SPIL centres are obliged to follow a common operational framework and pedagogical plan and abide by agreed policies and protocols. Organisations involved include: welfare organisations (Lumens, K2), primary schools, daycare organisations¹¹ (one very large, Korein and 10 smaller with 1-3 locations in Eindhoven), the local health authority (GGD) and staff of Centre for Young Families (including Baby Health Clinic). The training and professional development organization, Fontys Hogeschool Eindhoven and CoACT Consultancy have also supported the development of guidelines. The elaboration of the pedagogical plan is intended as a collaborative exercise involving all participating partners in the SPIL centre, with support, where needed, of the Process Manager. It focuses on the direct work with children, work with parents in terms of child-rearing support, and the collaborative working between the professionals with respect to parental involvement, safety and health, child mistreatment and bullying. The intention is that by 2015, all 57 SPIL centres will have developed and be implementing a pedagogical plan. Given the requirements of Wet OKE with respect to tackling educational disadvantage and the provision of good quality VVE experiences¹² for young children, increasing attention is being paid to the educational aspect of the pedagogical plan for the SPIL centres.

¹⁰ There is one centralized administrative office for Centra voor Jeugd en Gezin in the offices of the Municipality. On two days per week, representatives from all the professional groups are present and can be telephoned for general advice. A second role, relates to the so called 'difficult cases'.

¹¹ In total there are 40 childcare organisations operating in Eindhoven, but only 11 are linked to a SPIL centre.

The target from the Municipality is that all target group children (0-4 years) (100%) should be attending a centre-based VVE Programme within one of the 57 SPIL centres. Currently just 50% of target group children attend pre-school playgroups, and another approximately 30% attend daycare within a SPIL centre. The rest (approx.. 10%) attend child-minding services or are cared for by grandparents or other family members. Home based programmes, such as Op Stap and Spel aan Huis are offered to families who do not attend a centre-based service. Finally, there is a very small group who attend of special care services for children with special needs.

Engaging parents in learning and development of their children

Engaging and involving parents has been a central aim of SPIL from the outset. Parental involvement is conceptualized in three levels: *communication* – parents can give and receive information; *participation* – parents are involved in thinking together, doing together, learning together within the SPIL centre; *influencing* – parents have the possibility to influence developments within SPIL. Relevant questions for reflection for SPIL partners are: How do you communicate with parents? How do you ensure that parents can be involved? And how can parents influence or have a say in policy?¹³

According to the pre-school playgroup team leader it had been easier to involve mothers in the pre-school playgroup when the population was more homogeneous and was more or less split 50-50 between Dutch and Turkish communities. Organised coffee mornings were viewed by mothers as an opportunity to meet up with and share experiences amongst their own (cultural) community. Currently, the range of countries of origin of the families in the school is very diverse and turn-out to organized activities is low. The Pedagogical Advisor noted that you can respond in two ways to a poor show of parents to an activity: "We won't do this again, because parents don't come" or "How can we organize this differently so that parents are interested to attend or can attend"?

In addition to offering an accessible neighbourhood service for both children and parents, the design of SPIL is such that situations of risk for children's healthy learning and development are identified and acted upon in a co-ordinated fashion, focusing on the family context, rather than on the individual child. The approach pre-supposes that all practitioners working directly with children (whether in baby health clinic, preschool playgroup, daycare etc) have the skills and capacity to identify developmental concerns (cognitive, social-emotional, physical) and can recognize risky home contexts which threaten children's well-being.

¹² Each SPIL centre is free to choose which VVE programme to follow.

¹³ In collaboration with the Fontys Hogeschool Eindhoven (Sociaal Pedagogische Hulpverlening course), a very comprehensive handbook on parental involvement for SPIL practitioners was developed in 2005. It is full of practical ideas and suggestions for engaging with parents as well as providing a summary of the underlying theoretical frameworks informing the approach. It is organized under the following themes: vision and aims; analyzing the needs of the target group; informing (sharing information); participation (in the SPIL centre); influencing.

Within each SPIL centre, the key coordinating staff from each of the partners make up the Care Team – i.e. the school's IB, the staff member responsible for Opvoedingsondersteuning and Ontwikkelingstimulerend (O&O); the manager or practitioner of daycare, school social worker and the neighbourhood nurse (0-4 year-olds) and Youth doctor or nurse (4 to 12 year-olds) linked to the Centre for Youth and Families. They meet regularly in order to advise on and co-ordinate the Centre's response to children and families in need of extra attention. For example, if it is determined that a family needs extra specialized help, such as a family coach, or outreach workers this can also be organized in consultation with Centre for Children and Families. Special financial provision has also been made for families experiencing stress for their children to avail of services of daycare, which is considered as a family support measure. Addressing concerns from family context perspective rather than from individual

child perspective is also important in preventative work in relation to child maltreatment.¹⁴

Reaching all families

Both the SPIL process manager and Pedagogical advisor emphasised the importance of good and respectful communication in reaching and engaging with parents, when we discussed the pre-conditions for parental involvement particularly in relation to 'hard to reach' families.. They note that the starting position has to be that parents have questions rather than problems. The context within which families live needs to be taken into account when offering help and advice. Also noted was the variation among SPIL centres in what is viewed as acceptable in making contact with parents: for example, informal chats on the school playground at arrival and home time, or email contact with O&O, or a regular weekly consulting hour. It was emphasized that communication between families and professionals needed to be a two way process, where both parents and school have responsibility and are genuinely willing and able to work together. Professionals need to have skills and competences in working with and communicating with parents. On their side, it is important that parents do not relinquish all responsibility to the 'expert' professionals, and realize that they also have a role, and that the best approach is to work together.

The pedagogical advisor's¹⁵ prior experience as a primary school teacher, led her to the conclusion that there were a group of parents (primarily from Moroccan origin) who were not being reached by the child-rearing support services or school social work, primarily due their reluctance to seek help or to ask questions because of their perceived shame with having to seek help. With support from an alderman in the municipality, she has for the past two years ran a pilot project whereby, she focused on engaging personally with all the Moroccan parents in the neighbourhood to persuade them to send their children to the pre-school playgroup. She also offered child-rearing support by providing Triple P training for mother groups.

From January 2012, her role and position has been formalised within the Centre for Children and Youth – where she is a Pedagogical Advisor working primarily amongst 3 SPIL centres/schools. Her task is to stay close to the people (particularly non-native Dutch) in the neighbourhood and in the SPIL centres, tune into families and children's needs, and identify opportunities to make positive changes and step in and offer extra support where needed. For example, one of her observations had been that the mothers' involvement in training was the stimulus for fathers to take initiatives for their own personal development and capacity building as child-rearers. The Municipality, has since facilitated the establishment of fathers' groups, whereby fathers can also follow the Triple P training.¹⁶

The Pedagogical Advisor is also convinced of the importance in investing time in face to face contact to explain to parents how the Dutch system of pre-school education and primary school education works, and what the expectations of parents are.

Assuring quality and evaluating the impact of SPIL

Key to ensuring that SPIL continues in Eindhoven is being able to demonstrate that SPIL is having a positive effect. Two main indicators or outputs have been identified to measure the impact of SPIL: children's learning outcomes and children's well-being (including all aspects of psychological and physical health). The plan is to use existing data to

¹⁴ Municipality of Eindhoven are currently exploring the family context based Signs of Safety approach to dealing with child-maltreatment and 14 professionals have just been trained. This will be integrated into the 5 level response to children and families in risky situations, within which SPIL partners are involved as co-operating partners.

¹⁵ Her initiative was awarded a Civil Society Prize, in recognition for her achievements in involving everyone in the neighbourhood in child-rearing.

¹⁶ A few HBO trained non-native fathers initially followed the Triple P and they now being supported in delivering Triple P programme to other fathers within some of the SPIL centres.

measure input and effects (outputs) such as: “frequency of physical exercise per week” (input) “individual child measures on the BME index” (output), or measures and scores on the VVE assessments. It is acknowledged that it is difficult to separate out the impact of the SPIL as an independent influencing factor. Results of the impact study are not yet publically available.

Finally, in terms for the future sustainability of SPIL, the SPIL Process Manager takes heart in the fact that SPIL has cross-party support at the Municipal level. Although originally a proposal of a PvdA alderman, it continued to receive support from the responsible alderman from CDA and most recently from GroenLinks political party.

2.3.3 Vroeghulp Locket, Kind en Jeugd, Tilburg

Background

Vroeghulp Locket (VHL) (early help service) offers a preventative approach focusing on children between ages 0 and 7 years. In essence it involves early identification, diagnosis and intervention in a situation where parents or professionals are concerned about a child’s development and/or behaviour. The approach is based on the principle that problems at a later age can be reduced, and sometimes prevented through an early and integrated approach involving a co-ordinated multi-disciplinary team of professionals, with the active support and involvement of parents. This is a free service, which is open to all families with young children. It is estimated that there are 40,000 children across the Netherlands who could benefit from the approach (Chiel Bos, 2011).

This short case study describes the experiences in just one region where VHL exists – Midden Brabant. Discussions were held with one of the co-ordinators, with further input with her colleagues, in the VHL centre in the GGD offices in Tilburg, which is the co-ordinating centre for VHL in the Midden Brabant. Here the VHL shares space with the Centra voor Jeugd en Gezin (Centre for Children and Families).

The Midden Brabant region has been working with an integrated multi-disciplinary approach for young children with developmental concerns since 2002. Between 2006-2011 it was one of 11 regions selected to pilot the innovative Vroeg, Voortdurend, Integraal (VVI) approach. This initiative, led and financed by the Ministry of Health, Care (VWS) (Long-term care, social support and youth care) with co-operation of the Ministry of Education, Culture and Science (OCW) (Youth, Education and Care) gave an extra impulse to integrated support of families of young children. It is now implemented nationwide and 37 integrated early help teams (Vroeghulp Locket) are in place.

Which organizations are involved?

The VHL team, who are located in the GGD building in Tilburg, consists of a manager, three co-ordinators and an administrator. In 2011, the service supported 187 new children and their families – this represented a 50% increase compared to 2010, and beginning 2012 two additional co-ordinators have been recruited to deal with the extra demand on the service. The VHL team is supported in their work, by a multi-disciplinary core team, who come together two times per month to discuss diagnosis and suitable interventions and advice/ care plans regarding individual children. This team consists of the following experts: a pediatrician; a

psychologist; physiotherapist; speech therapist; a pedagogue specializing in special educational needs; a rehabilitation doctor, a behavior expert from Bureau Jeugdzorg; a school social worker, and an advisor from MEE (state supported organization for people with disabilities or chronic illness, their parents and carers).

Key characteristics of the approach

The VHL service is characterized by a number of key principles:

Early intervention: the earliest age of child with which VHL deal with is about 2.5 years. However, the team would very much like to reach children at an earlier age in the belief that the earlier the diagnosis takes place, the more effective the intervention, and better for the child. Furthermore, behaviour patterns are less established and easier to change at an earlier age.

Child in context: attention is paid to analysing the whole childrearing and relational context around the child, including both vertical and horizontal relationships, and parents' strengths and limitations.

Speed of response during the whole trajectory - waiting times for appointment for intake interview, for follow up, interventions, reporting are all kept to a minimum.

Continuity of support: the co-ordinator, who first meets with the parents and child at the intake interview, is the key contact person for the parent and family throughout the whole process.

Co-ordinated support: in Midden Brabant region, 18 different organizations successfully collaborate to devise a co-ordinated plan for a child and family.

How does the Vroeghulp Loket initiative work in practice?

First contacts

The catalyst for the intervention of VHL is concern, typically by a parent or a staff member from the Baby and Child Health Clinic (Consultatie Bureau), that something is 'wrong' with their child. Once a parent makes initial telephone contact with the Loket, an appointment for an intake discussion is made. This normally takes place within 5 working days.

Intake discussion with parents and child

During intake discussion, to which both father and mother and child are invited, information is gathered on a broad ranges of issues covering the parents' own childhood history (own parenting, whether they were victims of abuse), pregnancy and birth experience with concerned child, child's development on a range of domains, general behavior, play behaviours, current family situation (relationship quality, possible tension, abuse, violence)¹⁷, whether parents themselves are receiving professional (psychiatric) support, parents' strengths and limitations in child-rearing. An important part of the intake is to explore with parents what they view as the problem or concern about their child and their expectations of VHL. At the end of the intake next steps are explained and agreed and parents are asked their permission for VHL to approach other services for information on child. The intake discussion takes on average between 1.5 and 2 hours.

Information gathering

Following the intake, the co-ordinator approaches other services and

¹⁷One of the tools used to support the exploration of family relations is play mobile figures representing children, parents, grandparents etc and their positioning in relation to each other, sensitivities and difficulties in relationships. In this respect, the intake interview has a therapeutic character.

professionals which have contact with the child, such as daycare centre, health clinic, school, for a report on the child from their perspective, based on standard questions.

Multi-disciplinary core team meeting

Once all information gathered, the multi-disciplinary core team meets and discusses the individual case guided particularly by questions and concerns of parents (which in 95% of cases, centre on the question if there is something 'wrong' with their child, and if so, how do they deal with the situation). Typically, 15 children are discussed in the 1.5-hour core team meetings, which are chaired by one of the co-ordinators. These discussions are managed in a very efficient way, in terms of attendance, time-keeping. A decision was made in the Midden-Brabant region not to include parents in this discussion because of the extra time this would involve. A strength of the multi-disciplinary core-team is that many of the members have been involved for up to 10 years, they know each other well, value the opportunity to exchange views and experiences and are thus motivated to attend.

Reporting back to parents

The next step is that the co-ordinator reports back the outcome of the core-team discussion to the parents in a face-to-face meeting. The advice, whether a diagnosis, further investigation, testing, home based support or intervention is carefully explained. Importantly, parents are free to decide whether or not to follow up the advice except in the case where the child's development is viewed as being in danger.¹⁸

Supporting transition to intervention

The co-ordinator is also involved in supporting parents to take the next steps in the child's care and education. If for example it is recommended that the child attend a daycare for children with additional needs, the co-ordinator will accompany the parents in their orientation visit to the centre. Attention is paid to creating the conditions for a 'warm' transition involving direct person-to-person contact with the professionals, parents and children involved, rather than merely passing on a paper or computer file.

Bringing the VHL support to a formal close

Approximately 6 weeks to 2 months following the hand-over of the child to a new service, or the beginning of a new intervention, the responsible co-ordinator will phone the parents to ask how things are going. If they are satisfied then the dossier is closed within the VHL, although parents are free to phone VHL at any time with further questions. At this point a formal end report is sent to parents, and a copy to the child's general practitioners (Huisarts) and if applicable the IB'er in the primary school. Parents decide whether or not they wish to make report available to staff in daycare centre or pre-school playgroup. The whole trajectory lasts, on average, about 9 months.

Pre-conditions for parental involvement in early learning and development

We discussed what could be core pre-conditions for parental involvement in early learning in the home context. In the co-ordinator's view, the most critical factor is healthy vertical relationships within a family i.e. parents relationships with their own parents, and with their child. In order to engage parents in supporting their children's development or engage them in a process of support such as offered by VHL, it is essential that parents feel welcome. This begins with the first contacts by phone. Other important factors mentioned were the importance of reacting quickly; a warm welcome for parents and children to the intake meeting; treating parents respectfully;

¹⁸ In these cases, the co-ordinator explains the implications of the Meldcode Kinder mishandeling, and their responsibility to ensure that adequate measures are taken to support the safe development of child.

attention to supporting parents when giving 'bad' news for example a diagnosis of autism.

Reaching all families

Families from all backgrounds and education levels have availed of the service. However, so far, non-native Dutch speaking families are less likely to avail of the service (as proportion of the population in Midden-Brabant) compared to native Dutch families. The reasons for this are varied and include: lack of awareness about available services and possibilities, a feeling of shame in having to seek help as a parent and language barriers.

In cases where parents do not speak Dutch, a neutral interpreter is involved.¹⁹ Another option is to ask a member of the own community to support interpretation. Whilst this service is free, not all parents like to involve other members of the community, because of private, sensitive nature of what is discussed. In the co-ordinator's view, the neutral unknown interpreter is often a better option.

Particular attention is also paid to including both fathers and mothers in the process. In cases where parents are separated, divorced and where relationship is very difficult, a separate discussion takes place with each parent separately. In 99% in cases fathers are involved.

VHL is also dependent on others to direct parents to their service. In order to raise awareness about the VHL, co-ordinators also regularly give presentations about the service to different audiences such as: Centre for Non-Dutch women, groups of speech therapists or physiotherapists, pediatricians, GPs, primary school interne-begeleiders (school care team co-ordinators). They are also regularly invited to give guest lectures in the Fontys Hogeschool (Higher Education college for professional education and training) or at the ROCs (vocational college training for classroom assistants).

Assuring quality and evaluating the impact of the initiative

Quality is assured through the well-developed methodology (described above) and the quality of the personnel involved. Co-ordinators are all trained at a HBO+ level. Necessary skills and qualities for the role highlighted are: knowledge of child development and therapeutic interview skills with adults and children, involvement, empathy, listening, ability to follow through. Attention is also paid to co-ordinators' continuing professional development.

Monitoring and evaluation occurs at a number of levels. The VHL manager monitors the performance and functioning of the individual co-ordinators. Parental satisfaction with the service is monitored via evaluation forms sent to all parents – parents are typically very satisfied with the service received in Midden Brabant region. Annual subsidy to the service is linked to its satisfactory reach, implementation and parental satisfaction, which needs to be documented and submitted to the management group of VHL initiative on an annual basis.

An overall cost-benefit analysis of the approach (business case) has also been conducted, which has indicated the later savings if problems are tackled earlier.

¹⁹Up to end of 2011 the costs for this service have been covered. However, beginning in 2012 families must pay for interpreter.

However, the team in VHL in Midden-Brabant are very keen to do further more in-depth research to assess the impact of their work on children and are currently exploring options in this regard.

Future?

The current subsidy from national government for the service is guaranteed until 2015. There is some uncertainty about how the service will be affected by the decentralization of financing and management to the municipalities and the services likely location with the Centre for Children and Families structure. There are nine different municipalities in Midden-Brabant, each with their own Centre for Children and Family. The team is aware that they need to make a strong case for the value of the early identification, diagnosis and intervention, in each of the nine municipalities in the Region, especially given the current climate of budget cuts at municipal level. However, VHL in Midden-Brabant is optimistic for the future and sees the current structural changes in services for children as an opportunity rather than a threat.

2.3.4 Learning from case studies of good practice

A commonality across the case studies is attention to providing a **continuum or joined-up services for young children and their families**. In some instances this entails enhancing the connections and sharing between home and ECEC settings (SPOREN, Amsterdam; VBJK, Flanders), making sure services are physically close to where families live (SPIL) and taking the whole child-rearing and relational context in account when supporting children's early learning and development (Early Help Service, Tilburg). In other cases, we see explicit attention to formal and non-formal centre based ECEC services working collaboratively with home based services, social and health services and sometimes adult education (SPIL, Eindhoven; Ouderconsulenten, Rotterdam).

Political commitment and a longterm vision has been a key success factor for sustainability of policies and practice. This is particularly evident in the cross-political party support in the municipality of Eindhoven for SPIL, ensuring coherence and continuity even with government changes. Governments depend on sound information and research data from 'the field' to inform policies. Some of the organisations featured in the case studies have also succeeded in forging strong links with government agencies and research institutions as well as with parents, practitioners and community organisations ensuring a meaningful flow of learning between practice, research and policy, leading to better chances of success.

Another important theme addressed in the case-studies of good practice was **engaging fathers as well as mothers in supporting their children's learning** and development. Examples described include: the development of guidelines and a monitoring instrument to support ECEC services to critically reflect on the level of father's involvement in ECEC (VBJK, Flanders); the facilitation of fathers groups (Parenting course delivered by fathers for fathers in Eindhoven; Dad's Group and Father Infant massage, Pen Green, UK); and the organisation of a fathers' week in schools (Rotterdam). In the Early Help Service in Tilburg it is viewed as essential to include both fathers and mothers in the early intervention process.

Supporting **parents, practitioners and children as active learners** is a key principle of underpinning practice in the SPOREN ECEC approach in the Netherlands, Pen Green, UK and the projects of Bureau Mutant. This ensures a greater balance of power and respectful relations between parents and practitioners, where the roles of professional knowledge and parents' experience are seen as complementary and equally important. In SPOREN, parents, children, and practitioners are all stimulated to develop

an explorative attitude. In Pen Green this is characterised as action for the parent (helping parents to reclaim their own education and build up their self-esteem) and action for children (encouraging parents to child-watch, to be involved in and respectful of their children's learning process and development). In both these cases good pedagogical documentation supported learning.

All organisations and initiatives described the need for **professionals to be skilled in responding to a diversity of families and parents** (different countries of origin and cultural background, social class, educational level, fathers and mothers) and to families' changing needs and circumstances. The importance of good communication skills with fathers and mothers, parents feeling listened to, respected and supported was a recurrent theme. So too was the need for practitioners to actively seek alternative means of reaching parents if the usual approaches were not working. The cross national Parent-Professional Partnerships (IPP) research study has also stressed that early childhood professionals need to develop a variety of flexible and family sensitive models of cooperation given that parents differ individually in their capacity to develop and maintain partnerships with teachers (Hujula et al. 2009).

Finally, the structural changes with respect to local governance and financing of social and educational services for young children which gives municipalities more responsibilities, coupled with municipal budgetary cuts means that at the beginning of 2012 there is **uncertainty regarding the future sustainability of many of the initiatives and programmes described in this report**. Thus, while on the one hand national government is advocating improved partnership between parents and educators, the available resources to support this work are under threat.

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<http://www.boink.info/oudercommissie>

<http://www.onderwijsraad.nl/upload/publicaties/571/documenten/ouders-als-partners.pdf>

<http://ernape.net> (*European Network about Parents in Education*)

<http://vng.nl>

<http://voorzorg.info>

<http://home-start.nl>

<http://nji.nl>

<http://www.ouders.nl>

<http://www.vbjk.be>

<http://www.mutant.nl>

<http://www.pengreen.org>

<http://www.kopopouders.nl>

<http://pedagogiekontwikkeling.nl>

<http://www.stichtingdemeeuw.nl/web/>

<http://www.tienermoeders.nl>

<http://www.jongvader.nl>

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APPENDIX 1: Pre-requisites and success factors for partnership

Within the practice and policy literature on ECEC it is possible to find so called 'success factors' or prerequisites for optimal partnership between parents and ECEC services, which have been drawn up based on research and experience in different contexts. Five examples are mentioned here: two from the Netherlands, and three international.

Wissemá et al. 1996 identified the following as necessary for optimal partnership between parents and VVE services, namely: partnership culture, partnership structure, willingness to partnership and skills in partnership.

Smit, Driessen, de Wit (2009) Stappenplan optimaliseren ouderbetrokkenheid in de Voor- en Vroegschoolse Educatie.

One of the outcomes of the **2002 Central and Eastern European Child Childhood Care and Development Regional Meeting** was the development of principles that would support practitioners in establishing partnerships with parents, which were subsequently published as '12 principles for a successful cooperation between childcare workers and parents' (Prott and Hautumm, 2004), financially supported by the Bernard van Leer Foundation. These are organised under three broad headings:

Pre-conditions for co-operation

1. Find out about your understanding of co-operation and partnership and what you are really striving for.
2. Check whether the interests of the stakeholders immediately concerned – the childcare centre, the parents and the institution – really meet.
3. Clarify the precise assignment of your institution in order to develop a realistic concept of co-operation
4. Mind the barrier between the institution and the individual: childcare workers should anticipate the parents' cautiousness or even anxiety due to earlier experiences
5. Take into consideration that the parents have met many well-meaning consultants and their well-intentioned recommendations before

Basis for co-operation

6. Assume that most children, parents and childcare workers live in normal circumstances – at least according to the variety admitted by the society they live in and whatever this means in reality for the quality of daily life.
7. Take into consideration that professionals need the parents' knowledge and expertise.
8. Childcare workers have to explain their work – parents do not need to justify their actions,
9. Take into account that vague agreements and/or serious reasons might be at the root of the parents' reactions if something goes wrong – they neither wish to disappoint nor insult you
10. Discuss competences and resources – not deficits

Ensuring co-operation

11. Securing partnership means granting equal rights to all people involved
12. First of all look for reasons within the institution or the organisational context if parents do not co-operate.

Based on research, and good practice case studies within the **PEAL project in the UK (Connor and Wheeler, 2009)**, it was concluded that respectful relationships and partnerships with families is achieved when:

- » ECEC services think through the quality of relationships with families and avoid making assumptions about parents or assigning 'group characteristics' to any particular community
- » Listen to parents as individuals and spend time getting to know families
- » Show interest in different perspectives and build on families existing strengths
- » Regularly exchange information about individual children with parents
- » Listen to what parents have to say about their own child's capabilities and interests, and make use of these observations for future planning
- » Directly support children's learning at home with suggested activities and the load of materials that complement what happens in the setting.

Outcomes of parental engagement in early learning

In 2011, the Office of Head Start, US Department Health and Human Services identified seven parent and family engagement outcomes as follows:

- » Family well-being Parents and families are safe, healthy and have increased financial security.
- » Positive parent-child relationships Beginning with transitions to parenthood, parents and families develop warm relationships that nurture their children's learning and development.
- » Families as lifelong educators Parents and families observe, guide, promote and participate in the everyday learning of their children at home, school and in their communities.
- » Families as learners Parents and families advance their own learning interests through education, training and/or other experiences that support their parenting, career, and life goals.
- » Family engagement in transitions Parents and families support and advocate for their child's learning and development as they transition to new learning environments, including Early Head Start (EHS) to Head Start (HS), EHS/HS to other early learning environments, and HS to kindergarten through elementary school.
- » Family connections to peers and community Parents and families form connections with peers and mentors in formal or informal social networks that are supportive and/or educational and that enhance social well-being and community life.
- » Families as advocates and leaders Parents and families participate in leadership development, decision making, programme policy development, and in community and state organising activities to improve children's development and learning experiences.

(Office of Head Start, Administration for Children and Families, US Department of Health and Human Services, 2011, cited in Early Childhood Matters, November 2011: 23).

APPENDIX 2: Letter from Minister for Education, Culture and Science, Marja van Bijsterveldt-Vliegenthart to Chair of the Parliament, on topic of parental involvement, 29th November 2011

> Retouradres Postbus 16375 2500 BJ Den Haag

De voorzitter van de Tweede Kamer der Staten-Generaal
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Onze referentie
350297

Datum 29 november 2011
Betreft Ouderbetrokkenheid

De Onderwijsraad adviseert in haar advies 'Ouders als partners' de komende tijd vooral te investeren in partnerschap tussen ouders en school. Investeren in educatief partnerschap is belangrijk. Het thema ouderbetrokkenheid gaat voor mij echter over meer dan dat. Het gaat ook over de ouders als opvoeder, de school als gemeenschap en het gezag van de leraar.

Ouderbetrokkenheid: een opgave voor ouders en scholen

Goed ouderschap is van fundamenteel belang. Ouders die investeren in een goede opvoeding hebben daar thuis veel plezier van én leggen het fundament voor prestaties en welzijn op school en later in de samenleving. Ik heb grote waardering voor ouders die hun kinderen een goede basis meegeven. Hoewel een groot aantal ouders zich actief en betrokken opstelt bij de leerontwikkeling van hun kinderen, constateer ik tegelijkertijd dat de opvoeding onder druk staat. Het is voor veel ouders een hele opgave de juiste balans te vinden tussen werk, gezinsleven en andere activiteiten, dat realiseer ik mij terdege. Toch vind ik het van belang dat alle ouders prioriteit geven aan de opvoeding en aan de overdracht van waarden en normen. En dat ze, wanneer hun kinderen naar school gaan, tijd maken om deze cruciale fase zo goed mogelijk te begeleiden. Dit geldt niet alleen voor ouders die worstelen met het vinden van de juiste balans. Maar ook voor ouders die door andere factoren een beperking ervaren in de relatie met de school, bijvoorbeeld omdat zij door een taalachterstand een barrière ervaren in het contact met de school van hun kinderen. De verantwoordelijkheid voor een goede schoolontwikkeling van het kind mag en kan niet alleen bij het onderwijs worden neergelegd. Ook ouders hebben daarin een cruciale rol. Door de keuze voor een school worden ouders medeverantwoordelijk voor het onderwijs en voor de schoolgemeenschap. Deze medeverantwoordelijkheid vraagt om betrokkenheid en openheid van twee kanten, zowel van ouders als van school.

Voor de school komt met de ouders een sociaal kapitaal van onschatbare waarde de school binnen. Van scholen en leraren vraagt het betrekken van ouders bij het leerproces dezelfde professionaliteit, zorg en aandacht als die ze besteden aan het onderwijs. Of zoals de pedagoog Micha de Winter het onlangs zei: 'Goede ouder-school relaties zijn minstens zo belangrijk als taal en rekenen'. Het een gaat niet ten koste van het ander, beide aandachtsgebieden zijn belangrijk en versterken elkaar. Uit de monitor ouderbetrokkenheid (2009) blijkt dat op dit moment 39% van de scholen in het primair onderwijs, en 31% in het voortgezet onderwijs,

Pagina 1 van 6

beleid hebben voor het verbeteren van het pedagogisch klimaat bij de leerlingen thuis, bijvoorbeeld om ouders te bewegen hun kinderen voor te lezen. Ik wil scholen stimuleren om dit op te pakken als onderdeel van hun professionaliteit.

Datum
29 november 2011

Onze referentie
350297

Wat betreft het vergroten van de ouderbetrokkenheid zie ik meerdere belangrijke kansen. Ouders kunnen een grotere rol spelen bij het verbeteren van de leerprestaties van hun kinderen. Verder zijn ze onmisbaar bij loopbaanoriëntatie en –begeleiding en bij het voorkomen van schooluitval en schoolverzuim. Als derde zijn ouders van belang voor de schoolgemeenschap, en kunnen scholen de vitaliteit van deze schoolgemeenschap versterken door ouders meer te betrekken.

Inzet van ouders en scholen voor betere leerprestaties

Het verhogen van de kwaliteit van het onderwijs is de belangrijkste opgave van scholen. Het verbeteren van de leerprestaties, en ervoor zorgen dat jongeren met een diploma het onderwijs verlaten, zijn dan ook belangrijke uitgangspunten in de actieprogramma's Basis voor Presteren (po), Beter Presteren (vo) en Focus op Vakmanschap (mbo). Deze opgave ligt niet alleen bij de scholen, betrokkenheid van ouders hierbij is essentieel. Onderzoek wijst keer op keer uit dat ouders een grote invloed hebben op de leerprestaties van hun kinderen. Dat begint bij het bieden van een veilige en stabiele omgeving, en bij een gestructureerd en stimulerend klimaat. Het helpt enorm als ouders thuis op jonge leeftijd lezen met hun kinderen, doorpraten over belevenissen, verhalen vertellen en discussiëren over maatschappelijke thema's. Daarnaast heeft positieve interactie met de school een gunstig effect op prestaties, zowel bij formele als bij informele ouderparticipatie.

De betrokkenheid van ouders is in het bijzonder van belang bij de taalontwikkeling van jonge kinderen. In het kader van de voor- en vroegschoolse educatie (vve) heb ik met de gemeenten afgesproken dat ze meer gaan doen om ouders te betrekken. De gemeenten gaan stimuleren dat ouders thuis ontwikkelactiviteiten doen, en ouders gaan participeren in de activiteiten op de voor- of vroegschool. Ook zijn er afspraken gemaakt over betere toeleiding van kinderen naar vve.

Het verbeteren van de leerprestaties vraagt om *wederkerigheid*. Scholen mogen ouders aanspreken op hun betrokkenheid. Andersom mogen ouders van scholen verwachten dat zij ouders actief betrekken bij de school en bij de ontwikkeling van de leerling. Het vraagt daarnaast actieve en blijvende inzet van scholen richting die ouders die vanwege bijvoorbeeld hun achtergrond of cultuur minder bij school betrokken zijn. Het vraagt ook om openheid van de school over de leerresultaten. Om voor ouders betrokkenheid mogelijk te maken moeten scholen ouders inzicht geven in de leerprestaties en de studievoortgang van hun kinderen, en in de kwaliteit van het onderwijs op de school. Met de PO-Raad en de VO-Raad ben ik in gesprek om de kwaliteitsgegevens van scholen toegankelijk te maken via een zogenaamd ouderportaal.

Inzet van ouders en scholen bij loopbaanoriëntatie en schooluitval

Het onderwijs is van grote waarde voor de toekomst en voor de maatschappelijke loopbaan van kinderen. Het is van belang dat ieder kind een startkwalificatie haalt en kiest voor een beroep dat niet alleen bij hem of haar past, maar dat ook goede kansen biedt op de arbeidsmarkt. Dit is niet alleen van belang voor de kinderen,

en het tot bloei laten komen van hun talenten, maar ook voor het onderwijs en voor de maatschappij.

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Scholen hebben de belangrijke taak hun leerlingen te helpen bij hun loopbaanoriëntatie en – begeleiding (lob). Omdat ouders belangrijke 'medebepalers' zijn voor een vervolgopleiding en een baan, liggen er kansen voor scholen bij het sterker betrekken van ouders bij dit proces. De samenwerking met ouders is dan ook een belangrijk onderdeel van de loopbaanscan die scholen gebruiken om hun loopbaanbeleid te beoordelen. In de bijbehorende 'Toolbox LOB' staan ook concrete suggesties voor, en goede voorbeelden van, de versterking van de samenwerking met ouders. Bijvoorbeeld het gedegen informeren van ouders over vervolgopleidingen, en het inzetten van ouders als stagebegeleiders of coach. Daarbij kan veel meer dan nu benut worden dat ouders zelf ook een beroep uitoefenen, waarmee zij een uitstekend rolmodel kunnen zijn voor de kinderen op school. Met de VO-Raad maak ik afspraken over extra aandacht voor de rol van ouders bij loopbaanoriëntatie en -begeleiding. Ook met de PO-Raad en de MBO-Raad wil ik hier het gesprek over aangaan.

In het kader van de aanpak voortijdig schoolverlaten zet het Regionale Meld- en Coördinatiepunt (RMC) de extra middelen ook in op het vergroten van de ouderbetrokkenheid. Hiermee worden ouders ingezet om schoolverzuim en schooluitval te voorkomen. Een voorbeeld hiervan is de toepassing van een systeem waarbij ouders een sms-bericht krijgen als hun kind ongeoorloofd afwezig is.

De ouders als onderdeel van de school als gemeenschap

Betrokkenheid van ouders bij hun eigen kind is noodzakelijk, maar niet voldoende. Ouders zijn ook van grote waarde voor de school als gemeenschap. Uit gesprekken die ik de afgelopen periode met scholen en ouders heb gevoerd, blijkt dat veel scholen en ouders hier ook al actief in zijn. Scholen dienen hierbij een visie te hebben op de rol van ouders bij de schoolgemeenschap, die past bij de wijk, bij de ouders en bij de school. Dit gaat verder dan dat ouders vrijwilliger zijn als voorleesvader of luizenmoeder, dat ze hun talenten en deskundigheid inzetten om het onderwijs te verrijken of dat ze participeren in de besluitvorming op de school. Het gaat mij er ook om dat ouders een rol spelen in de school als waardengemeenschap.

In het kader van de school als waardengemeenschap wil ik stimuleren dat scholen en ouders aan de voorkant goede afspraken maken over de wederzijdse verwachtingen, en over de waarden en normen die op de school gelden. Het gaat daarbij om het maken van niet-vrijblijvende afspraken, die vastgelegd worden in overeenkomsten tussen ouders en scholen waar beide voor tekenen. Bij de afspraken horen ook afspraken over het omgaan met conflicten. Het is belangrijk om hier aan de voorkant heldere afspraken over te maken, om te voorkomen dat een conflict uit de hand loopt. Ik zie mooie praktijkvoorbeelden van scholen die daarmee enorme winst boeken in de relatie tussen school, leerling en ouders.

De ouders hebben een belangrijke voorbeeldfunctie waar het gaat om het respecteren van de waarden en normen van de school. Dit betekent dat ouders een belangrijke taak hebben in het ondersteunen en respecteren van het gezag van de leraren. De leraar is de baas in de klas en de schooldirecteur bepaalt de regels binnen de school. De rol van ouders is om hun kinderen hierin op te

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voeden. En niet om aangifte te doen tegen leraren die optreden tegen disrespect en een gebrek aan gezagsgetrouwheid. Als het desondanks uit de hand loopt, en escaleert tot geweld tegen leraren, is het aan de overheid om in te grijpen. Geweld tegen leraren wordt niet getolereerd. Sinds november 2010 is de strafeis voor geweld tegen werknemers met een publieke taak, waaronder leraren, dan ook verdubbeld. De aangiftebereidheid bij veel scholen en leraren blijkt echter laag. Om de aangiftebereidheid te verhogen heeft de regering afspraken gemaakt in het kader van het programma Veilige Publieke Taak (VPT). Hierin is opgenomen dat werkgevers namens de medewerker aangifte kunnen doen, dat er anoniem aangifte kan worden gedaan, dat er sprake zal zijn van lik-op-stuk beleid en dat het mogelijk zal zijn schade te verhalen.

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Het maatschappelijk debat over ouderbetrokkenheid

Het verbeteren van ouderbetrokkenheid is niet primair een kwestie van meer geld of meer regels. Het gaat om een mentaliteitsverandering bij betrokkenen. De afgelopen maanden heb ik met veel ouders, leerkrachten, schoolleiders en ouder- en onderwijsorganisaties gesproken over ouderbetrokkenheid. Hieruit komt een nieuw besef naar voren dat de rol van de ouder te zeer een vergeten rol is. Veel ouders zijn, gewild of ongewild, in een consumentenrol terecht gekomen. Dit wil ik veranderen door een beroep te doen op scholen om niet te bescheiden te zijn om ouders te vragen zich in te zetten voor de school van hun kind. Ouders zijn vaker bereid om iets te doen dan scholen soms denken, maar de school moet de vraag om betrokkenheid en participatie wel expliciet maken. Dat vraagt voor sommige scholen om lef, maar het levert dan ook het nodige op. Daarnaast wil ik een appèl doen op ouders om prioriteit te geven aan de ontwikkeling en opvoeding van hun kinderen. Om in deze drukke tijden ten volle verantwoordelijkheid te nemen voor deze belangrijke taak.

In de mentaliteitsverandering bij scholen en ouders wil ik als minister van Onderwijs een voortrekkersrol vervullen. De laatste tijd merk ik ook dat er al veel discussie is over het thema ouderbetrokkenheid. Daarbij gaat het om de volgende vragen. Wat zijn de rollen en verantwoordelijkheden voor de ouders en voor de school? Wat heeft de school nodig in de thuissituatie? Wat hebben ouders nodig van de school? Hoe kunnen scholen op de beste manier het sociaal kapitaal van ouders benutten, die past bij de school en de wijk? Hoe kunnen andere organisaties als gemeentes en opvoedinstituten helpen om ouderbetrokkenheid tot een succes te maken? Hoe kunnen ouders er mede voor zorgen dat leerlingen de leraren met respect behandelen? Vanuit mijn rol zal ik het thema landelijk sterker op de kaart zetten en ga ik met zoveel mogelijk scholen, ouders en andere betrokkenen, zoals gemeentes en opvoedinstituten, het debat aan over ouderbetrokkenheid. Met deze debatten wil ik beter inzicht krijgen in wat er nog meer leeft op scholen en bij ouders, en wat ze nodig hebben om hun verantwoordelijkheid waar te maken.

De acties

Het verbeteren van ouderbetrokkenheid is zoals gezegd niet primair een kwestie van meer geld of regels. Het gaat om een mentaliteitsverandering en om het inschakelen van zoveel mogelijk maatschappelijke organisaties om scholen en ouders te helpen. Daar concentreren de acties zich op. Daarnaast wil ik als minister extra aandacht geven aan het gezag van de leraar.

Dariusz J. Jansen

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29 november 2011

Onze referentie

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Betrekken van maatschappelijke organisaties

Scholen en ouders kunnen alle hulp gebruiken bij het verbeteren van de ouderbetrokkenheid. Naast de acties die ik al eerder in deze brief heb genoemd, zet ik de volgende stappen:

- In de prestatie convenanten met de po- en vo-sector maak ik afspraken om de ouderbetrokkenheid te versterken. Belangrijk doel hierbij is te zorgen dat ouders ondersteunend zijn om het doel uit de actieprogramma's, het allerbeste uit onze kinderen halen, te realiseren.
- In de afspraken van het programmamanagement MBO15 over de voortgang van het Actieplan MBO "Focus op vakmanschap 2011-2015" is er ook aandacht voor het verbeteren van ouderbetrokkenheid.
- Mede door de motie van het lid Biskop bij de behandeling van de Verzuimwet in februari 2011 ben ik in overleg met de MBO Raad en Ingrado over een verzuimaanpak gericht op het beter melden van verzuim door de mbo-instellingen en op een grotere betrokkenheid van ouders.
- Met de landelijke ouderorganisaties heb ik prestatieafspraken gemaakt over het ondersteunen van scholen tot het sluiten van school-ouderovereenkomsten, en bij het betrekken van ouders bij taal- en rekenprestaties.
- Van de Landelijke Pedagogische Centra heb ik gevraagd begin 2012 een overzicht van goede voorbeelden van ouderbetrokkenheid te leveren. Deze voorbeelden komen digitaal beschikbaar en ik zal ze nadrukkelijk onder de aandacht brengen van scholen en ouders.
- Met de partijen in de onderwijsinfrastructuur (schoolbegeleidingsdiensten en uitgevers) ga ik afspraken maken om het vele materiaal dat ze hebben ontwikkeld voor ouderbetrokkenheid, en voor ouders om thuis te helpen bij het onderwijs, transparant te maken voor scholen en ouders.
- In overleg met de kennisinstellingen wil ik een bijzondere leerstoel instellen om robuuste kennis op te bouwen. Deze leerstoel richt zich op ouderbetrokkenheid, en zal verbonden zijn aan de lectoraten op de Pabo's.
- Met de VO-Raad ben ik in gesprek om onder de noemer Schoolkompas een ouderportaal te maken, zodat de gegevens over de kwaliteit van scholen die in Vensters voor Verantwoording staan toegankelijk worden voor ouders. Dezelfde afspraak wil ik ook met de PO-Raad maken, als onderdeel van Vensters Primair Onderwijs.
- In overleg met de Stichting Leraar Leerling Ouders zal worden bekeken wat ik kan doen om het recent door hen gelanceerde keurmerk ouderbetrokkenheid te ondersteunen.

De bovenstaande acties richten zich vooral op de organisaties die direct gelieerd zijn aan het onderwijs. Aan een deel van de uitdagingen op het gebied van ouderbetrokkenheid ligt een bredere problematiek binnen het gezin ten grondslag, en is een bredere samenwerking nodig. In overleg met de maatschappelijke organisaties op die terreinen zal ik bezien of het nodig is om ook hier nadere afspraken te maken.

Het gezag van de leraar

Het herstel van het gezag van de leraar is voor mij een belangrijk onderdeel van de waarden en normen op de school. Ik heb met de sectororganisaties en de vakbonden overleg gehad over wat hiervoor nodig is. Mede op basis van dit gesprek kom ik tot de volgende acties:

- Scholen wil ik stimuleren dat ze in de school-ouderovereenkomsten expliciet aandacht besteden aan de waarden en normen binnen de school, het gezag van de leraar, en aan de omgangsvormen tussen leraar, leerling en ouder.
- In samenwerking met de minister van Veiligheid en Justitie en Binnenlandse Zaken ga ik, in aanvulling op het programma VPT, in kaart brengen waarom de aangiftebereidheid op scholen laag is, en wat gedaan kan worden om dit te verbeteren. Op basis hiervan wil ik afspraken maken met de schoolbesturen om de aangiftebereidheid te verhogen.

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De sociale partners hebben in het genoemde overleg aangegeven dat ze de mogelijke meerwaarde verkennen van een ombudsfunctie voor leraren in de nasleep van geweldsdelicten.

Persoonlijk appèl op ouders en scholen

Vanuit mijn rol als minister van Onderwijs wil ik een persoonlijk appèl doen op ouders om zich in te zetten voor het leerproces hun kinderen, voor de school en voor het respect voor de school en het werk dat daar gedaan wordt. Hiervoor onderneem ik de volgende acties:

- In 2012 maak ik een tour door het land om het debat aan te gaan met alle betrokkenen bij de school en de opvoeding. De gesprekken vinden plaats op de scholen, de plaats waar ouders en scholen samen de schoolgemeenschap vormen.
- Via de social media wil ik het gesprek aangaan over onderwijs en de opvoeding. En over waarden op de school, en de betrokkenheid van ouders daarbij.
- Eind 2012 organiseer ik een conferentie waarin ouderbetrokkenheid centraal staat. De belangrijkste opbrengsten uit de schoolgesprekken, mijn tour door het land, online discussies en goede praktijkvoorbeelden, staan in deze conferentie centraal.

Vanzelfsprekend zal ik de Kamer informeren over de opbrengsten van de debatten en van de conferentie.

Tot slot

Veel ouders en scholen zetten zich dagelijks in voor de ontwikkeling en de opvoeding van hun kinderen en leerlingen, en voor de schoolgemeenschap. Mijn wens is dat alle ouders en alle scholen de handen ineenslaan voor wat hen beiden drijft: de ontwikkeling van de talenten van hun kind of leerling. Hier heeft niet alleen het kind recht op, maar dit is tevens van grote waarde voor de samenleving, nu en in de toekomst.

De minister van Onderwijs, Cultuur en Wetenschap,

Marja van Bijsterveldt-Vllegenthart

APPENDIX 3

Table 1A : *Forms of parental involvement in early learning at home and in community*

Form of parental involvement	Illustrative examples	Prevalence – Inclusive of all groups of parents, fathers and mothers, minority groups?	Research and evaluation findings
Informal at home parenting	<p>Sensitive responsive interactions between parents and children during:</p> <ul style="list-style-type: none"> » personal care, dressing, feeding, washing » playing together » singing songs/rhymes together » playing together, indoors -outdoors » sharing books/reading stories » household chores: preparing food, setting table, cleaning, sorting clothes, gardening » watching TV, DVDs, computer together <p>Walks – outings together: to park, playground, library, shops, kinderboerderij</p> <p>Transfer of norms, attitudes, values such as: motivation, respect, turn taking</p> <p>Parents communication of aspirations for children</p>	<p>Quantity and quality of cognitive stimulation and parental sensitivity related to positive child development. Generally lower in ethnic minority families and lower educated parents. Family stress due to socio-economic disadvantage main cause for difference – not cultural explanations (Mesman, 2010; Mesman et al. forthcoming).</p> <p>Up to 2008 number of poor children in NL falling but economic downturn has led to downturn in this trend. Single-parent families with only young children were relatively most often poor. Risk of long-term poverty also highest among these families + among non-Western households.</p> <p>Immigrant and non-immigrant fathers desire to be more involved in children's upbringing. Barriers identified in some immigrant groups:</p> <p>Chinese fathers working long hours in their restaurants; some Creole fathers not living with their children; average Moroccan father very insistent on breadwinner role – although large variation in Moroccan fathers (Distelbrink et al. 2005 in van de Hoek en Pels, 2008).</p>	<ul style="list-style-type: none"> » Amount of time Dutch parents invest in childrearing doubled in last 30 years. » Childrearing priorities amongst parents are: autonomy, assertiveness, conformity and social feeling . In general no difference between fathers and mothers in these priorities (Gezinsrapport, 2011). » Lower quality of childrearing evident in vulnerable groups: one parent families, lower educated parents, and low income parents (Gezinsrapport, 2011). » 72% parents report talking daily to their primary school going children about school. » 50% parents report reading aloud at least once per week to child. » A third of parents report helping with homework at least once a week (Monitor Ouderbetrokkenheid, Kans et al. 2009)

Form of parental involvement	Illustrative examples	Prevalence – Inclusive of all groups of parents, fathers and mothers, minority groups?	Research and evaluation findings
Non-formal/semi-organised with other parents and children in the community	<p>Meeting up with other parents and children in the playgroundswimming pool</p> <p>Attendance with children at (occasional) community organized play and cultural events:</p> <ul style="list-style-type: none"> » library read books aloud events (free); » family events in museums; » music festivals; » national play day events; » cinekids; theatre. 		
Regular and organized non-formal learning activities in the community	<p>Music, movement, dance classes/groups in community centres, and cultural centres</p> <p>Swimming lessons, sports clubs</p> <p>Primarily focused on children from age 4 years</p>	<p>Poor children less likely to participate in non-formal, extra curricular activities than non-poor children.</p> <p>In 2008 and 2009 Municipalities received extra financial support from government so non-participating children can join sport clubs, attend music lessons. Initiative called: Kinderen Doen Mee</p>	<p>Monitoring report of Kinderen Doen Mee initiative: impact of initiative was much less than envisaged. Non participation reduced by 9% (aim was 50%).</p> <p>Reasons:</p> <ul style="list-style-type: none"> » Parents insufficiently aware of possibilities » Poor children whose parents not on social assistance benefit not fully on radar of local authorities » Children participate less if social participation of parents also low (Roest, 2011)

Table 1B. *Forms of support and interventions for childrearing and parental involvement in early learning at home and in the community*

Forms of support	Illustrative examples	Prevalence	Research and evaluation findings
<p>Informal support for parents (informal network support)</p>	<p>Asking family advice regarding child-rearing and education.</p> <p>Sharing care and education with extended family or friends/ neighbours</p> <p>Sharing experiences with other parents in informal parent networks in parents (mothers) groups, or at school</p>	<p>Low educated parents and parents where neither working receive relatively little informal support from parents/parents-in law, friends, compared to middle and higher educated and working parents (Gezinsrapport, 2011).</p> <p>According to Onderwijsraad (2010) parents involvement in informal parent community not sufficiently developed</p>	<ul style="list-style-type: none"> » Van de Hoek en Pels (2008) note a hybrid form of upbringing amongst immigrant groups. Authoritarian and more 'authoritative' approaches hand-in-hand and continuity remains an important aspect. » Maintenance of culture of origin in host country can be adaptive to parental well-being. More connectedness to the culture of origin does not necessarily lead to less connectedness to the culture of the immigration country (Yaman et al. 2010). » Older children play a part in increasing involvement of first generation mothers – spur them on to learn Dutch, take classes, become more involved in education of their younger children (van der Hoek and Pels, 2008).
<p>Online support from other parents, parents-support networks</p>	<p>Discussion forum pages on Ouders online: www.ouders.nl</p> <p>Other online parenting support for particular groups: www.tiernermoeders.nl www.jongvader.nl</p> <p>www.kopopouders.nl for parents with stress, psychiatric illness or addiction problems.</p>	<p>Ouders Online described as the largest parent community in the Netherlands – 300,000 visitors per month, 30,000 messages on Forum</p>	<p>Young fathers often seek information online (van Lier, 2007). Fewer support advice services available to young fathers, more difficult for them to ask and receive help (Raap and van Coblign, 2009).</p>

Forms of support	Illustrative examples	Prevalence	Research and evaluation findings
Drop-in (professional) advice and helplines in the community	<p>Family Centres (CJG) including Health Clinic 4 core tasks of CJG:</p> <ol style="list-style-type: none"> 1. Signaling, analyzing and referral to more specialized help 2. Support, information and advice to parents 3. Organisation of integrated care 4. Monitoring, screening and vaccination (VNG, 2011) <p>Asking advice from practitioners in daycare, play groups (PSZ), school</p>	<p>In May 2011, 313 (out of total of 421) municipalities had CJG working according to statutory criteria.</p> <p>In most municipalities CJG consists of one or more walk in points plus a back office.</p>	<ul style="list-style-type: none"> » Parents more likely to get upbringing support/advice from kinderopvang, psz and school than from CJG/consultatie bureau/school doctor/social work services (Gezinsrapport, 2011) (See Table 2) » Parents of younger children have more frequent contact with these services for advice and are more satisfied about contact, and have more need for advice (Gezinsrapport, 2011) » Groups of parents who are not receiving sufficient support are: parents with low income, lone parent families and families with young children (Gezinsrapport, 2011).
Parenting courses	<p>Delivered by local welfare organisations and GGD: Focussed primarily on positive behavior management strategies rather than learning and development.</p> <p>Examples: Triple P (Positive parenting programme), a multi-level parenting course which includes both individual parent training and group parenting training.</p> <p>Opvoeden & Zo, easily accessible training for parents of primary school age children</p> <p>Gordon Effective Communication with Children</p>	<p>Triple P on offer in more than 100 municipalities. Only way for professionals to access Triple P materials is through training offered by NJi. In 2010, 155 trainings provided to more than 6,000 people</p> <p>Gordon Parenting Courses available in locations around NL.</p> <p>Cost to parents: €250 for 10 sessions. Some health insurance companies cover part of the costs. Client group primarily middle-class parents</p>	

Forms of support	Illustrative examples	Prevalence	Research and evaluation findings
Home-based parenting support (professional led)	<p>Voorzorg (-9 to 19 months), intended for young, low educated women pregnant with first child. Intervention lasts 2.5 years</p> <p>Stevig Ouderschap (0-18 months) considered a primary prevention programme against child maltreatment.</p> <p>Note: neither of these interventions could be considered as focusing on early learning.</p>	In 2012, 36 Voorzorg nurses operating in 27 municipalities, reaching 352 young women.	<p>Interventions aimed at improving ethnic minority children's well-being should focus both on reducing family stress and enhancing parental sensitivity (Mesman et al. forthcoming).</p> <p>Voorzorg effect study shows that correct group being reached. 98% have 4 or more risk factors. Smoking decreased during pregnancy. At 6 months, more likely to be breastfeeding (14%) compared to control group (6%) (www.voorzorg.info)</p>
Home-based parenting support (para-professional/trained volunteers)	<p>Moeders Informeren Moeders (MIM) (first time mothers, 0 – 18 months)</p> <p>Home Start (one child at least under 6)</p>	<p>In 2010, MIM implemented in 19 locations reaching 844 mothers in total. 64% mothers non-native Dutch. 39% volunteers non-native Dutch. Sometimes delivered in combination with HomeStart (in 5 municipalities) or with Boekenpret (in 2 municipalities)</p> <p>HomeStart implemented in 119 municipalities. 2350 families supported each week involving 4750 children.</p>	<p>MIM 2002 effect study: No significant effects on health or feeding factors. Did have a positive effect on childrearing competencies (Hanrahan, 2002).</p> <p>HomeStart evaluation: positive impact on parental well-being, child-rearing competencies, increase in positive parenting behaviours, decrease in negative parenting behaviours (Asscher, 2005).</p>
Community based parenting support. Parents and Children together	<p>Facilitated (often by Welfare organisations): mother and baby/toddler groups: Example: Moeder-Babygroepen in Overvecht – Cumulus Welzijn – separate groups for Turkish, Dutch and Moroccan communities, and Parent-Child groups (1.5 to 4 yrs) weekly meetings for mothers and children who don't attend any form of centre-based ECEC. www.cumuluswelzijn.nl/BabysPeuters/Voorouders.aspx</p> <p>Teenage parents groups: Jonge Moedergroep, CJG Haarlemmermeer</p> <p>See Case Studies (Part 2) for further examples</p>		Immigrant parents look for support from outside the home, clubs, associations to maintain continuity in values, culture and religion with country of origin (van de Hoek en Pels, 2006).

Forms of support	Illustrative examples	Prevalence	Research and evaluation findings
<p>Home-based play, learning and language/literacy programmes</p> <p>(some of which work as Combination home-based and centre based play and learning programmes)</p>	<p>Approved by NJi as theoretically effective: Instapje (1 year-olds) Opstap (2 – 4 year olds) Opstap (4-6 year olds) Linked to school based Overstap and Stap Door!</p> <p>Jij bent belangrijk Boekenpret (0-6 yrs, focus stimulating parents to read aloud)</p> <p>VVE Thuis (for parents of children attending VVE centre-based programmes)</p> <p>Not yet approved as theoretically effective: Bij de Hand, Rugzaak, Spel aan Huis, Samenspel</p>	<p>These programmes tend to be specifically designed for and targeted at so called 'target group' families (low ses and /or migrant groups).</p> <p>In 2012, NJi estimate that 4,000 to 5,000 families avail of home-based programmes. 58 municipalities support Opstap, 11 support Instapje, and 15 support VVE Thuis (although this number is growing). Smaller numbers are supporting Jij bent belangrijk and Boekenpret.</p>	<p>Critical Learning Community and academic researchers consulted strongly in favour of combination approach. Better coherence and linkages between services around young children (Roetman and Schepers, 2012)</p>

Table 2. Forms of parental involvement in early learning in formal centre-based ECEC settings (daycare, preschool playgroups, pre-schools)

Forms of parental involvement	Illustrative examples	Prevalence – Inclusive of all groups of parents, fathers and mothers, minority groups?	Research and evaluation findings
Daily informal contact	<p>Informal face to face discussions, sharing information about children between parents and practitioners at arrival and home time.</p> <p>Email, sms and telephone contact</p> <p>Recipients of information via newsletters, notices</p> <p>centre website</p>	<p>There has been no national monitoring research regarding parental involvement in centre based ECEC settings (daycare, preschool playgroups, pre-schools). See Case Study reports (Part 3) and Research and evaluation (right side column for further information)</p>	<p>Parents more likely to get upbringing support/advice from kinderopvang, psz and school than from CJG/consultatie bureau/school doctor/social work services (Gezinsrapport, 2011) (See Table 1)</p> <p>Parents differ greatly regarding the kind of interaction they need. Can range from fairly neutral availability of information, to self-help style group discussions on subjects relating to child-rearing, to a range of courses (van der Hoek en Pels, 2008).</p> <p>One sided flow of information from educators to parents failing to meet parents' needs. Little communication with parents about pedagogic methods professionals use, and about parents own views (van der Hoek en Pels, 2008).</p> <p>Little help for immigrant parents for issues and problems they face such as finding the balance between their traditional ways and many demands of the new society (Pels, 2004).</p> <p>Mutual sharing of information regarding children's learning and development between parents and practitioners not evident in study of primary schools in Rotterdam (Smit et al. 2005)</p>
Planned and organized parent and practitioner meetings	<ul style="list-style-type: none"> » Intake meeting » Home visit of practitioner » Developmental/progress meeting » Special room where parents and practitioners can talk <p>Parents asked their views on programme, how they deal with current issues at home</p>		

Forms of parental involvement	Illustrative examples	Prevalence – Inclusive of all groups of parents, fathers and mothers, minority groups?	Research and evaluation findings
Parents participation in centres events	<p>Parents welcome as observers in centre</p> <p>Occasional open days with children</p> <p>Occasional 'festive days' with children</p> <p>Centre based parent talks and information events (ouderavond)</p>		
Parents as volunteers	<p>'Helping hands' on trips, art projects/messy play, reading stories</p> <p>Parents active in organization of events</p> <p>Participation in workgroups</p> <p>Participation in fundraising events</p>		
Parents representing parents in advice and governance	Oudercommissies		<p>Recommendations arising from eQuality-Boink research regarding diversity in Oudercommissie:</p> <ol style="list-style-type: none"> 1. advisability of approaching parents personally re becoming involved in daycare centre 2. Subdividing oudercommissies into Activity, events group and management and governance group.
Parent organized crèches	Creches managed and staff by parents cooperative	<p>Only 6 parent organized crèches in NL, four of them in Wittevrouwenwijk, Utrecht (Huisman, 2011).</p> <p>On 24 Nov. announced that law is being amended so these 6 creches don't have to meet regulations regarding minimum training for staff. From 2013, parents will not be eligible for Kinderopvangtoeslag.</p> <p>http://www.nationaleonderwijsgids.nl/ANP/kov/7845/Oudercreches-mogen-blijven-bestaan</p>	

Table 3. *Forms of parental involvement in early learning in primary school settings*

Form of parental involvement	Illustrative examples	Prevalence – Inclusive of all groups of parents, fathers and mothers, minority groups?	Research and evaluation findings
Daily informal contact	Informal face to face discussions, sharing information about child(ren) between parents and practitioners at arrival and home time (Two-way sharing)		<p>Uneducated parents unable to offer much educational support, because of their lack of knowledge and have a great reverence for teachers' authority and expertise (van de Hoek en Pels, 2008).</p> <p>82% primary schools have a vision for parental involvement. 10% have separate vision document. 37% schools have member of staff responsible for co-ordinating Parental Involvement (Monitor Ouderbetrokkenheid, Kans et al. 2009)</p>
Exchange of written information	<p>Email, sms and telephone contact</p> <p>Parents view/contribute to child's portfolio</p> <p>Parents recipients of information newsletters, notices</p> <p>School website</p>		<p>96% parents report schools inform them about learning progress of their child. Almost 40% parents report receiving written or oral advice about helping children with homework (Monitor Ouderbetrokkenheid, Kans et al. 2009).</p>
Planned and organized parent and teacher meeting	<p>Intake meeting</p> <p>Introductory visit</p> <p>Home visit of practitioner</p> <p>Developmental/progress meeting: 10 minute meetings</p>		
Parents participation in schools events	<p>Opendays</p> <p>Occasional 'festive days'</p> <p>School based parent talks and information events</p>		

Form of parental involvement	Illustrative examples	Prevalence – Inclusive of all groups of parents, fathers and mothers, minority groups?	Research and evaluation findings
Parents as volunteers	<p>'Helping hands' on trips, art projects, reading stories, checking hairlice</p> <p>Parents active in organization of events</p> <p>Participation in workgroups</p> <p>Participation in fundraising events</p>		<p>55% Primary school directors report its important to involve parents in organization of out-of-school events .</p> <p>Almost ¾ of parents report they are active at least once a year in helping out in school events (Monitor Ouderbetrokkenheid, Kans et al. 2009).</p>
Parents as learners	<p>language and literacy interventions:</p> <p>Story Sacks</p> <p>Language classes for parents</p>		
Home-school liaison	<p>Rotterdam –ouderconsulenten operating, strengthening relations between schools, parents and other services. Organise house visits, with present and information folder about all early learning services in neighbourhood. Reach 80% of 2 year olds (see Case Studies, Part 2)</p>	<p>200 ouderconsulenten 150 focus on families with primary school children 50 focus on families with 2 year-olds.</p> <p>Ouderconsulenten in Rotterdam reach 80% of 2 year olds</p>	
Parents to parent contact	<p>Ouderkamer- parent room</p>		
Parents representing parents	<p>Ouderraad MR Ouderplatform/Klankbordgroep (Consultation groups)</p>	<p>Primarily higher educated parents participate in MR and School management board (Monitor Ouderbetrokkenheid, Kans et al. 2009)..</p>	<p>84% Primary schools have ouderraad. 32% Primary schools have Klankbordgroep (Consultation groups) Monitor Ouderbetrokkenheid, Kans et al. 2009).</p>
Research, advice and capacity building of ECEC organisations and primary schools re parental involvement	<p>Relevant organisations:</p> <p>Boink, eQuality, Mutant, Stichting de Meeuw, Sardes, Kleurrijke Scholen, Verwey Jonker Institute, Expertise Centrum Ouder School en Buurt, ITS, Radboud Universiteit</p>	<p>Relevant websites: Ouderbetrokkenheid.nl Oudersbijdeles.nl</p> <p>Relevant Linked-in Group: @ouders, school, buurt</p>	<p>On 30th November 2011, Min. OCW announced the establishment of a Special Professorship on parental involvement (Minister OCW, 2011)</p>



STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Ensuring and coordinating services that support young children's healthy development requires strong and effective partnerships between families and health care providers.

This *State Health Policy Briefing* puts forth a three-part framework for engaging parents in supporting healthy child development: parents engaging with: 1) their child, 2) the services and programs they receive, and 3) the larger systems and policies that govern those services. It describes each level of engagement, explains why each is critical to improving care coordination and services for young children, and gives examples of how states can incorporate parent partnerships into their work. The framework represents a dynamic structure in which the three types of partnership support and inform each other.

State policymakers can use the recommendations to support efforts to engage parents at all three levels of the framework. States can create intentional strategic mechanisms to build on and support each level of engagement by drawing from and connecting each level of parent engagement; inviting parents to represent the experience of broad networks of parents; and creating an extensive infrastructure to support parent leadership.

NATIONAL ACADEMY
for STATE HEALTH POLICY

Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

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Engaging Parents as Partners to Support Early Child Health and Development

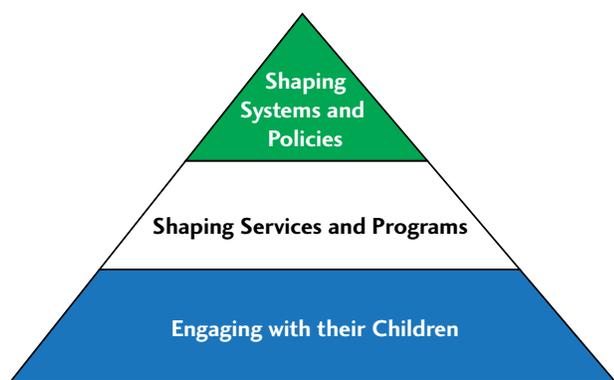
BY NILOFER AHSAN AND JILL ROSENTHAL

WHY DO PARENTS AND PROVIDERS OF PRIMARY CARE AND OTHER CHILD AND FAMILY SERVICES NEED TO PARTNER TO IMPROVE CARE COORDINATION SERVICES FOR YOUNG CHILDREN?

Ensuring and coordinating services that support young children's healthy development requires strong and effective partnerships between families and health care providers. The effectiveness of each provider recommendation and/or referral depends on effective communication with parents, and parents accepting and implementing the advice. Children's health and well-being depends on the day-to-day choices families make. Because a child's health and development is deeply rooted in the environment that the parent creates—the prenatal care they seek, the food they bring into the house, the guidance they provide for children—engaging parents as active partners with providers is essential. Consequently, providing patient and family education to build care-management skills is a critical characteristic of high performance pediatric care coordination.¹

A THREE-PART FRAMEWORK FOR BUILDING PARTNERSHIPS WITH PARENTS

The pyramid on page 2 illustrates a three-part framework for engaging parents in supporting healthy child development. It includes engaging with their child, with the services and programs they and their child receive, and with the larger systems and policies that govern those services and programs.



Level 1—Engaging with their Children: Supporting parents in their parenting role and creating opportunities for them to be involved in decisions about their child’s health and development.

Level 2—Shaping Services: Creating opportunities for parents to actively shape services so that they are parent-centered and approachable.

Level 3—Shaping Systems: Supporting parents’ efforts to shape state policies and systems that promote children’s healthy development and to advise states in their efforts to develop broader systemic improvements.

The remainder of this brief describes each level of engagement, explains why each is critical to efforts to improve care coordination and services for young children, and gives examples of how states engaged in these initiatives can incorporate parent partnerships into their work.

LEVEL I: PARENTS EFFECTIVELY ENGAGED WITH THEIR CHILDREN

WHAT IS IT?

The foundation for partnering with parents is enhancing their engagement in their child’s health and development. Parents can be supported in a number of health-related functions including:

- Involvement in decision-making about their child’s health care—e.g. choosing and accessing services for their child, expressing needs and perspectives during care visits
- Engagement in activities that help to promote child health and development—e.g. reading and playing with their child, preparing healthy meals, modeling positive health behaviors
- Knowledge and awareness of their child’s needs—e.g. understanding child development, communication with their child, understanding how to motivate their child

- Ability to reflect on and understand their ability to influence and promote their child’s health and development

WHY IS IT IMPORTANT?

At the heart of a parent’s ability to positively impact their child’s health and development is their relationship with their child.

- If parents understand where their children are developmentally, are sensitive to the children’s needs, and are tuned in when problems arise, the parents can be more effective partners in helping ensure that children get the services they need. Parents also will have the ability to communicate more effectively about their children’s health and development issues.
- Understanding the link between children’s health and their physical, social and emotional development, and the importance of intervening with problems as early as possible, can help parents understand the need to follow up on provider referrals.
- Evolving research shows that very simple aspects of parenting—how often a parent holds or touches an infant, the amount of eye contact and affirmative responses parents give, and the level of conflict within the household—can have a profound impact on a child’s health and development.
- It is often a parent’s connection to their child that motivates them to try to improve the services and systems their child needs.

HOW TO GO ABOUT IT

Primary care and other child and family service provider settings can support parents’ engagement with their child by:

- Supporting parents as active decision makers in care planning including setting aside time to explain any health and developmental concerns to them, assuring parents understand the information provided, being clear about decisions that need to be made and connecting them to other resources they can use to inform their decision.
- Modeling important skills; providing interactive anticipatory guidance; having tip sheets and information available that explain different health or development issues and provide ideas, actions and at-home activities that parents can take to support their children.
- Structuring the waiting room to ensure that there is a play space and toys that encourage parent and child interaction; for example, have children’s books and ideas for activities that parents can do with their kids while waiting.

- Providing space and resources for support groups for parents of children with similar health and development issues.
- Training staff members how to reach out to parents, talk with a parent about difficult issues, and communicate effectively with parents.²
- Distributing and providing assistance with parent-administered developmental, behavioral and other health screening tools.

State policymakers can support efforts to assist primary care providers in engaging parents through a variety of mechanisms, including:

- Clarifying existing or establishing new policies, changing claims processing systems or managed care contracts, and updating provider handbooks to recommend or require the use of parent-administered developmental, behavioral, and other health screening tools.
- Providing incentives for providers to engage parents in their practices, such as reimbursement for using parent-administered screening tools.
- Using and reimbursing local health department staff for providing materials and in-service staff training to health care providers, aimed at assisting families in the appropriate use of children's health services under the EPSDT benefit.
- Supporting efforts to help engage parents, through mechanisms such as parent and community cafés, described on page 3.

LEVEL 2: PARENTS SHAPING SERVICES

WHAT IS IT?

Parents who are engaged consumers actively participate in the programs that serve them and their children. There are many ways this can manifest itself. In addition to active participation in program services (preparing questions in advance, arriving on time, engaging with staff, taking part in decision making about services, following-up on referrals and giving feedback to the service provider even when it has not been solicited), they also belong to the larger community within the program by:

- Volunteering within the program—or otherwise contributing by donating resources and/or time
- Participating in social events and other activities that bring together program participants
- Participating in advisory or leadership boards or other decision-making structures within the program

- Helping advocate for the program
- Mentoring or providing support to other program participants

Clearly not every parent will participate in each of these ways. For most parents, it is sufficient if they are actively engaged in the ways described in the first point. Providers and program administrators alike can promote multiple opportunities for improving consumer engagement, including creating a culture where parental involvement is reinforced as a shared value across program participants.

WHY IS IT IMPORTANT?

- Partnering with parents improves service delivery. Parents who are engaged are more likely to provide accurate information and discuss sensitive issues that can help inform service planning. They are more likely to follow advice and complete referrals. They are also more likely to engage with services in a genuine way, heightening the impact of the intervention.
- Creating opportunities for parents to serve in leadership and decision-making roles at the program level and providing regular and structured input helps ensure that the program has useful and accurate information about what timing, structure, and type of services families would be most likely to use, and can identify barriers to effective care.
- Engaging parents as partners can also have positive benefits for them as well as for their children. Headstart has numerous examples of the transformative impact of participating in parent leadership councils. Similarly, success breeds success. Parents who feel more confident about themselves as a result of actively partnering with their child's service providers can transfer that sense of effectiveness to other venues.

HOW TO GO ABOUT IT

Explain why: To help parents feel valued as partners in shaping the delivery of services and supports that children receive, providers must dedicate time to explain developmental concerns, why any proposed services are important, and how the services will help the parent promote their child's health and development. Other programs have used parents as ambassadors to explain from their own experience why a developmental delay is important to address early and how the service has affected their own lives.

Present choices: Make sure that there are multiple options for parents to engage with programs that are part of their child's care plan. Choices allow parents to identify ways to participate that fit their schedules, interests and skills.

PARENT CAFÉS AND COMMUNITY CAFÉS: EXAMPLE OF LEVEL 1

Strengthening Families is a national initiative that engages programs working directly with children and families in building five, research-based, protective factors that have been found to be linked to the reduction of child abuse and neglect and children's optimal development. Parent and Community Cafés are an important tool used in many Strengthening Families states for directly engaging parents in building protective factors for themselves and their families. Adapted from the World Café, Parent Cafés and Community Cafés are structured small group conversations that bring parents together to discuss issues that are important to them.

Parents are invited to join conversations at Café Tables set up to host an intimate conversation. A casual café environment is created by limiting the participants to six to eight to a table and including food, tablecloths, flowers and other accessories to create a informal nature for the conversation. A parent leader trained in hosting café conversations leads each table.

Carefully crafted questions guide the conversation. Each group spends a short period on a particular question and then joins a new table for a second question. Table hosts convey the key points from the previous group's conversation to help each conversation build on the previous discussion. Generally a total of three inter-related questions are used.

In many cases, cafés are offered in series instead of a one-time event. Café series provide an opportunity for parents to build relationships over time, and to engage in thinking in a deeper and ongoing way about a particular issue.

A number of states have used the café process to engage a broad range of parent leaders who have been trained as café hosts, but also manage and lead the larger café process in the state.

WHY CAFÉS ARE EFFECTIVE TOOLS FOR PARENT ENGAGEMENT:

The intimacy of the conversation and parent leadership help create a level of candor that might not be achieved in a standard focus group or other feedback or input process.

The careful structuring of the questions and the iterative nature of the conversation in which groups reflect on previous group discussion help to create a structure for synthesizing knowledge across individual experience.

The infrastructure that has been developed around cafés in states has been an important tool for developing parent

leadership at the state level. Parents that have been trained as Café hosts feel that they have an area of expertise and a skill base that gives them confidence in leadership roles. The very act of hosting conversations with other parents helps to create a knowledge base for café hosts that is much broader than their own individual experience. This makes them valuable contributors in planning processes.

HOW ABCD SITES CAN USE PARENT CAFÉS

Arkansas has developed guidelines for Community Cafés that describe Cafes, their purpose, what the state agency will provide, and responsibilities of Café hosts. The Arkansas ABCD project plans to adapt its Community Café model to conduct Cafés in its ABCD pilot sites. The Cafés in these sites will focus on developmental screening, referrals, follow up and linkages to community services.

At this level of parent engagement, the focus is on enhancing the parent's role in supporting the health and development of their child. The following questions would help in understanding how parents view their own role regarding their child's health and development and what parents feel they need (both in terms of barriers to overcome and in terms of resources in their community) to more effectively support their child's development. These questions could help inform thinking about what linkages are needed to support parents as active agents in their child's healthy development.

Questions that may be considered in designing a Café about care coordination and linkages to services include:

- What does healthy development mean for you and your child?
- What stands in your way in terms of supporting your child's healthy development?
- What do you do on a day-to-day basis to keep your child healthy?
- How could your community be more supportive of healthy child development?

RESOURCES TO LEARN MORE:

To learn more about World Cafés: <http://theworldcafe.com/>

To learn more about Parent Cafés: http://www.strengtheningfamiliesillinois.org/index.php/line/category/parent_cafe/

To learn more about Community Cafés: https://www.msu.edu/user/nactpf/initiative_parents-2.htm

Create a culture of engagement: Voice the desire and expectation that parents be engaged. Early and frequent communication about the value and options for consumer engagement is critical. Celebrating parent contributions publicly helps to send the message that parents are valued contributors. Parents are often the best ambassadors for a practice or program. Encourage parents to reach out to others and provide them with opportunities and tools to describe the options and benefits of engagement.

State policymakers can support efforts to engage parents in shaping services in a variety of ways, including:

- Requiring that practices that serve as medical homes develop parent advisory committees or include family members on practice leadership teams.
- Linking practices to Family-to-Family Health Information and Education Centers.³
- Supporting parent practice consultants through efforts such as Rhode Island's Pediatric Practice Enhancement Project (PPEP), described below.

LEVEL 3: PARENTS SHAPING POLICIES AND SYSTEMS

WHAT IS IT?

Parents can play a leadership role in shaping systems and initiatives that are broader than the day-to-day services in which they and their families participate. They may serve on a statewide leadership team for a particular initiative, actively engage in a parent or consumer advocacy group or provide testimony in hearings or other deliberations on policies that affect children and families. At this level, parents are asked to extend their involvement beyond their own personal experience to represent the interests of a much broader constituency, thus informing and shaping important policy improvements relevant to their child's care.

WHY IS IT IMPORTANT?

Engaging those most affected in decision-making about policies and systems is crucial for ensuring that services and systems are responsive to the needs of families and structured in a way that will truly support families. Too often decisions about families are made without family representation. The well worn phrase, "Nothing about me without me" applies.

RHODE ISLAND'S PEDIATRIC PRACTICE ENHANCEMENT PROJECT (PPEP): EXAMPLE OF LEVEL 2

Rhode Island's Pediatric Practice Enhancement Project (PPEP) is a partnership between the Rhode Island Department of Health and Department of Human Services, the state's chapter of the American Academy of Pediatrics, the Rhode Island Parent Information Network/Family Voices, and the Neighborhood Health Plan of Rhode Island. It places and supports specially trained parent consultants in pediatric primary and specialty care practices that serve large numbers of children with special health care needs and their families.

Parent consultants help physicians provide comprehensive medical homes, which support both families and practitioners. They link families with community resources, help providers and families get specialty services and identify systems barriers to coordinated care. Each parent consultant works 20 hours per week in a participating medical practice. When a provider learns or suspects that a patient has needs beyond the medical scope of the practice, the family is referred to the parent consultant. The parent consultant talks with the family regarding the family's concerns and develops a plan to address the family's needs. These needs could include resource identification; community referrals for social, developmental or mental health services; links with the education system; eligibility or application assistance for health

insurance, nutrition, or housing services; navigation across services; and peer-to-peer support. Parent consultants call families to confirm that they make appointments and ensure they know what to expect when they arrive for a service. Families are served regardless of insurance status. Parent consultants also educate practice staff about state and community-based programs and services.

A 2008–2009 evaluation suggests that PPEP may result in more early interactions with the health care system, preventing costly interactions later. On average, PPEP children had fewer outpatient visits, emergency visits, and hospital stays when compared to the same children prior to PPEP; and PPEP children had more outpatient visits and less hospital stays when compared to a control group. PPEP children have less costly health care than both control groups and slightly more emergency room visits, but fewer hospital stays.* As a result of these cost savings, the Department of Health is working with health plans that want to become Medicaid providers to pay for peer navigators as a cost reduction strategy, providing a source of sustainability for PPEP.

* Sharon Silow-Carroll, "Rhode Island's Pediatric Practice Enhancement Project: Parents Helping Parents and Practitioners," (New York, NY: The Commonwealth Fund April 2009). Pub. 1361, Vol. 36, http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2010/Jan/1361_SilowCarroll_Rhode_Island_PPEP_case_study.pdf. Retrieved May 26, 2010.

Parental involvement helps identify barriers and strategies and is likely to result in overall system improvements.

HOW TO GO ABOUT IT

States are engaged in a variety of strategies designed to engage parents as leaders. Parents are members of many state policymaking advisory boards, including Medicaid Medical Care Advisory Committees, Maternal and Child Health advisory councils, and Early Intervention Interagency Coordinating Councils. They also have opportunities to review and comment on proposed rules and to lobby state legislatures. However, they face many challenges, including dedicating time and resources to follow all of the intricacies of state policies and policymaking. For example, Strengthening Families began by mandating that states engage parent leaders on their statewide leadership teams. In an initial two-year state pilot the program found that states struggled to attract and retain parents within their state level leadership teams. Most states had high turnover in the parent representative positions. The parent leadership efforts are robust in a minority of states. Illinois, New Jersey and Washington have each pioneered a sophisticated infrastructure for supporting parent leadership at multiple levels. The strategies these states have developed are now transforming how other states are approaching the work. Lessons from these states include:

- *Draw from the other levels of the pyramid.* Leadership at the state or initiative level cannot be divorced from engagement in the other levels discussed in this brief. States

with robust leadership efforts draw from a cadre of leaders that are being developed through their parent café efforts, leadership training institutes, or through structured efforts to attract leaders from operating programs.⁴

- *Invite parent leaders who have experiences that connect them to and give them insight into the experiences of a broad range of parents.* When parent leaders are connected to a broader effort, they can bring a specific expertise that is grounded not only in their own experiences but also in their conversations and experiences with other parents. For example, in states that attracted leaders through their parent café or community café process, café hosts can speak not only from their own experience but from lessons learned through structured dialogues with other parent leaders. The role of parent leaders is not to represent their own experience within state leadership teams, but rather to represent the experience of the broader networks of parents that are affected by the issue. Similarly, parents that participate in statewide advocacy groups, parent support networks, or parent-led organizations often are engaged in structured activities that allow them to hear from and represent the voices of a broad range of parents.
- *Don't only invite parents to share their own story.* While sharing a personal story can be powerful within the context of state policymaking, asking parents in leadership positions to “tell their story,” can also create a challeng-

COLORADO MEDICAL HOMES INITIATIVE: EXAMPLE OF LEVEL 3

Colorado's Medical Home Initiative is a joint effort of Colorado's Department of Public Health and Environment, the Department of Health Care Policy and Financing and community stakeholders to ensure that, as required by law, every Colorado child enrolled in Medicaid or the CHP+ have access to a medical home by 2010. Colorado, being part of the NICHQ Medical Home project, has continued to expect parent involvement in all aspects of the program. Colorado Medicaid has hired parents to complete the Medical Home Indices with practices and parents to measure the extent of compliance with medical home principles and parent satisfaction. They have also been hired to be the front line staff for technical assistance to practices. Families are integral to the medical home concept as leaders and partners within the community as well.

Family Voices Colorado provides information for health care providers and families; referral resources; advocacy support; training; and systems change support. Family Voices Colorado was involved in the development and manages a certification process for primary care providers based on the Medical Home Index. The group also engages in family leadership development and makes family navigators available to assist families in negotiating the medical home system.

The Colorado Family Leadership Task Force is dedicated to assuring that the Colorado Medical Home Initiative is culturally responsive and family-centered. By engaging the expertise of family leaders from across Colorado, the task force ensures that a family perspective is considered at all levels of medical home implementation. The task force is committed to developing strong family leaders who participate in policy and systems change efforts to assure children's health care quality. This task force currently is working on the development of a Family Leadership registry and exploring leadership curricula that promote strong civic engagement.

ing environment for them. The expertise they are asked to contribute requires a level of self-disclosure that many would find difficult (and undercutting) in a professional environment. Parent leaders should never be pressed to share their own personal story unless they are comfortable doing so. Some parent advocacy groups assist parents in limit setting—clarifying what parts of their story they are comfortable sharing and what they want to hold private. Most importantly, parents should be treated as active participants in the decision-making process—above and beyond the story they have to tell.

- *Create a larger infrastructure to support parent leadership efforts.* To be effective partners in state or initiative-wide efforts parents need training, support and opportunities to interact with other parent leaders as well as resources to resolve the demands that leadership involvement makes on their work and family lives. Parent leadership organizations such as Family Voices and Voices for America's Children, and programs of the Family-to-Family Health Information and Education Centers, and Center for Study of Social Policy provide resources on which to draw.

State policymakers can support efforts to engage parents in policy and systems changes by enacting family-centered policies, and ensuring that parents are partners in shaping systems. States can require that children have functioning medical homes, and can include within medical home initiatives strategies that encourage practices to be child- and family-centered. These can include parent satisfaction measures, support for parent leadership development, and parent compensation for involvement. Colorado's Medical Homes Initiative, described on page 6, provides an example.

HOW THE THREE TYPES OF PARTNERSHIP SUPPORT AND INFORM EACH OTHER

The pyramid does not represent three alternate strategies for parent partnership, but rather a dynamic structure in which the three types of partnership support and inform each other. As mentioned above, effective leadership within state or initiative-wide efforts often is more successful with a base built from both parent and consumer engagement efforts. The reverse is also true; efforts to engage parents in their children's care are supported by

PUTTING THE PIECES TOGETHER: PARENT PARTNERSHIPS IN RHODE ISLAND

The Pediatric Practice Enhancement Project (PPEP), described earlier, is a Medical Home initiative of the RI Department of Health and a project implemented by the Rhode Island Parent Information Network (RIPIN). Parent consultants complete project paperwork, which is entered into a data system developed and maintained by the Rhode Island Department of Health. The Department of Health administers PPEP and is responsible for the project's financial management, data and evaluation, and communication with participating physicians and practices. Staff at the department generate periodic reports and present the information to each PPEP site quarterly so physicians and staff can learn how many of their patients and families have been served, major issues and concerns, and whether problems were resolved. The PPEP database helps identify system-wide barriers facing families trying to obtain appropriate care for their children. The Family Voices leadership team functions as the PPEP steering committee and includes representatives of state agencies (human services, education, and health) and community stakeholders. The leadership team meets monthly to review the barriers identified through the PPEP database.

The department contracts with the Rhode Island Parent Information Network, which includes Family Voices, to hire, train, and supervise the parent consultants. RIPIN provides information, support, and training to help all Rhode Islanders become their own best advocates in

school, health care, care, and other settings. RIPIN has cultivated and supported its Peer-to-Peer Support Model for a variety of settings and topic areas. For example:

- The Rhode Island State Parent Training and Information Center and Parent Information Resource Center has Family Involvement Specialists and Family/School Liaisons who take calls from parents, families, and professionals and provides technical assistance to schools on a wide variety of topics.
- All Early Intervention sites include at least one parent on their team, who is hired and supported by RIPIN.
- Family Voices within RIPIN provides healthcare information, family to family health information and support, and leadership development related to health insurance and policy issues for families of children with special healthcare needs.
- RIPIN's Statewide Resource Center is staffed by multiple programs to holistically address the complex needs of families seeking support.

RIPIN provides empowering experiences so parents can advocate for their own children; learn to help other parents and families; shape services systems; and have a voice in policy. RIPIN's architecture and the state's broad commitment to parent leadership have helped make PEPP a success as a medical home initiative that provides enhancement services in a high quality and cost effective manner.

services and policies that are developed with parent input to facilitate parent engagement. Creating opportunities for input both at the program and system level can help all stakeholders jointly design strategies that are truly effective at meeting parents' needs and most likely to further promote healthy child development.

Rhode Island's Pediatric Practice Enhancement Project (PEPP) described earlier provides an example of a state initiative that supports the three types of parent partnerships, and the synergy created in doing so. Parents who are involved in PEPP are engaged with their children, as parent consultants to practices, and in informing state policymaking. The infrastructure created to support parent leadership supports not only PEPP, but also a multifaceted parent engagement, as described on page 7.

RECOMMENDATIONS

State policymakers can support efforts at all three levels of the framework for parent engagement.

Level 1: Assist primary care providers in engaging parents:

- Clarify policies to recommend or require the use of parent-administered developmental, behavioral, and other health screening tools;
- Provide incentives for providers to engage parents in their practices, such as reimbursement for using parent-administered screening tools;
- Use and reimburse local health department staff to provide materials and in-service staff training; and
- Support efforts to help engage parents, through mechanisms such as parent and community cafés.

Level 2: Support efforts to engage parents in shaping services:

- Support parent advisory committees or parents on practice leadership teams;
- Link practices to Family-to-Family Health Information and Education Centers and leadership training opportunities; and
- Support parent practice consultants.

Level 3: Support efforts to engage parents in policy and systems changes:

- Enact family-centered policies, including medical home initiatives;
- Call on parent leadership organizations to help identify parents for state policymaking advisory boards; and
- Include within medical home initiatives strategies that encourage practices to be child and family centered, such as parent satisfaction measures, support for parent leadership development, and parent compensation for involvement.

Finally, states can create intentional strategic mechanisms to build on and support each level of engagement by:

- Drawing from and connecting each level of parent engagement;
- Inviting parents to represent the experience of broad networks of parents; and
- Creating a broad infrastructure to support parent leadership through training, support and opportunities to interact with other parent leaders; and resources to resolve the demands that leadership involvement makes on their work and family lives to be effective partners in state or initiative-wide efforts.

ABOUT THE ABCD PROGRAM

Since 2000, the National Academy for State Health Policy (NASHP) has administered the Assuring Better Child Health and Development (ABCD) program. From 2000-2003 and 2003-2006 NASHP administered two 3-year, multi-state learning collaboratives to develop and test Medicaid-based models for improving the delivery of early child development services to low-income children and their families by strengthening primary health care services and systems. A total of eight states participated in the collaboratives. From 2007-2008 NASHP administered the ABCD Screening Academy. Nineteen states, Puerto Rico and the District of Columbia participated. With NASHP support they worked to develop and implement policy improvements designed to promote, support, and spread the use of a standardized

developmental screening tool as part of regular well-child care. Screening Academy members also supported selected primary care practices' efforts to incorporate standardized developmental screening tools into regular well child care—and continue to work to spread those improvements to other practices within their state. In 2009 NASHP initiated ABCD III, which includes a multi-state learning collaborative of five states designed to develop and test sustainable models for improving care coordination and linkages between pediatric primary care providers and other providers who support children's healthy development.

ABCD Resource Center:

<http://www.nashp.org/abcd-welcome>

ABOUT STRENGTHENING FAMILIES

The information in this policy brief is grounded in the experience of Strengthening Families, a national initiative that engages programs working directly with children and families in building five, research-based, protective factors that have been found to be linked to the reduction of child abuse and neglect and children’s optimal development. Currently over half of all states are part of the Strengthening Families National Network. Strengthening Families parent engagement strategies have focused on multiple levels:

- Helping programs on the ground shift program structure and worker practice to make them more welcoming environments for parents.
- Convening thousands of parent-to-parent conversations regarding the protective factors and why they are important in parents lives.
- Supporting parent engagement in the self-assessment and decision-making structure at the program level.
- Emphasizing parent engagement and partnership in work with state level leadership teams.

Over the past nine years Strengthening Families has learned a lot—some about what works to build authentic parent engagement, and some about what doesn’t work.

Strengthening Families: <http://www.strengtheningfamilies.net/>

ENDNOTES

- 1 R. C. Antonelli, J. W. McAllister, and J. Popp, Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework, The Commonwealth Fund, May 2009, retrieved May 20, 2010. http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/May/Making%20Care%20Coordination%20a%20Critical%20Component/1277_Antonelli_making_care_coordination_critical_FINAL.pdf. Retrieved May 26, 2010
- 2 Strengthening Families has created a self-assessment tool that programs can use to assess their program structure and day-to-day practice and make small but significant changes in practice. This self-assessment tool can be downloaded at www.strengtheningfamilies.net and is appropriate across child and family serving settings. Brazelton Touchpoints provides training, technical assistance, and consultation to early childhood educators, early interventionists, and health care and social service providers to create strong partnerships with families of young children and change the way families are served, <http://www.touchpoints.org/index.html>. Retrieved May 26, 2010
- 3 Family-to-Family Health Information and Education Centers (F2F HICs) are family-led organizations that seek to ensure that families of children with special needs have access to adequate information about health care and community resources in order to make informed decisions. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal Child Health Bureau (MCHB) provides the primary funding support. Family Voices provides training and technical assistance to F2F HICs, <http://www.familyvoices.org/info/ncfpp/f2fhic.php> Retrieved May 26, 2010
- 4 The Connecticut’s The Parent Leadership Training Institute (PLTI) provides one example, http://www.cga.ct.gov/COC/plti_about.htm. Retrieved May 26, 2010

NATIONAL ACADEMY for STATE HEALTH POLICY

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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Section Three: Research Support for Evidence-based Engagement Interventions from related Child Serving Systems

Engaging Families into Child Mental Health Treatment: Updates and Special Considerations

Geetha Gopalan LCSW, PhD¹; Leah Goldstein LMSW¹; Kathryn Klingenstein²; Carolyn Sicher Psy.D¹; Clair Blake BA¹; Mary M. McKay LCSW, PhD¹

Abstract

Objective: The current paper reviews recent findings regarding how to conceptualize engagement and factors influencing engagement, treatment attendance rates, and interventions that work. **Method:** Research related to the definition of engagement, predictors of engagement and treatment termination, attendance rates, and engaging interventions are summarized as an update to the McKay and Bannon (2004) review. **Results:** Despite ongoing advances in evidence-based treatments and dissemination strategies, engaging families into mental health treatment remains a serious challenge. Within the last several years, a number of technological advances and interventions have emerged to address this problem. Families with children who present disruptive behavior challenges and symptoms of trauma are considered in terms of the unique barriers they experience regarding engagement in treatment. **Conclusions:** Potential solutions to increase treatment utilization and further research in this area are discussed.

Key words: *engagement, child mental health treatment, service utilization*

Résumé

Objectif: Réviser les récentes conclusions sur la manière de représenter l'engagement des familles; analyser les facteurs qui influent sur cet engagement, sur le respect du traitement; présenter des interventions efficaces. **Méthodologie:** Les travaux de recherche portant sur la définition de l'engagement, les prédicteurs de l'engagement, la décision de mettre fin au traitement, le taux de participation et les interventions sont présentés, résumés, sous forme d'actualisation de l'étude de McKay and Bannon (2004). **Résultats:** Bien que les traitements factuels et la diffusion de l'information progressent constamment, faire participer les familles au traitement des enfants atteints de maladie mentale reste un défi de taille. Au cours des dernières années, les progrès techniques et les interventions ont permis de résoudre de problème. L'étude porte notamment sur les obstacles cliniques particuliers auxquels se heurtent les familles qui participent au traitement d'enfants qui présentent des troubles du comportement et des traumatismes. **Conclusion:** L'article présente les solutions susceptibles d'améliorer la mise en place du traitement et propose des pistes pour la recherche future.

Mots clés: *engagement, traitement troubles mentaux, enfants, utilisation des services*

Introduction

Engaging families in child mental health treatment remains challenging despite continuing advances in evidence-based treatment approaches and efforts to disseminate these practices into the field (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Over the last three decades, rates of child psychopathology in the United States have ranged from 17–26% (Brandenburg, Friedman & Silver, 1990; Costello et al. 1996; Costello, Egger, & Angold, 2005; McCabe et al., 1999; Tuma, 1989; U.S. Public Health Service, 2000), with approximately 1 in

8 children manifesting a psychiatric disorder serious enough to cause significant functional impairment (Costello et al., 2005). This problem is particularly exacerbated in low-income, urban communities, where children are exposed to poverty, community violence and trauma, high rates of psychosocial stress, as well as insufficient housing, health, and mental health resources (Attar, Guerra, & Tolan, 1994; Gustafsson, Larsson, Nelson, & Gustafsson, 2009; Ingoldsby & Shaw, 2002; Jenkins, Wang & Turner, 2009; Leventhal & Brooks-Gunn, 2000; Self-Brown et al., 2006; Siefert, Finlayson, Williams, Delva, & Ismail, 2007).

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These environmental factors render children more vulnerable to developing mental health problems. Not surprisingly, rates of child psychopathology in low-income inner-city settings have been found to be as high as 40% (Tolan & Henry, 1996; Xue, Leventhal, Brooks-Gunn & Earls, 2005). At the same time, the National Institute of Mental Health (2001) reports that approximately 75% of children with mental health needs do not have contact with the child mental health service system. As challenges in meeting children's mental health needs persist, national efforts to encourage improved children's access to treatment continue (New Freedom Commission on Mental Health, 2003).

In response, McKay and Bannon's 2004 review focused on empirically supported factors related to engaging families in child mental health treatment. The current paper serves as an update to the 2004 review, as new knowledge has emerged over the last 6 years regarding the definition of engagement, rates of treatment attendance, predictors of engagement, barriers, and engagement interventions. Additionally, as little information has focused specifically on the unique needs of clinical sub-populations, this paper also summarizes issues related to engaging families whose children manifest disruptive behavior disorders and symptoms of trauma. Finally, recent findings are used in a discussion of implications for research and clinical practice.

Definition of Engagement

As indicated by McKay and Bannon (2004), engagement generally encompasses a multi-phase process beginning with (1) recognition of children's mental health problems by parents, teachers, or other important adults; (2) connecting children and their families with a mental health resource; and (3) children being brought to mental health centers or being seen by school-based mental health providers (Laitinen-Krispijn, Van der Ende, Wierdsma & Verhulst, 1999; Zwaanswijk, van der Ende, Verhaak, Bensing, & Verhulst., 2003; Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst., 2003). Engagement can also be measured by (Step 1) rates of attendance at the initial intake appointment with a mental health provider, as well as (Step 2) retention in treatment over time. Each of these steps in the engagement process is related to the other. However, rates of engagement, as well as associated child, family, and service system characteristics differ between steps 1 and 2 (McKay & Bannon, 2004). Moreover, Alan Kazdin's work at the Yale Child Study Center argues for a more nuanced definition of service engagement into distinct phases, whereby children exit treatment at diverse points (i.e., while waiting for treatment, after 1–2 sessions, or later in treatment; Kazdin, Holland, & Crowley, 1997; Kazdin & Mazurick, 1994; Kazdin, Mazurick, & Siegal, 1994). Kazdin and Mazurick (1994) further noted that characteristics of children and families vary as a function of the point in time at which they exit services.

More recently, however, Johnson, Mellor and Brann (2008) argued that categorizing drop-outs by the number of sessions

attended can be misleading, as each treatment program requires a different number of treatment sessions to reach completion. Moreover, appropriate termination may occur after only a few sessions, particularly as many clinics limit the number of sessions offered. Instead, Johnson et al. (2008) assert that a more appropriate method for defining dropout rates utilizes the treating therapists' judgment regarding the appropriateness of treatment termination. As a result, inappropriate termination, or dropout, occurs when the therapist believes further treatment is needed while the client explicitly states they wish to discontinue treatment or fails to attend follow-up appointments. Treatment completion occurs when there is no further need for treatment, when the treatment program has been completed, and/or when both the therapist and family agree to terminating treatment.

While attendance is necessary for treatment to be delivered and for outcomes to be attained, many studies maintain that session attendance alone does not effectively describe treatment engagement. More recently, a review by Staudt (2007) emphasizes the importance of differentiating between the behavioral and attitudinal components of engagement. The behavioral component includes attendance, as well as other tasks performed by clients considered necessary to implement treatment recommendations and attain desired outcomes. Such behaviors can include participation in sessions (e.g., talking about relevant topics, practicing new skills), completion of homework assignments, demonstration of progress towards goals, discussing feelings, and engaging in efforts outside of sessions (Cunningham & Henggeler, 1999; Hansen & Warner, 1994; Prinz & Miller, 1991; Staudt, 2007). In relation to attitudes, engagement also refers to the emotional investment and commitment to treatment resulting from clients' belief that treatment is worthwhile and beneficial (Staudt, 2007; Yatchmenoff, 2005). The distinction between behavioral and attitudinal components of engagement is significant, given that many clients attend mental health treatment and other services in a perfunctory manner without ever fully investing in the therapeutic enterprise (Staudt, 2007; Staudt, Scheuler-Whitaker & Hinterlong, 2001).

Attendance at Initial Intake Appointments and Ongoing Treatment Retention

Currently, engagement in mental health care continues to be measured primarily by attendance at treatment sessions. McKay & Bannon (2004) indicated that no-show rates for initial intake appointments ranged from 48% (Harrison, McKay & Bannon, 2004) to 62% (McKay, McCadam, & Gonzales, 1996). More recently, McKay, Lynn and Bannon (2005) reported on attendance rates for 95 caregivers and children seeking treatment in an urban child mental health clinic. Among those who made an initial appointment via a telephone intake system, 28% of children accepted for services never attended an initial face-to-face intake appointment. Consequently, even conservative estimates

indicate that close to 1/3 of children and their families fail to engage at the initial face-to-face intake appointment.

It is not uncommon for length of treatment to average 3–4 sessions in urban, low-income communities (McKay, Harrison, Gonzales, Kim & Quintana, 2002). Studies from across the country estimate that 40% to 60% of children receiving outpatient mental health services attend few sessions and drop out quickly (Andrade, Lambert & Bickman, 2000; Burns et al., 1995; DeBar, Clarke, O'Connor & Nichols, 2001; Goldston et al., 2003; Kazdin & Mazurick, 1994; Lavigne et al., 1998). McKay et al. (2005) found that at the end of 12 weeks, only 9% of children remained in treatment in urban inner-city clinics. Similarly, a national study of private insurance recipients found that children and adolescents averaged 3.9 mental health visits within a six month period, with an average length of stay of less than three months (Harpaz-Rotem, Leslie & Rosenheck, 2004). However, mean number of visits and length of stay varied as a function of age, diagnosis, service setting, provider type, and insurance plan. A recent study of treatment attendance at publicly funded, community-based outpatient child mental health centers in San Diego County indicated that children attended an average of 13.8 treatment sessions (Brookman-Fraze, Haine, Gabayan & Garland, 2008). While this number is substantially higher than the average 3–4 sessions reported in mental health clinics in urban, inner-city communities (McKay et al., 2002), this discrepancy likely reflects the differing characteristics associated with service engagement between a predominantly urban, low-income setting (e.g., McKay et al., 2002) and a more heterogeneous mix of families from different socioeconomic and geographic circumstances (e.g., Brookman-Fraze et al., 2008).

Predictors of Engagement

In considering the factors affecting engagement rates, McKay & Bannon (2004) reported on associated child and family level characteristics. At the child level, males are more likely to be referred and use more services compared to females (Griffin, Cicchetti, & Leaf, 1993; Padgett, Patrick, Burns, Schlesinger & Cohen, 1993). However, this disparity in service use rates by gender decreases as children get older (Griffin et al., 1993; Wise, Cuffe, & Fischer, 2001). Children with mental health diagnoses and impaired functioning are more likely to engage in services than children without diagnoses or functional impairments (Bird et al., 1996; Burns et al., 1995; Leaf et al., 1996; Offord et al., 1987; Viale-Val, Rosenthal, Curtiss, & Marohn, 1984; Zahner, Pawelkiewicz, De-Francesco & Adnopoz, 1992). Family level factors impacting service engagement include family poverty, parent and family stress, single parent status, effectiveness of parental discipline, whether parents actually receive the type of child mental health services they prefer, and family cohesion and organization (Angold, Erkanli & Farmer, 2002; Angold et al., 1998; Armbruster & Kazdin, 1994; Bannon & McKay, 2005; Brannan, Heflinger, & Foster, 2003; Gavidia-Payne &

Stoneman, 1997; Harrison et al., 2004; Hoberman, 1992; Kazdin et al., 1997; McKay, Pennington, Lynn, & McCadam, 2001; Perrino, Coatsworth, Briones, Pantin & Szapocznik, 2001; Takeuchi, Bui, & Kim, 1993; Verhulst & van der Ende, 1997).

Research also continues to highlight that minority children and their families are less likely to be engaged in mental health services compared to non-Hispanic Caucasian families (Garland et al., 2005; Freedenthal, 2007; Lopez, 2002; Miller, Southam-Gerow & Allin, 2008; Zimmerman, 2005). Even among those receiving mental health treatment, minority children make fewer mental health treatment visits (Harpaz-Rotem et al., 2004) and receive less adequate mental health treatment (Alexandre, Martins & Richard, 2009) than Caucasian children.

Rates of treatment drop-out have also been found to vary by children's clinical diagnoses. Although children with more serious Axis I disorders (internalizing and disruptive behavior disorders) continue to be more likely to receive treatment than those with Axis I adjustment disorders only (Miller et al., 2008), a number of studies indicate that children who drop out of treatment are more likely to display behavioral difficulties, such as Conduct Disorder and delinquency (Baruch, Vrouva & Fearon, 2009; Burns, Cortell & Wagner, 2008; Johnson et al., 2008; Robbins et al., 2006). In comparison, children with higher levels of mood and anxiety disorders are less likely to drop-out of treatment prematurely (Baruch et al., 2009; Burns et al., 2008; Johnson et al., 2008).

The relationship between service engagement and child age remains unclear. It was noted in McKay & Bannon (2004) that some studies found an inverse relationship between child age and rates of engagement (Griffin et al., 1993; Wise et al., 2001) while others reported a positive relationship (Roghamann, Haroutun, Babigian, Goldberg, Zastowny, 1982; Wu et al., 1999). To date, while some findings indicate that pre- and early adolescents are more likely to drop out of treatment than older adolescents (Baruch et al., 2009), others suggest that adolescents in general may be less likely than younger children to engage in formal mental health services due to fears of being stigmatized by peers (Cavaleri, Hoagwood & McKay, 2009; Logan & King, 2001).

Research also indicates that homeless adolescents are vulnerable to service disengagement. Baruch et al., (2009) found that homeless adolescents are more likely to drop out of treatment than those with more stable housing. Instead, street dwelling homeless youth are more tied to 'street' culture and informal peer networks, which meet their primary needs for survival (i.e., eating at soup kitchens, asking for change, etc.) and emotional support (Garrett et al., 2008). Homeless youth who have fewer peers in street culture or who feel rejected by such peers may be more likely to access mental health services than those who have stronger bonds in their street dwelling community (Garrett et al., 2008).

Regarding the attitudinal component of engagement, commonly described as “buy-in,” research further indicates that adolescents are more likely to attend treatment when they perceive their mental health as poor (Brookman-Frazee et al., 2008). It has been suggested that treatment engagement for adolescents may require a certain level of self-awareness of mental health symptoms. Moreover treatment attendance increases when parents and adolescents can agree on at least one treatment goal, which may render youth less resistant to investing in the treatment process (Brookman-Frazee et al., 2008).

Research on treatment engagement has also examined the relationship between family process and treatment attendance. Parent interactions with children, for example, have been shown to be strong predictors of treatment drop out. For example, mothers who make more negative statements and praise less are more likely to drop out of Parent-Child Interaction Therapy (Fernandez & Eyberg, 2009). Recent research also indicates that families are more likely to seek treatment in times of stress or crisis (Burns et al., 2008), but are most at risk of dropout due to family difficulties. Similarly, Johnson et al. (2008) found that the highest proportion of dropouts occurred for those families with psychosocial difficulties and problems related to family dynamics. In a qualitative study of factors influencing premature termination of mental health treatment by parents, Attride-Stirling, Davis, Farrell, Groark and Day (2004) found that treatment non-completers were more likely to arrive with multiple family-level problems, while completers were focused on the specific problems of the identified child. These results suggest that non-completion of treatment may result, at least in part, from elevated family distress. Such findings underscore the importance for considering how high levels of family stressors impede treatment engagement. Although highly stressed families may be more in need of supports, such stressors can hinder families’ ability to seek and retain child mental health treatment (Thompson et al., 2007).

Barriers to Engagement

McKay & Bannon (2004) reported on specific logistical barriers to service use, which included concrete (e.g., insufficient time, lack of transportation), contextual (e.g., community violence), and agency obstacles (e.g., time on waiting lists) (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Bui & Takeuchi, 1992; Cohen & Heselbart, 1993; Kazdin & Mazurick, 1994; Miller & Prinz, 1990; Russell, Lang, & Brett, 1987; Wahler & Dumas, 1989). Additionally, perceptual barriers including poor therapeutic alliance, perceived need for treatment, perception of barriers, expectations for therapy, and beliefs about the therapeutic process also impacted engagement beyond logistical barriers (Garcia & Weisz, 2002; Kazdin et al., 1997; MacNaughton & Rodrigue, 2001; Nock & Kazdin, 2001). Ethnocultural beliefs and attitudes further influenced service engagement, as some cultural groups subscribe to a belief that parents should overcome

child mental health problems on their own (McCabe, 2002; Snowden, 2001).

Specific barriers which impede successful mental health service use engagement for adolescents include fears of labels or anticipating stigma from others (Boldero & Fallon, 1995; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). The adolescent developmental period is characterized by a strong need to establish a sense of competence, social acceptance, and autonomy. As a result, adolescents may have great difficulty coming to terms with the undesirable implications of having a mental health difficulty for their sense of normalcy, identity, and independence (Wisdom & Green, 2004). Not surprisingly, adolescents often refuse services due to stigma about mental health difficulties and fears that peers may have knowledge of their psychiatric issues (Cavaleri et al., 2009). Other barriers to engagement in mental health services for adolescents include lack of knowledge about the need for mental health treatment, what services might be helpful, as well as details about the overall treatment process itself (Goldstein, Olfson, Martens, & Wolk, 2006; Logan & King, 2001). Finally, the developmental goals of adolescence, which involve establishing independence from adults, may lead to an increasing tendency to avoid self-disclosure to adults in general (Seiffge-Krenk, 1989), consequently hindering the ability for adolescents to readily seek assistance from traditional mental health providers.

Poor therapeutic alliance is another substantial barrier in engaging and retaining families in child mental health treatment (Kerkorian, McKay & Bannon, 2006; Robbins et al., 2006). Kerkorian et al. found that parents who felt disrespected by their children’s prior mental health providers were six times more likely to doubt the utility of future treatment, and were subsequently likely to identify more structural and contextual barriers to treatment. Robbins et al. found that both adolescent and maternal alliances with therapists in Multidimensional Family Therapy for adolescent substance abuse declined significantly between the first two sessions among dropout cases, but not among treatment completers. Moreover, differences between maternal and adolescent therapeutic alliance, as well as differences between maternal and paternal alliance with therapists, predicted treatment dropout (Robbins et al., 2008). Furthermore, the relationship between different levels of therapeutic alliance among family members and treatment dropout has been found to be stronger among Hispanic than Caucasian families. Flicker, Turner, Waldron, Brody, & Ozechowski (2008) noted that among Hispanic families, those who did not complete functional family therapy for adolescent substance abuse experienced more intra-family differences in therapeutic alliances than treatment completers. However, the same effect was not observed among Caucasian families in the study. Flicker et al. (2008) suggested that therapists’ inexperience in addition to the insufficient attention to cultural factors (e.g., familism and hierarchy within Hispanic families) may contribute to engagement difficulties. Such

findings indicate that problematic alliance may be observable as early as the first few sessions, particularly the differential treatment alliance between family members and for specific cultural groups. Sufficient therapist training in addressing early alliance problems, as well as respecting culturally specific family processes could lead to increased retention rates.

Parents' beliefs about the causes of their children's problems may also hinder mental health service use. Yeh et al. (2005) determined that parents who believed that their children's problems were due to physical causes or trauma were 1.56 times more likely to use mental health services compared with those who had other etiological beliefs (e.g., personality, relationships with friends and family, family issues). However, parents who believed that their children's relationships with friends caused mental health difficulties were 25% less likely to use services compared to parents who believed that child mental health difficulties were caused by American culture, prejudice, economics, spiritual issues, and nature disharmony. Providing mental health education to parents on the bio-psycho-social model of children's mental health difficulties may assist in addressing this particular barrier to service use.

Interventions That Promote Engagement

McKay & Bannon (2004) identified a number of interventions and strategies designed to overcome logistical, perceptual, and cultural barriers to engaging in child mental health treatment. These involved using reminder letters and phone calls (Kourany, Garber, & Tornusciolo, 1990; MacLean, Greenough, Jorgenson, & Couldwell, 1989; Shivack & Sullivan, 1989), initial telephone contact strategies (i.e., when parents first contact clinics via telephone to set up an intake appointment; Coatsworth, Santisteban, McBride, & Szapocznik, 2001; McKay et al., 1996; Santisteban et al., 1996; Szapocznik et al., 1988) and face-to-face intake procedures (McKay, Nudelman, McCadam, & Gonzales 1996). Additional strategies include those which address parent concerns and barriers during the course of treatment (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Kazdin & Whitley, 2003; Prinz & Miller, 1994; Szykula, 1984). Moreover, dedicated paraprofessional and professional clinical staff are also helpful in promoting family engagement (Burns, Farmer, Angold, Costello, & Behar, 1996; Elliott, Koroloff, Koren, & Friesen, 1998; Koroloff, Elliott, Koren, & Friesen, 1994; 1996).

Technology-based interventions

Recent mental health and primary care engagement research indicates that telephone reminders continue to be an effective strategy to increase attendance at mental health treatment appointments, particularly when therapists, rather than clinic staff, make direct contact with clients or families (Shoffner, Staudt, Marcus, & Kapp, 2007). Additionally, new technology to improve appointment attendance includes the use of the internet and cellular telephones. A web-based appointment system that

allows clinicians and staff to make, change, and confirm therapy appointments led to an increased likelihood of attendance at first therapy sessions (74%), as compared to traditional therapist-based scheduling by telephone (54%) (Tambling, Johnson, Templeton, & Melton, 2007). Appointment reminders sent via text-messaging is also an effective way to improve attendance rates at primary care outpatient services (Downer, Meara, Da Costa, & Sethuraman, 2006; Leong et al., 2006), and could be easily implemented at mental health clinics.

Paraprofessional staff

Additionally, research continues to focus on the use of paraprofessional staff to promote engagement. Trained parent, or family, advocates are paraprofessionals who have special needs children themselves. Family advocates are trained to coach and support families in need of mental health services utilizing the skills and knowledge they have already developed by successfully navigating the mental health service system for their own children. Family advocacy and support programs increased in number nationwide (Hoagwood et al. in press; Olin et al., in press), and approximately 10,000 families access training, services, and support through family advocacy programs annually in New York State alone (Olin et al., in press). The Parent Empowerment Program (PEP) in New York State trains family advocates to address the needs of parents dealing with child mental health difficulties by focusing on empowering their clients as active agents of change (Olin et al., in press). PEP integrates practical principals of parent support, the Unified Theory of Behavior Change (UTB; Jaccard, Dodge, & Dittus, 2002; Jaccard, Litardo, & Wan, 1999), and evidence-based engagement strategies (McKay, McCadam, & Gonzales, 1996; McKay, Nudelman, McCadam, & Gonzales, 1996; McKay, Stoewe, McCadam, & Gonzales, 1998). Delivered by current or former parents of children with identified mental health needs, family advocates trained in the PEP model provide instrumental and emotional support, information about mental health services, care coordination, referral and linkage to other services, respite, recreation, and direct advocacy (Jensen & Hoagwood, 2008). Moreover, the personal experience of advocates increases credibility and the ability to engender trust with parents, thereby helping families become more actively engaged in their children's care (Gyamfi et al., 2010; Hoagwood et al., 2008; Koroloff, et al., 1994; 1996; Olin et al., in press; Robbins et al., 2008). Although research on family advocates is in the preliminary stages, it has been suggested that when family advocates are integrated in child mental health service delivery, families are more likely to engage in treatment (McKay et al., in press).

A related area focuses on outreach, engagement, and psychoeducation services provided by peer youth specialists as a promising way to address difficulties in engaging adolescents into mental health treatment. Peer youth specialists, who are adolescents and young adults themselves, are often seen as more

credible and may possess a greater understanding of youths' concerns compared to adult professionals. As a result, peer youth specialists possess an enhanced ability to engage adolescents to address a range of issues, including substance abuse, HIV/STD prevention, suicide prevention, and academic failure (Tindall & Black, 2009). Moreover, adolescents may be more responsive to younger service providers seen as peers rather than older adults (French, Reardon, & Smith, 2003).

Within the mental health field, peer youth specialists have been integrated into a treatment program for sexually abused children and adolescents. In the Peer Support Program (Alaggia, Michalski, & Vine, 1999), peer youth specialists, who have been affected by sexual abuse themselves, liaise with community agencies and schools to identify and engage sexually abused children and adolescents who might not otherwise seek treatment services through formal networks. Consumer feedback indicated that youth found the outreach efforts and availability of the peer youth specialist as one of the most important features of the program (Alaggia et al., 1999). Recent national attention has promoted the use of peers for transition-age (16–25) youth and young adults (e.g., Galasso et al., 2009) to provide support and assist in self-advocacy skills. Additionally, peer youth advocacy groups have emerged across the country (e.g., Youth MOVE: <http://www.youthmove.us/>) to ensure that youth voice is integrated into mental health program planning and service delivery.

Finally, the New York State Office of Mental Health has formalized the peer youth specialist role (called "Youth Advocates") within support services for families whose children manifest significant mental and behavioral health difficulties. Youth advocates are adolescents and young adults (aged 17–22) who have current or prior mental health challenges, for which they have received services through the child-serving system (e.g., mental health, child welfare, juvenile justice; Roussos, Berger, & Harrison, 2008). Currently, eighteen youth advocates in the New York City metropolitan area (1) engage children and adolescents and their families in identifying service needs and goals; (2) provide support, education on mental health issues, and guidance based on youth advocates' personal experiences; (3) organize social, recreational and educational activities for children and adolescents; and (4) represent the interests of youth mental health challenges in public forums (Personal communication with B. Lombrowski, 4/22/10). Although youth advocates have yet to be formally evaluated regarding their ability to promote engagement among youth in outpatient mental health treatment, they represent an emerging national interest in expanding peer outreach services for adolescents involved in the mental health system (Federation of Families for Children's Mental Health, 2001; Children's Mental Health Plan Youth Advisory Workgroup, 2008).

Beyond clinic walls

Improving engagement and access to child mental health services has also been improved by programs operating outside the traditional clinic environment. For example, combining school-based and family-directed mental health services for children through the Positive Attitudes toward Learning in Schools (PALS) program (Atkins et al., 2006) has contributed to success in service engagement and retention. PALS focuses on improving the classroom and home behavior of children with disruptive behavior disorders, consisting of both classroom-based (e.g., posting rules, behavior contingencies, individualized reward systems) and family-directed (e.g., parent groups co-facilitated by clinicians and parent advocates) services. Atkins et al. found that 80% of families agreed to enroll in PALS versus 55% of families engaging in traditional clinic services. At three months, 100% of PALS families remained enrolled in the program, while 0% of control families continued to receive clinic-based services. At 12 months, 80% of PALS families still remained in services, and among these, 83% agreed to re-enroll in PALS for the following year, while 36% of control families agreed to re-enroll in clinic-based services. Atkins et al. attributed the engagement and effectiveness success of the PALS program to the concurrent use of school- and home-based services, as well as the active involvement of parent advocates who were instrumental in helping low-income minority families overcome multiple barriers to mental health service use (Frazier, Abdul-Adil, & Atkins, 2007).

Home-based therapy is also an effective way to deliver mental health services to adolescents and their families. Slesnick and Prestopnick (2004) reported that providing in-home, as opposed to office-based, family therapy significantly increased attendance and participation in therapeutic sessions among adolescents and their family members. Thompson, Bender, Windsor, and Flynn (2009) recently confirmed this finding among adolescents with behavior problems receiving solution-focused family therapy. Participants who received home-based therapy enhanced by experiential activities designed to strengthen communication, relationship-building, and coping, remained in treatment significantly longer than a comparison group who received office-based family therapy (Thompson et al., 2009). Providing services in the home undoubtedly helps to eliminate structural barriers to treatment, such as transportation problems and childcare.

Strength-based approaches

An increasing number of programs that have adopted a strengths-based approach to delivering services to families, sometimes referred to as a family support perspective (Kagan & Shelley, 1987). This philosophy of practice builds on family members' competencies, supports families to make decisions for themselves, and focuses on enhancing the strengths of families, including cultural strengths, rather than fixing deficits (Green, McAllister, & Tarte, 2004). Strength-based practices are likely to

influence the extent to which parents actively engage in program services (Green, Johnson, & Rodgers, 1999). To the degree that parents feel respected, valued, and treated as if they are knowledgeable and capable, they may also be more likely to actively partner with program staff to work toward their goals (DeChillo, Koren, & Schultz, 1994).

Patient empowerment and activation has emerged as a strength-based strategy to increase engagement for minority adult mental health clients, and has potential for parents bringing their children to treatment for mental health problems. The Right Question Project-Mental Health (RQP-MH) program (Alegria et al., 2008) consists of three patient trainings, during which participants are encouraged to identify questions they have for their mental health providers, formulate comfortable ways of phrasing their questions, and engage in role-play to practice asking their questions and following-up on answers. Among a sample of low-income, primarily Spanish speaking adults, Alegria et al. (2008) found that intervention participants were over twice as likely as a comparison group to be retained in treatment, 29% more likely to attend their scheduled visits, and over three times more likely to have at least one follow-up visit.

As another strength-based approach, Motivational Interviewing (MI), is a directive, client-centered counseling style in which providers encourage patients to argue for behavior change for themselves and overcome ambivalence towards such change (Miller & Rollnick, 2002). MI is more focused and goal-directed than traditional counseling methods, with examination and resolution of ambivalence being its central purpose (Miller & Rollnick, 2002). According to Miller and Rollnick (2002), the value of motivational interviewing lies in the patient discovering the advantages and disadvantages of treatment for himself or herself. Essential components of the MI counseling style include reflective listening, use of open-ended questions to explore patients' motivations for change, affirm patient's own change-related statements and efforts, helping patients recognize the gap between current behavior and their desired life goals, asking permission before providing advice or information, using non-confrontational responses to resistance, encouraging patient's self-efficacy, and collaborating with patients on action plans (Miller & Rollnick, 2002).

MI has been found to improve retention rates among adults (e.g., Carroll et al., 2006; Murphy, Thompson, Murray, Rainey & Uddo, 2009; Sherman et al., 2009), and has been used as a treatment model with various adolescent populations, including youth in emergency room settings who are presenting for and currently being treated for injuries (Monti & Colby, 1999), and most commonly, adolescents with substance abuse and addiction issues (Colby, Monti & Barnett, 1998; Monti & Colby, 1999; Sciacca, 1997).

Most recently, MI techniques, such as the expression of empathy, development of discrepancy, rolling with resistance, and support

for self-efficacy, have been integrated into a 1–2 session intervention designed to increase the likelihood that adolescents with serious psychiatric illness successfully participate in mental health treatment (Making Connections Intervention [MCI]; Lindsey, Bowery, Smith, & Stiegler, 2009). The MCI program addresses factors that influence treatment acceptability (i.e., engagement, perceived relevance, and service satisfaction) prior to treatment participation. The MCI program has the potential to enhance help-seeking behaviors by empowering adolescents to identify perceptual and actual barriers that influence their treatment acceptability and equip them with the skills to overcome these barriers. Plans to evaluate the impact of MCI in combination with an evidence-based treatment for adolescent depression (i.e., Interpersonal Psychotherapy for Adolescents [IPT-A]; Mufson, 2010) are currently underway.

Additionally, MI techniques have been integrated into engagement-specific interventions for depressed mothers whose children receive psychiatric treatment (Swartz et al., 2007; Zuckoff, Swartz, & Grote, 2008; Zuckoff, Swartz, Grote, Bledsoe, & Speilvogle, 2004). MI in combination with ethnographic interviewing (EI) has been formulated into a single engagement session designed to enhance clinicians' ability to identify, comprehend, and resolve patients' ambivalence regarding help-seeking and entering treatment. Developed in response to the difficulty in engaging depressed mothers of psychiatrically involved children into their own treatment, the MI/EI intervention was designed to address patient ambivalence as well as clinician biases which could serve as barriers to engaging patients into treatment. A recent study utilized the MI/EI engagement session in combination with brief Interpersonal Psychotherapy (IPT-B as described in Grote et al., 2004). Grote, Zuckoff, Swartz, Bledsoe, & Geibel (2007) found that 96% of women in the MI/EI plus IPT-B condition attended their initial treatment session vs. only 36% of women in the IPT-B alone condition ($p < .001$). Although the MI/EI intervention has been designed to engage adult patients into their own treatment, it may have potential utility with those parents whose children require psychiatric treatment but who may be especially resistant to formal child mental treatment models.

Special Populations

Families of children with disruptive behavior disorders

Childhood disruptive behavior difficulties, including persistent oppositional and/or aggressive behavior, are among the most common reasons for referrals to child mental health clinics (Frick, 1998; Kazdin, 1995). These disorders are particularly concerning because of the high degree of impairment and poor developmental trajectory (Lahey & Loeber, 1997). However, as stated earlier, families whose children manifest such difficulties have an increased likelihood of dropping out of treatment

prematurely (Baruch et al., 2009; Burns et al., 2008; Johnson et al., 2008; Robbins et al., 2006), losing any progress families may have made before terminating services. Such families experience additional stressors and commitments that limit the resources available to facilitate attendance at appointments (Miller & Prinz, 1990), such as insufficient time, lack of transportation, and concerns that services might not help (McKay et al., 2005). Moreover, parents often need support and education on providing reinforcement, using alternatives to physical punishment, focusing on treatment gains rather than on negative behaviors, effective communication skills, and problem solving (Miller & Prinz, 1990). Additionally, these children, by the nature of their difficulties, may not fully participate in sessions despite being physically present. It is not uncommon for such children to disagree with the treatment plan, or resist treatment altogether (McKay et al., 2005).

The Multiple Family Group (MFG) service delivery model to reduce disruptive behavior disorders, developed by Dr. Mary McKay and colleagues at the Mount Sinai School of Medicine (MSSM), is specifically tailored to improve engagement, retention, and effectiveness of services for urban children and families of color (Franco, Dean-Assael, & McKay, 2008; Gopalan & Franco, 2009). This model involves school-age, inner-city children (ages 7 to 11) who meet diagnostic criteria for Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) and their families (including adult caregivers and siblings between the ages of 6 to 18 years) in a 16-week series of group meetings with 6 to 8 families. The MFG service delivery model addresses those family factors (i.e., poor parental discipline and monitoring, inadequate behavioral limits, lack of parent-child bonding, family conflict, stressors, family disorganization, family communication, within family support, and low level family interactions) which are consistently implicated in the onset and maintenance of childhood behavioral difficulties, and predict the development of child ODD and CD (Alexander, Robbins, & Sexton, 2000; Dishion, French & Patterson, 1995; Egeland, Kalkoske, Gottesman, & Erickson 1990; Keiley, 2002; Kilgore, Snyder, & Lentz, 2000; Kumpfer & Alvarado, 2003; Loeber & Farrington, 1998; Loeber & Stouthamer-Loeber, 1987; Patterson, Reid, & Dishion, 1992; Reid, Eddy, Fetrow, & Stoolmiller, 1999; Sampson & Laub, 1994; Shaw, Vondra, Hommering, & Keenan, 1994; Tremblay, Loeber, Gagnon, & Charlebois, 1991). In addition, MFG content addresses specific family factors related to urban living, socioeconomic disadvantage, social isolation, high stress, and lack of social support. These factors hinder effective parenting and contribute to childhood conduct difficulties, as well as relate to early drop out (Kazdin & Whitley, 2003; Wahler & Dumas, 1989). In addition, intervention sessions have been designed to target factors (e.g., parental stress, use of emotional and parenting support resources, family involvement with the child in multiple contexts, and stigma associated with mental health care) which potentially impact inner-city child mental

health service use and outcomes. Key components are delivered via content and activities based on core elements of parent training and systemic family therapy.

The use of MFGs has been shown to increase family engagement in treatment (McKay et al., 2005). A preliminary study of the MFG model examined the impact of MFGs on 138 children with conduct problems and their families, who were assigned to MFG or service as usual (family therapy or individual therapy). Families in the MFG groups attended on average 7 ± 3.3 sessions during a 16-week period. In comparison, families in the “treatment as usual” family therapy group attended an average of 4 ± 3.2 sessions, while families in the “treatment as usual” individual therapy group attended an average of 3.1 ± 2.7 sessions. Currently, the MFG service delivery strategy to reduce child disruptive behavior disorders is being tested in a large-scale effectiveness study funded by the National Institute of Mental Health (NIMH). Preliminary data indicates that engagement rates for families in the MFG treatment condition far surpass what would normally be seen in urban child mental health clinics (McKay et al., in press; McKay et al., 2005).

Families and children affected by trauma

In a recent study conducted by the Office of Juvenile Justice and Delinquency Prevention (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009), more than 60% of children in the United States reported being exposed to violence within the past year. Children exposed to trauma can experience a number of short-term and long-term disturbances in self-regulation (e.g., avoidance, withdrawal, sleep disturbance, changes in appetite, difficulties regulating mood, and difficulties concentrating, exaggerated startle response, hyper-vigilance, a need to repeat the event through words and/or play, flashbacks or re-experiencing), somatic complaints (e.g., headaches, stomachaches and back pain), as well as increased disturbances in mood, developmental achievements, behavior, and risk-taking activities (e.g., using drugs and alcohol, promiscuous sexual activity, skipping school, running away from home) (La Greca, Silverman, Vernberg, & Roberts, 2002; Cohen, Mannarino, & Deblinger, 2006). If symptoms do not subside over time on their own or with treatment, individuals may develop depression, anxiety, PTSD, personality changes, substance abuse, and impaired school functioning (La Greca et al., 2002; Cohen et al., 2006). Additionally, traumatized children are more likely to be involved in violent relationships, either as victims or perpetrators (Harpaz-Rotem, Murphy, Berkowitz, & Rosenheck, 2007).

Recommended treatment includes early engagement to identify and monitor initial reactions to trauma which may lead to future disorders (Berkowitz, 2003), ensuring that concrete needs (e.g., safety, shelter, employment, medical care) are met (Saltzman, Layne, Steinberg, Arslanagic, & Pynoos, 2003), providing psychoeducation about normal and abnormal reactions to trauma, and enhancing coping skills (Saltzman et al., 2003).

However, several factors impede engagement for those who have been exposed to violence and trauma. Individuals who suffer post-traumatic reactions often do not recognize the effects of the event until a significant and persistent loss of functioning has occurred (Elhai & Ford, 2009). When someone experiences a traumatic event, they become physically, emotionally, and cognitively dysregulated (Osofsky & Osofsky, 2004). One reaction is a desire to avoid the traumatic incident and any reminders. Moreover, individuals frequently withdraw from the very support systems and routines which are likely to assist with recovery (Cohen et al., 2006). Other engagement barriers specific to trauma include perceived intrusiveness of clinicians, trauma fatigue (a weariness of discussing the tragic event), aversion to being probed about the event and the associated feelings, and parents underestimating the exposure and effects of the traumatic event on themselves and their children (Levitt, Hoagwood, Greene, Rodriguez, & Radigan, 2009). Families often withdraw from their normal daily routines and social supports in order to avoid further exposure to potentially traumatic events or traumatic reminders. Unfortunately, such a withdrawal limits access by mental health providers to victims (particularly children), especially when caregivers fear that children could be re-traumatized if asked to discuss the trauma (Elhai & Ford, 2009).

Early identification is a significant challenge to treating children and families who have been exposed to violence and trauma. Most of the time, families do not seek treatment until and unless their child is exhibiting significant behavioral problems. Many children may minimize their reactions to the traumatic event to avoid upsetting their parents or caregivers (Levitt et al., 2009). Moreover, as typical trauma reactions include internalizing behaviors (e.g., avoidance, denial, depression, withdrawal, sleep disturbances, changes in appetite and concentration), parents who are unaware of such symptoms or who lack education on what to look for may be unlikely to seek appropriate and timely treatment. The result is that a large percentage of children in need of services are never identified or seen by mental health professionals (Finkelhor, Ormond & Turner, 2007).

Even when parents are aware, many feel guilty that they were unable to protect their child from the initial trauma. Fears of being judged and attempts to protect their child from re-traumatization may lead parents to avoid treatment (Elhai & Ford, 2009). Strategies to overcome trauma-specific barriers include providing psychoeducation for children and parents about normal reactions to abnormal events, orienting parents to the treatment process, and assuring them that successful treatment will help children get better faster. As many parents may experience their own difficulties following a traumatic event (deVries et al., 1999), parents should also be educated on the importance of treatment for themselves and provided referrals. Moreover, framing parent well-being within a family systems context helps parents to understand how their own mental health status affects their child.

Finally, additional treatment barriers include socio-economic status, lack of health insurance, negative experiences with clinic staff, lack of knowledge regarding how to access services, bureaucratic red tape, familial discord, lack of transportation, child-and-family care, finances, employment schedules, and environmental chaos (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008). While these obstacles are not unique to those who have experienced trauma, violence tends to occur in the most vulnerable communities (Self-Brown et al., 2006). Community-based interventions that intervene beyond the clinic walls provide an opportunity to collaborate with community stakeholders and provide access to those who need it most. Moreover, collaborative community-based interventions in the acute phase following trauma exposure may assist in early identification and engagement. One example, the Child Development Community Policing Program (CDCP), involves collaboration between the New Haven Department of Police Services and clinicians from the Yale Child Study Center. The model involves a partnered response to children and families following incidents where children are involved as victims and/or witnesses of violence and trauma. This partnered response allows police to secure the scene while clinicians intervene by providing psychoeducation, acute coping strategies, and treatment options. As a result, the family's sense of physical and emotional safety is enhanced. Police/clinician teams follow up with the family within a week to assess current functioning and symptoms, answer questions related to the incident, and continue ongoing treatment planning with the family (Marans, 2004). Recent findings indicate the CDCP program has been particularly successful in reaching Hispanic children, and in responding to incidents involving gang involvement, accidents, felony assaults, property crimes, family violence, and psychiatric crises. Moreover, children and families involved in the most severe incidents and those with a primary mental health component are more likely to utilize intensive CDCP services (Murphy, Rosenheck, Berkowitz, & Marans, 2005).

Implications and Conclusions

Beginning with McKay and Bannon's (2004) review, recent studies suggest broadening the definition of treatment engagement beyond simple treatment attendance. From a clinical perspective, providers are well-advised to pay attention to indicators of treatment disengagement prior to sessions being missed (e.g., difficulty scheduling appointments, lack of follow-through on intervention plans, insubstantial treatment goals, uneven treatment progress, lying about important issues; Cunningham & Henggeler, 1999). Furthermore, future research can measure different behavioral indicators of engagement beyond simple treatment attendance (e.g., participation and cooperation in sessions, homework completion, demonstrating progress towards goals). When distinguishing between appropriate treatment completion and drop-out, clinician/client agreements to treatment

termination should be considered (Johnson et al., 2008). Measurement of engagement should also include an attitudinal component to distinguish those clients who are invested in treatment from those who are simply complying (Staudt, 2007). This may be accomplished by incorporating treatment process measures such as the Metropolitan Area Child Study (MACS) Process Measure (Tolan, Hanish, McKay, & Dickey, 2002).

Although recent data show discrepancies between the average number of treatment sessions attended in child mental health clinic settings (i.e., Brookman-Frazee et al., 2008; McKay et al., 2005), such differences may result from the differing socioeconomic and geographic characteristics between low-income urban settings (i.e. McKay et al., 2005) compared to an entire county consisting of urban, suburban, and rural communities (i.e. Brookman-Frazee et al., 2008). Given an inverse correlation between service use and poverty, parent and family stress, and minority and single parent status (Angold et al., 1988; Armbruster & Kazdin, 1994; Brannan et al., 2003; Freedenthal, 2007; Garland et al., 2005; Gould et al., 1985; Hoberman, 1992; Kazdin et al., 1997; Lopez, 2002; Miller, Southam-Gerow & Allin, 2008; Zimmerman, 2005), it is not surprising that urban clinics may experience greater challenges in retaining low-income, single-parent families of color who typically utilize community mental health services. Moreover, an overall lack of sufficient child mental health service providers in urban, inner-city settings (Asen, 2002) creates even greater obstacles to accessing treatment. Recent findings additionally identify that families whose children have disruptive behavior disorders, homeless adolescents, families where parents and children disagree on treatment goals, families with more hostile parent-child interactions, and families with multiple psychosocial issues are particularly difficult to engage and retain in treatment. Moreover, the quality of the therapeutic alliance with parents and children, as well as parents' etiological beliefs regarding their children's mental health difficulties, also influence child mental health treatment engagement. Clinical solutions may entail the use of more culturally appropriate services and provider engagement of minority families, multi-level services to address complex family needs, psychoeducation about the bio-psycho-social model of child mental health difficulties and continued attention to promoting productive working relationships between parents, children, and therapists. This is particularly important as problems with alliance may be prevalent even within the first few sessions. Finally, specialized treatment programs focused on engaging families whose children manifest disruptive behavior disorders (e.g., Franco, Dean-Assael, & McKay, 2008; Gopalan & Franco, 2009), particularly for urban, low-income, minority families, may be beneficial for those families least likely to engage in child mental health treatment.

Although previous research presents equivocal findings regarding the relationship between child age and engagement, it may be worth exploring how reluctance to seek treatment and treatment

disengagement varies across the different developmental stages of childhood and adolescence. Moreover, clinicians who elicit adolescents' perspectives on their own mental health symptoms to increase self-awareness may be more likely to increase adolescents' motivation for treatment. Finally, resolving potential conflicts between parents and youth by finding common treatment goals may have utility in increasing treatment retention.

The advent of new technology means that treatment engagement can be further improved through the use of web-based appointment systems and texting to mobile phones. Additionally, making treatment available outside the traditional clinic walls through school- and home-based service delivery models is promising for the promotion of initial engagement and service retention. Patient empowerment and activation may provide parents with skills to advocate for their children's treatment. As a result, future clinical and research activities may focus on ways to adapt the RQP-MH and MI interventions for the child mental health context. Moreover, the use of paraprofessional family advocates and peer youth specialists are gaining increasing popularity, particularly given a growing demand for consumer-led services in mental health (New Freedom Commission on Mental Health, 2003). Finally, this article focuses attention towards those families whose children manifest disruptive behavior disorders and traumatic symptoms. As these special populations present with unique treatment barriers, both clinical and research activities should explore how the highlighted programs can help to overcome obstacles to treatment engagement faced by families with such needs.

Acknowledgements/Conflicts of Interest

The authors have no financial relationships or conflicts to disclose.

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Engaging families in child mental health services

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The last decade has brought important advances in the area of children's mental health, including a concerted focus on building a scientific base for understanding the mental health difficulties that our most vulnerable members of society experience and examining the impact of services that potentially reduce child mental health needs [1,2]. Serious concern remains, however, as to whether the current child mental health service delivery system can identify and reach youth in need of care. The US Surgeon General identified meeting the mental health needs of youth by ensuring the receipt of appropriate and relevant mental health care as a national priority [2,3].

These calls to attend to children's mental health needs are not new. In the early 1980s, Knitzer [4,5] severely criticized the child mental health service delivery system as failing to respond to youths in serious need of mental health care. Two decades later, rates of child mental health difficulties remain at alarming levels, with an estimated 17% to 26% of youths in need of mental health care across the United States [6–9]. Within low-income, urban communities, rates of child mental health care need have been found to be even higher, with as many as 40% of youths evidencing signs of mental health difficulties [10].

Numerous recent reports and research studies highlight the fact that most children with mental health difficulties do not receive any type of mental health care [2,3,8,11,12]. For example, a report by the National Institute of Mental Health [13] concluded that approximately 75% of children with mental health needs do not have any contact with the child mental health service system. This disparity between need and use of services was found to be highest for minority youth [13,14]. Unfortunately, these rates are identical to those reported in the

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mid-1980s by the Office of Technology Assessment [15], which indicates that the level of need for services remains unchanged despite advances in developing evidence-based assessments, treatments, and services for these children. There is a significant need to understand and enhance the ability of the child mental health care system to reach out effectively to youth and their families and engage them in acceptable and effective child mental health care.

Addressing the mental health needs of minority youth who live in urban areas has emerged as a most critical issue given the substantial evidence that these youth are most deeply affected by the stressors that exist within inner-city communities, notably poverty, community violence, inadequate child serving resources, under-supported schools, substance abuse, and multiple health epidemics [16–20]. This article pays specific attention to issues related to engaging urban youth of color and their families in services and provides an overview of the larger body of research on engagement of youth and their families in mental health care.

Defining child mental health service engagement

Multiple conceptualizations of the process of engagement of youth and families in mental health care have been offered and tested. For example, in a series of articles, engagement has been defined as a process that begins with a child being identified as experiencing mental health difficulties and ending with a child receiving mental health care [21–23]. More specifically, engagement in care is described as beginning with the recognition of a child mental health problem by parents, teachers, or other adults within a child's context. Next, there is a process of addressing the unmet need by connecting a youth and the family with a mental health resource, generally via a referral for care. The final phase of engagement consists of a child being brought to a child mental health center or being seen by a school-based mental health care provider.

Within the literature, engagement in child mental health services also has been divided into two specific steps: initial attendance and ongoing engagement [24]. Each step is considered related to the other, but each one also emerges as a distinct construct being independently related to characteristics of the child, the family, and the service system. Rates of service engagement also differ at each of the two steps and warrant specific consideration. For example, studies that focused on attendance at initial appointments for care within an urban child mental health care center found that rates of failure to attend an initial intake appointment can range from 62% [25] to 48% [26] of youth accepted for an evaluation. In relation to ongoing urban service engagement, estimates of average length of care can be as low as four sessions [27] or rates of as few as 9% of youth and their families remaining in care after a 3-month period.

Researchers have suggested that a more precise definition of service engagement may contribute to more reliable research findings and generalizability. Kadzin et al [28–30] noted that grouping children and families who discontinue services into one category (ie, dropouts) may contribute to inconsistent and biased

findings. The authors noted distinct phases of ongoing engagement and observed that children who exit treatment do so at diverse points, such as while waiting for treatment, after one or two treatment sessions, or later in treatment. It was hypothesized in a study conducted by this team involving youth with disruptive behavioral difficulties at the Yale Child Study Center that the characteristics of children and families who drop out of services vary in relation to the point in time at which they exited services [29]. Subsequent findings supported this hypothesis.

More specifically, the study sample was divided into three groups: early dropouts (attended ≤ 6 weeks of treatment), late dropouts (attended 7–14 weeks of treatment), and individuals who completed therapy (approximately 7–8 months). Children and families who dropped out early in the treatment process averaged 3.8 sessions, whereas later dropouts averaged 10.8 sessions of treatment. Analyses indicated that child, parent, and family characteristics differed significantly between the overall group of families who terminated treatment prematurely and completed treatment. Most of the domains and measures that predicted early termination from treatment in analyses did not predict late termination from treatment, however. In comparison to completers, families that dropped out of treatment early were significantly more likely to belong to a minority group, have greater stress, and be headed by a single parent. Children in families that dropped out early were characterized by more severe child impairment in relation to conduct disorder and delinquency, academic functioning, and social behavior problems. When comparing late terminators versus completers, late terminators differed by nonbiologic head of household, child antisocial history, and poor adaptive functioning at school.

A direct comparison between early and late terminators revealed that the two groups differed significantly by minority status, family income, poor living accommodations, adverse family child-rearing practices, child contact with antisocial peers, and poor adaptive functioning at school. The authors noted that the literature is often at odds, reporting inconsistent findings of which families drop out of treatment prematurely. This study identified that a reason for these conflicting findings may be that combining all dropouts into a single group is potentially misleading and can obscure our understanding of the process of families prematurely exiting services. A more precise definition and conceptualization of different categories of dropouts may be needed by the child attrition literature. These findings also potentially can guide specific engagement interventions by helping to identify and target risk factors associated with families that drop out at different points of the treatment process.

Characteristics of youth and families that influence service engagement

Past research that examined engagement in child mental health services focused largely on child and family social, demographic, and clinical mental health characteristics and their association with engagement. These data are often retrieved from administrative sources and related to service engagement patterns. Commonly examined child characteristics include demographic and clinical

status variables. In terms of child characteristics, findings regularly reveal that male children are more likely to be referred and use mental health services in comparison to female children [31,32], and they tend to use more services when involved in treatment [33,34]. As children get older, the disparity between rates of service use by gender tends to decrease [31,35]. Findings that relate a child's age and rates of engagement are mixed, however, with some studies indicating an inverse relationship [31,35] and others noting a positive association [34,36].

In terms of child mental health need and engagement, prior research has identified a clear association between the presence or diagnosis of a child mental health disorder [37–40] or impaired functioning [41] and a greater likelihood of service engagement. The relationship between the severity of impairment and service use is somewhat less identifiable, however [42,43]. Findings indicate a positive relationship between need and engagement [44,45], no relationship [37], and counterintuitive findings such that the more serious the level of child mental health care need, the less likely the child is to receive treatment [28,46–48].

In relation to the impact of family characteristics on child mental health service engagement, poverty status has been linked with an underuse of child mental health services [49]. Prior studies also have found that minority families are less likely to be engaged in services in comparison to white families [30,50–54]. Less studied examples of family characteristics that have been associated with reduced service engagement include higher levels of parent and family stress, single parent status [55–58], higher levels of discipline effectiveness [26,59,60], parents receiving their preferred form of child services [61], and family cohesion and organization [62,63].

Although significant findings are summarized earlier, the relationships between these typically studied variables and service use patterns are often unclear. Reviews of these studies frequently reported conflicting findings and cited failures to replicate findings [56,58,64]. It is difficult to compare findings because most studies only focus on one or two variables at a time [56]. It seems evident that no single characteristic was, by itself, necessary or sufficient to explain child mental health care service engagement [28,29,65]. It is not surprising that it has been difficult to use these findings to inform specifically targeted engagement interventions [66–68].

The most recent research on engagement of children and their families in care attempted to examine this important phenomenon by emphasizing the role that adult caregivers play in helping a child to obtain care [69] and the influence of family interactional patterns on engagement [70]. Research that examines how these unique family influences relate to service engagement has presented a new way to understand the reasons why families do or do not enter services and a way to design interventions to increase the continuity of service use.

Research findings guiding service engagement interventions

A growing set of studies that inform engagement interventions has required researchers to go beyond identifying child and family characteristics and relating

these factors to service use. These research studies survey family members directly to reveal the inner workings of the family unit to identify influences on the complex decision to seek care for a child. For example, through child and caregiver reports, studies have identified several concrete obstacles (eg, insufficient time, lack of transportation), contextual obstacles (eg, community violence), and agency obstacles (eg, time spent on a waiting list) experienced by the family [29,47,50,71–74] that interfere with use of services. Recent research has extended these investigations to include consideration of not only logistical barriers to service use but also perceptual barriers.

An innovative series of studies has been conducted that examines the impact of adult caregivers' perceived barriers. Recent findings support the influence of perceptual barriers as being significantly more salient to understanding engagement in services than logistical barriers [30,75,76]. For example, Kazdin et al [30,77–81] published a series of articles that specifically examined the effects of perceived barriers to child mental health treatment. A barrier to treatment participation scale also was developed by this group. Although findings linked logistical barriers to treatment dropout, evidence also emerged that parental perceptions of barriers to treatment (eg, alliance with the therapist, perceived need for treatment) predicted engagement significantly beyond the variation explained by logistical barriers [30].

Later research findings replicated these results with studies that significantly linked family perceptions of aspects of the therapeutic relationship (eg, the degree to which they are involved in service planning) and service use [82–84]. For example, Garcia and Weisz [82] examined factors that distinguished treatment completers from treatment dropouts. The factor that accounted for the largest variance and distinguished dropouts from completers was therapeutic relationship problems. MacNaughton and Rodrigue [75] examined predictors of parents' adherence to recommendations made by psychologists after the evaluation of clinic-referred children. Parental perceived barriers were the most salient predictor of adherence to recommendations. The implication is that continuity of care may be compromised seriously if the perception of barriers by families is high. This body of research findings focused engagement intervention researchers on the need to impact perceptions of barriers, attitudes regarding help seeking, perceptions of relevance, and potential helpfulness of care.

Despite these advances, authors note limited usefulness of data concerning barriers as a means of enhancing child mental health care treatment engagement [79]. More specifically, logistic and parent-perceived barriers are often assessed after treatment has begun and may not provide any opportunity to identify families at risk of dropout during the pretreatment phase. Consequently, investigations of pretreatment indicators of which families are at risk of treatment dropout have been conducted. More specifically, Nock and Kazdin [79] found that parents with high expectations for child therapy perceived fewer barriers to treatment. Parents who did not expect therapy to be effective and who had negative beliefs about the therapeutic process reported significantly more barriers to treatment participation. This new series of engagement research studies suggests

the possibility of being able to identify and support families at risk of treatment dropout even before treatment begins.

Past research also emphasized the need to address the cultural background of families when attempting to identify the influence of parent attitudes on service use [84,85]. McCabe [84] found that among a sample of Mexican-American children in outpatient psychotherapy, premature termination was predicted by parental perceptions that they should be able to overcome their child's mental health problems on their own and emotional and behavioral problems should be handled by increasing discipline. Adult caregiver expectations and beliefs concerning child mental health care are significantly related to a greater risk of premature termination of services. McCabe suggested that more culturally sensitive interventions are needed to improve retention and prevent dropout. In sum, it has been suggested that engagement of families in child mental health services rests on parental attitudes about professional services and providers, their receptivity to involvement in services, and their previous experiences with the mental health care system [59]. Attitudes and expectations may influence not only parents' decision to seek mental health care for their child but also their interest in ongoing involvement with the child mental health care system. These factors could offer targets for specific engagement interventions [86].

Overview of existing interventions to increase engagement

Strong evidence exists that intensive engagement interventions implemented during initial contacts with youth and their families can boost service use substantially. For example, supplying simple reminders to adult caregivers of upcoming sessions has proved to be an effective method of increasing attendance at initial appointments. Shivack and Sullivan [87] reported a 32% increase in attendance when clients were reminded of their appointment through a telephone prompt. Kourany et al [88] found significant differences in attendance at initial appointments between adult caregivers who received a reminder letter, phone call, or both compared with caretakers who received neither reminder. Similarly, MacLean et al [89] found rates of no shows between families that received a reminder letter (6.8%) to be significantly lower when compared with families that did not (20.6%). Results of these studies consistently indicated that reminding families of upcoming sessions is a basic but useful tool to increase attendance at initial appointments. Limitations of using these methods identified in past research include applying these techniques in inner-city settings, in which many low-income families may not be reached by phone or may change residences frequently and fail to have a reliable mailing address [87].

Several studies have shown that telephone intake procedures that go beyond information gathering and focus on the complex array of potential barriers to service involvement can increase substantially the attendance at initial appointments and ongoing service involvement. Some of the most important work conducted in the area of developing and testing engagement interventions has

been conducted by Szapocznik et al [90]. This investigative team has achieved significant success engaging adolescent substance abusers and their families through use of an intensive, family-focused engagement intervention delivered via the telephone and then throughout the treatment process. More specifically, an intervention—strategic structural systems engagement, which is based on family therapy concepts and guided by family systems theory—was developed to overcome resistance to involvement in care and address patterns of interaction that were hypothesized to interfere with engagement into treatment [70].

Details of the engagement intervention tested by this team are provided in three journal articles [70,90,91]. Briefly, the initial contact with the adult caregiver of the youth is viewed as the beginning of service provision. The provider attempts to establish a working alliance with the caregiver and develop strategies that will help all family members attend an intake appointment. The strategies include strengthening parents' confidence in their ability to bring the adolescent to an initial mental health appointment and enhancing their perceptions of potential impact on their child. The provider often reaches out to other family members who are defined as critical to successful involvement in services.

In one study, 108 Latino families of youth suspected of or observed using drugs were randomly assigned to a strategic structural systems engagement experimental engagement intervention condition or an “engagement as usual” arm of the study [90]. Participants in the experimental condition were engaged at a rate of 93%, compared with an engagement rate of 42% for persons assigned to the control condition. There were also indications that the engagement method had impact beyond attendance at an initial intake appointment. In the comparison condition, 41% of families that were engaged eventually dropped out of treatment prematurely, whereas only 17% of families intensively engaged later dropped out of care. In a second study, conducted by the same team of investigators, these impressive results were replicated. With an even larger sample of “hard to reach” families, the strategic structural systems engagement strategy was associated with an engagement rate of 81%, compared with a 60% involvement rate for youth and families in the control condition [90]. Significant findings that replicate the strength of strategic structural systems engagement in involving families in treatment continue to be published [91].

This body of work by Szapocznik et al was highly influential in the design of another series of engagement interventions, which takes place either during the initial telephone intake call or at the point of first face-to-face contact between provider and families, within inner-city mental health settings. A series of tests has been conducted to examine the use and effectiveness of these engagement strategies in outpatient clinical centers for urban youth. First, in a study meant to test systematically, a telephone intervention strategy focused on increasing attendance at intake appointments at urban child mental health clinics was conducted [92]. This engagement intervention aimed to help the primary adult caregiver of a child invest in the help-seeking process and systematically problem solve barriers to help seeking. More specifically, the telephone initial telephone exchange was meant to (1) clarify the need for child mental health care for the

caregiver and the provider, (2) maximize the caregiver's investment and efficacy in relation to help seeking, (3) identify attitudes about and previous experiences with mental health care that might dissuade the adult from bringing the child for services, and (4) develop strategies to overcome concrete obstacles, such as lack of time, transportation, child care, and issues.

The initial show rates of a sample of 27 urban families that received the telephone intervention were compared with a match sample within a quasi-experimental study. Results revealed that the engagement strategy increased initial attendance by 29% in comparison to the more traditional telephone intake procedures ($\chi^2 = 5.08$; $P < .05$).

To address some of the methodologic limitations of the previous study related to sample size and design, the investigator tested the telephone intervention strategy by randomly assigning 108 new requests for inner-city child mental health services to one of two study conditions. In the first condition, 55 telephone intakes were assigned to an intensive engagement and problem-solving intervention. The second condition consisted of a routine telephone intake assessment that consisted of obtaining typically obtained information related to presenting problem of child and appropriate fit for agency. Of the 55 families that received the telephone intervention, 72.7% ($n = 40$) came to the first appointment or called at least a day before the interview to reschedule. Of the families that were assigned to the more traditional screening, only 45.3% came to the appointment or called independently ($\chi^2 = 8.42$; $P < .01$).

McKay et al [93] also conducted a study to determine if additional training related to engaging families in the first interview could improve return rate for a second appointment and ongoing rate of engagement. This first interview engagement strategy consisted of working on the following tasks during the first face-to-face contact between provider and youth and family: (1) clarifying the roles of the worker, agency, intake process, and possible service options, (2) setting the foundation for a collaborative working relationship, (3) identifying concrete, practical issues that could be addressed immediately, and (4) developing a plan to overcome barriers to ongoing involvement with the agency.

In this study, 107 new cases at an urban child mental health center were randomly assigned to trained first interviewers or a comparison group of therapists who did not receive specific engagement training. Of the 33 children assigned to first interviewers, 29 (88%) came for a first appointment and 28 (97%) returned for a second appointment. In comparison, of the 74 clients assigned to the routine first interview condition, 47 (64%) came for an initial appointment and only 83% ($n = 39$) returned for a second appointment. The average length of treatment during the 18-week study period for experimental participants was 7.1 sessions, as opposed to an average of 5.4 sessions for the comparison group. First interviewers lost only five cases between assignment and the third interview, compared with therapists without specific engagement training, who lost 35 families between assignment and the third session.

The next study conducted by this team tested the combined effects of a telephone and a first interview engagement intervention on initial attendance and

ongoing retention in services in comparison to the impact of the telephone intervention alone and a no-treatment comparison group ($n = 100$) [94]. The combined condition and the telephone-alone condition were associated with significant increases in attendance at intake appointments in comparison to the control group ($P < .01$). There was not a significant effect for the telephone engagement intervention alone in relation to ongoing use of services, however. On average, families assigned to the combined condition attended 7.3 sessions during the 18-week study period. Families that were seen by comparison therapists averaged between 5 and 5.9 sessions attended during this same time period ($t = 9.07$; $P < .01$). Families that received the combined engagement intervention attended 74% of the sessions scheduled, which represents a 25% increase over the telephone intervention alone and a 16% increase above the clinic comparison families [94].

Alternative approaches that address parental concerns and barriers during the course of treatment also have evidenced greater treatment retention [95,96]. For example, in the comprehensive referral pursuit and maintenance approach, the referral source, the client, and the therapist meet to collaborate in identifying needed resources (eg, transportation, housing) that may impact engaging families in services [96]. Results of studies of this intervention revealed that at the tenth week of treatment, 46% of families in the traditional services had dropped out, compared to only 26% in the comprehensive referral pursuit and maintenance approach group. Printz and Miller [95] used a method known as the enhanced family treatment, which examined and attempted to address parental concerns or barriers not directly related to the parent-child interaction, but in a larger context of their lives. One hundred forty-seven families were randomly assigned to either a standard family treatment that focused exclusively on parental management or an enhanced family treatment that also promoted frequent discussions of adult issues (eg, attitudes toward therapy, financial concerns, marital relations, and work concerns). Enhanced family treatment produced a significantly lower drop-out rate in comparison to standard family treatment overall (29% versus 46.7%) but particularly for high adversity families (29.6% versus 58.8%).

More recent interventions also have been conducted that focus not only on addressing specific barriers that parents present but also on reducing the sheer number of barriers to treatment reported by parents as a means of increasing service engagement. Kadzin and Whitley [81] tested a parent problem-solving intervention that built on their prior research findings that perceptions of barriers by parents negatively impacted service engagement [29,77]. In this intervention, 127 children and families referred to treatment for aggressive and antisocial behavior were randomly assigned to receive or not receive an additional component (parent problem solving) that addressed parental stress over the course of treatment. The parent problem-solving intervention successfully reduced the barriers that parents reported experiencing during treatment.

An essential component of successful models of engagement interventions is the identification of treatment barriers across multiple levels [25]. This ecologic approach to understanding service engagement is either explicitly or implicitly

stated in all of the effective interventions. Interventions of this type are associated not only with initial involvement in child mental health care but also treatment retention and completion.

This ecologic approach is supported by the program of research on multi-systemic therapy. Henggeler et al [97] identified that families of delinquent or substance-abusing youth who received multisystemic therapy had a higher rate of treatment completion compared to families that received usual services. Multi-systemic therapy includes a comprehensive assessment of barriers to engagement and subsequent problem solving that focuses on the ecology of children and families. These problem-solving approaches are used throughout the course of treatment [98]. Although it seems evident that a broad consideration of factors that influence engagement is most effective in enhancing attendance at initial appointments and treatment retention, it is not entirely clear which components of these ecologically based approaches are the most salient factors that affect service engagement.

Adding case managers and paraprofessionals to the child mental health service delivery system to enhance engagement

Although the engagement interventions described previously seem promising in their ability to impact service involvement for youth and their families, alternative strategies to increase service use also merit attention. For example, there is a growing tradition of collaborating closely with family members, particularly as a means of overcoming barriers to help seeking. An important example of the critical role that family members can play is provided by Koroloff et al [99] in their tests of family associates as links to services for youth and families in need. The family associate engagement strategy was designed to provide outreach to low-income families whose children were identified as needing mental health care. The family associate was trained to encourage and enable families to enroll their children in mental health services and assist families in continuing with services that were recommended for the child. Family associates were paraprofessionals who served as “system guides” and provided families with information, emotional support, and help with specific barriers, such as lack of transportation or child care. In a study of 239 families with a child (4–18 years of age) referred for mental health care, the presence of a family associate was significantly associated with families initiating and continuing contact with the child mental health service delivery system [100,101].

In addition to considering a family associate model of engagement, Burns et al [102] conducted a test of the impact of the addition of a case manager on engagement of youth with serious emotional disturbance and their families in care. Findings from a randomized control trial of 167 participants revealed that involvement in the experimental case manager condition was associated with significantly longer participation in services, use of a wider variety of services, fewer inpatient hospitalization days, and use of more community-based services.

Summary and implications

The continued presence of a substantial portion of youth experiencing significant mental health issues calls for new models of child mental health services and research that addresses these needs and specifically focuses on the issue of engagement of youth and their families in care. The findings summarized in this article point to potentially effective methods for decreasing no-shows at initial appointments and increasing engagement in child mental health care across diverse samples of youth and their families. Even with effective service engagement interventions, rates of dropout and no-shows remain significant concerns. More data are needed to identify families that are missed by the child serving system.

It is important to note that this article largely examines engaging families in child mental health services based on factors that impact a family's use of services. When one considers factors that influence engaging families in child mental health services, however, one also must consider issues related to service access. For example, families may not be engaged in child mental health services simply because services may not be available. The sheer volume of children and families estimated by large epidemiologic studies to be in need of child mental health services far outstrips the number of available mental health care practitioners [103]. The disparity between estimated need and available practitioners alone speaks of problems in accessing services.

The problem of availability may be intensified depending on where a child and family live. Research has shown that most mental health care professionals tend to be concentrated in urban areas and are less likely to be found in the most rural sections of the country [104]. Children and families in rural areas in need of mental health care may not be able to locate appropriate services. Perhaps the most significant issue in accessing services concerns the lack of family health insurance to pay for child mental health care [14]. These problems may be intensified for minority families. For example, approximately one fourth of African-American families are uninsured [105], which is 1.5 times more than white families. The issue of service access is often a significant influence on engaging children and families in mental health services. A comprehensive survey of the factors that influence engagement in child mental health services would need to consider this important topic.

Another important issue to consider in reviewing research on engagement is the underlying assumption that children and families that drop out of services would have benefited from services if they had not terminated early. Several studies have indicated a significant relationship between the number of treatment sessions attended by children and families and better mental health outcomes [29,106]. These investigations are far from comprehensive, however. It is an unfortunate reality that over the past several decades many children have received inappropriate mental health care that, at best, may have been ineffective and, at worst, damaging [1]. Efforts to extend engagement in these instances would not be desirable. Data must be gathered from

families directly to identify more clearly their service preference and assessments of outcomes in addition to their reasons for lack of engagement in treatment.

Another confounding factor in examining engagement in child mental health services is that many referrals are not made by the children and families themselves but are mandated by schools courts or other agencies [2]. Many children and families do not keep initial appointments or drop out because they never desired or recognized a need for child mental health services in the first place. It seems evident that the future of service engagement research involves an increasing amount of direct inquiry of child, family, and provider perspectives when attempting to account for service use.

Of note, collaborative research efforts between consumers and researchers hold considerable promise for addressing these issues, particularly in urban settings. Many impoverished urban communities evidence high rates of mental health care need and low treatment participation. Often in these settings there is a mistrust of outsiders, who may be the very people providing mental health services or conducting research. In such instances, researchers may not be privy to consumers' views of services because of their choice not to share their perspective with outsiders. Collaborative research efforts between researchers and consumers may have the advantage of creating alliances and increasing relevance of services, however. These alliances may facilitate an understanding of the practical realities families face and how problems related to engaging families in child mental health services may be solved.

It is clear that mechanisms exist to increase the involvement of urban youth and their families in needed mental health services. To accomplish this task, however, child mental health agencies and providers might consider the following: (1) Examine intake procedures and develop interventions to target specific barriers to service use. (2) Provide training and supervision to providers to increase a focus on engagement in the first face-to-face meetings with youth and families. (3) Consider service delivery options with input from consumers regarding types of services offered. The most important theme that seems to run through all the engagement research efforts reviewed in this article is that involvement of youth and their families is a primary goal that must receive as much attention as any other part of the service delivery process. It might be argued that without youth and family participation, effective services will never be provided to youth and families in need.

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INCREASING ACCESS TO CHILD MENTAL HEALTH SERVICES FOR URBAN CHILDREN AND THEIR CAREGIVERS

Mary McKernan McKay, Judith Stoewe, Kathleen McCadam, and Jude Gonzales

This article presents the results of a study that evaluated the effects of two engagement interventions on the initial attendance and ongoing retention in child mental health services of 109 primarily children of color and their families. Both the combined intervention (telephone and first interview) and the telephone-alone intervention were associated with significant increases in attendance at initial intake appointments over the usual intake procedure, but only the combined intervention was related to the greater ongoing use of services. Implications for future research and recommendations for modifying procedures in outpatient child mental health centers are also presented.

Key words

barriers
caregivers
children
mental health
service utilization

Urban children are at a greater risk of developing psychopathology, yet are less likely to be adequately served by outpatient child mental health services (Griffin, Cicchetti, & Leaf, 1993). There is a growing concern that 50 percent to 75 percent of the children who need such services never have contact with them or drop out prematurely (Kazdin, 1993). Previous research documented the numerous barriers that urban families encounter in attempting to gain access to the child mental health system (Aponte, Zarski, Bixenstene, & Cibik, 1991; Boyd-Franklin, 1993; Flaskerud, 1986; Sue, Fujino, Hu, & Takeuchi, 1991; Wallen, 1992). However, only a few studies have evaluated interventions meant to reduce these barriers and to increase the use of services (Russell, Lang, & Brett, 1987; Shivack & Sullivan, 1991; Szapocznik et al., 1988). This article presents the results of a study that evaluated the combined effects of a telephone intervention and a first-interview engagement intervention, compared to the effect of the telephone intervention alone and of the usual intake procedure, on initial attendance and ongoing retention in services. Implications for future research and recommendations for modifying procedures in urban outpatient child mental health centers are also included.

REVIEW OF THE LITERATURE

The prevalence of mental health difficulties among children has been estimated to range from 17 percent to 26 percent (Brandenburg, Friedman, & Silver, 1987; Tuma, 1989). However, the prevalence of the use of mental health services is substantially lower than the estimated rates of psychiatric disorders (Padgett, Patrick, Bums, Schlesinger, & Cohen, 1993; Regier et al., 1993). Rates of service use are particularly low for children in low-income, urban communities (Griffin et al., 1993). In fact, there is mounting evidence that children with the most serious presenting problems and those whose social situations are the most complex are less likely to be retained beyond the first session and are more likely to discontinue

services prematurely (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Bui & Takeuchi, 1992; Cohen & Hesselbart, 1993; Kazdin, 1989, 1993; Miller & Prinz, 1991; Russell et al., 1987; Wahler & Dumas, 1989).

Barriers to the use of mental health services by low-income clients of color have been identified to some extent. Underutilization has been explained by the stigma associated with counseling services, the lack of information regarding available services, inaccessible locations, unresponsive service providers, and the reliance on alternative methods of help (Acosta, 1980; Aponte et al., 1991; Boyd-Franklin, 1993; Flaskerud, 1986; Keefe, Padilla, & Carlos, 1979; Lin, 1983; Muecke, 1983; Sue et al., 1991; Sue & Morishima, 1983; Wallen, 1992).

A growing number of empirical studies have identified differences in the demographic and clinical characteristics of children and families who remain in service and those who drop out (see, for example, Armbruster & Fallon, 1994; Costello, 1993; Kazdin, Mazurick, & Siegel, 1994; Oxford, Boyle, & Szatmari, 1987; Tolan, Ryan, & Jaffe, 1988). However, few studies have focused specifically on interventions that are meant to increase the use of services (Szapocznik et al., 1988). Furthermore, studies that target urban children and families are clearly needed.

There is some evidence that more-focused telephone intake procedures are associated with significant increases in initial attendance rates (Russell et al., 1987; Shivack & Sullivan, 1991). In the most rigorous test of an engagement intervention to date, Szapocznik et al. (1988) successfully engaged adolescent substance abusers and their families through the use of a structural family therapy intervention over the telephone; that is, 57.7 percent of the families in the usual intake condition failed to come to their first clinic appointment, but only 7.1 percent of those in the experimental condition failed to come. There were also indications that the engagement intervention had an impact beyond attendance at intake: 41 percent of the families in the control group, but only 17 percent of those in the experimental group, dropped out of treatment prematurely.

The engagement interventions evaluated in the study reported here are based on a conceptual model for understanding the process of engagement with urban families that was developed from the existing empirical literature. Specifically, the model relies on the recognition of the numerous

barriers that interfere with families' involvement with mental health services (McKay, Bennett, Stone, & Gonzales, 1995; Tolan & McKay, in press). These barriers include within-family impediments (like parental efficacy, low investment in help seeking, and previous negative experiences with mental health services) and external barriers (such as the lack of time and transportation). The primary goal of the study was to evaluate specific engagement interventions that help caregivers invest in seeking help for their children and break down the barriers to the use of services.

METHOD

The impact of a telephone-engagement intervention and a first-interview intervention (combined condition) was examined in relation to three outcome measures: (1) attendance at initial appointments, (2) the average duration of contact with a mental health agency, and (3) the proportion of appointments kept during the study period.

Setting and Sample

The study was conducted at an inner-city, child mental health agency. Of the children who were seen at the agency in 1996, 67.3 percent lived with their mothers in single-parent households, and approximately 85 percent of the 450 families who requested services in that year were supported by public assistance. Almost two-thirds of the children seen at the agency are African American, 12 percent are Latino, and the remainder are white.

The 109 caregivers who were involved in the study made consecutive requests for services at the agency. The 109 children who were accepted for services (34 boys and 75 girls) ranged in age from one to over 14 (with a mean age of 10.1 years). Sixty-eight percent of the children lived with their biological mothers in single-parent households and 13 percent resided in foster care (see Table 1).

Procedures

For the study, consecutive requests for services at the mental health agency were randomly assigned to one of three conditions: combined engagement intervention ($n = 35$), telephone intervention alone ($n = 35$), and the usual intake procedure ($n = 39$). Random assignment was implemented in two stages. First, adult caregivers requesting services for their children were randomly assigned to speak either to one of the two master's-degree social workers who conducted the telephone-engagement intervention or a third master's-degree social

Table 1. Demographic Characteristics of the Sample

Characteristic	<i>n</i>	%
Age of the child		
1–5 years	7	6
6–9 years	38	35
10–13 years	37	34
Over 14 years	21	19
Missing data	6	6
Gender of the child		
Male	34	31
Female	75	69
Primary caregiver		
Biological mother	68	62
Foster mother	13	13
Grandmother	20	18
Aunt	4	4
Uncle	3	3

worker, who completed the clinic comparison telephone intake procedure. This assignment was accomplished by evenly dividing the messages from parents for intake appointments among the three social workers.

Following the initial intake telephone call, the families were randomly assigned to therapists for their initial intake appointments and, if appropriate, for ongoing mental health services. At this juncture, a case could be assigned to either one of six master's-level social work trainees who received specific training in engagement skills for first interviews (the second component of the combined engagement condition) or one of 20 other therapists (all of whom were at least master's-level interns who were completing clinical programs in social work, psychology, or psychiatric nursing or fellowship training in child psychiatry) who participated in the clinic comparison condition of the study. All the families were informed about the evaluation component of the study and the specific research focus related to how long children and families remain in services.

Telephone Intervention Alone. This 30-minute intervention was implemented by two master's-level clinicians at the research site. It was meant to help the primary caretakers invest in the help-seeking process by clearly identifying their children's presenting difficulties, framing their actions as having the potential to have an impact on the current situation, and having them take some concrete steps to address the situation even before the initial appointment. In addition, it was meant to explore systematically the barriers to help seeking, in both the family and the environment, such as experiences with previous helpers and issues related to poverty, community violence, and racism. Finally, an active problem-solving approach was used to develop the means to address obstacles to contact with the agency (McKay, McCadam, & Gonzales, 1996). Table 2 summarizes the active intervention elements and their empirical bases.

Combined Engagement Intervention. This condition included not only the telephone intervention just described, but also the random assignment of families to therapists who had been specifically trained to focus on the process of engagement in the first interview. The eight-hour engagement training defined the initial interview with a client system as having two primary purposes: to understand why a child and family were seeking mental health services and to engage the child and family in a helping process, if appropriate. Four critical elements of engagement were highlighted in this intervention: (1) the need to clarify the helping process for the client; (2) the importance of establishing a collaborative working relationship with the client; (3) a focus on immediate, practical concerns; and (4) an emphasis on identifying and ameliorating barriers to help seeking (McKay, Nudelman, McCadam, & Gonzales, in press).

Six master's-level social work interns were trained to introduce themselves, the agency's intake process, and possible service options carefully

Table 2. Description of Telephone Intervention and Empirical Bases

Target of Intervention	Empirical Basis
1. Clarify the need for mental health care	Lerman & Pottick (1995)
2. Increase the caretaker's investment and efficacy in relation to help seeking	Szapocznik et al. (1988)
3. Identify attitudes about and previous experiences with mental health care	Flaskerud (1986), Muecke (1983), Sue, Fujino, Hu, & Takeuchi (1991), Sue & Morishima (1983), Wallen (1992)
4. Overcome concrete obstacles to access to services	Acosta (1980), Sue & Morishima (1983)

during the first interview. Practice exercises encouraged them to balance the need to obtain intake information with the need to help a child and his or her family “tell their own story” about why they had come to the agency. In this way, a collaborative tone was set from the beginning of the first interview. Furthermore, crisis situations or concrete requests for help in negotiating with other systems, such as a school, were responded to immediately during the first appointment. The training of the interns focused on raising their awareness that many situations necessitate the scheduling of an appointment much sooner than the following week. Finally, a significant factor in every first interview was the exploration of potential barriers to obtaining ongoing services at the agency, as well as such obstacles as time and transportation. The effect of other types of barriers, particularly previous negative experiences with helping professionals and discouragement by others of seeking professional help, were explored. Differences in the race or ethnicity of the clinician and client were always raised. (See Table 3 for a summary of key elements of the first interview intervention and their empirical bases.)

Comparison Telephone Intake Procedures. During the initial telephone call to the agency, a parent or other caregiver speaks with a master’s-level social worker. The goal of this conversation, which lasts from 20 to 30 minutes, is to assess the child’s need for child mental health services and the fit between the child’s needs and the agency’s services. The focus of the conversation is on clarifying the presenting problem, identifying relevant referral sources, and obtaining identifying information. The social worker also gives the parent or other caregiver information about the agency’s services and, if appropriate, indicates that a therapist will be calling to schedule an intake appointment within the next several days.

Training for Comparison First Interviews. During orientation training at the research site, all the

therapists were informed of the diagnostic and demographic information that needed to be obtained during the first meeting with a client. This information included information about presenting problems, family composition and history, social and educational functioning, past psychiatric treatments, and medical problems. The orientation to the first interview emphasized information gathering and diagnostic assessment. The training for the combined engagement protocol also required therapists to gather information. However, it expanded the first meeting’s purpose substantially to focus on the process of gathering diagnostic data in a sensitive manner and with a primary focus on helping the client identify obstacles to returning for a second appointment.

Checks for the Integrity of the Intervention. For the telephone engagement intervention, a protocol was developed to address each clinical topic with caregivers systematically. Both master’s-level clinicians received training in the implementation of this protocol. Approximately 15 percent of the actual telephone calls were monitored by the first author to ensure the integrity of the intervention. The engagement training for conducting a first interview was also directed by a protocol. Approximately 25 percent of the combined engagement-intervention first interviews were videotaped to ensure the integrity of the treatment. Compliance with the study procedures was found to be high.

Measures. In the study, three outcome measures were of interest. First, the agency’s research staff obtained the number of clients who came for their first scheduled intake appointments from the therapists. Next, the number of sessions attended during the 18-week study period was recorded by the agency’s computerized tracking system to compute the average number of sessions that each subject attended. Finally, the proportion of appointments scheduled versus the number that were kept was computed using these same data sources.

Table 3. Description of First-Interview Engagement Intervention and Empirical Bases

Target of Intervention	Empirical Basis
1. Clarify the roles of the worker, agency, intake process, and possible service options	Lerman & Pottick (1995), Boyd-Franklin (1993)
2. Set the foundations for a collaborative working relationship	Hatch, Moss, Saran, & Presley-Contrell (1993)
3. Identify concrete, practical concerns that can be immediately addressed	Stanton & Todd (1981)
4. Overcome barriers to ongoing involvement with the agency	Acosta (1980), Sue & Morishima (1983)

RESULTS

As was noted earlier, the combined intervention and the telephone-alone conditions were associated with substantial increases in attendance at the initial intake appointments in comparison to the clinic comparison condition (see Table 4 for a summary of the results). Although the combined engagement condition evidenced slightly higher initial engagement rates, this difference was not statistically significant. Despite the evidence to suggest that the telephone engagement intervention could increase initial attendance rates, its impact did not extend to the ongoing use of services. On average, families who were assigned to the combined interventions attended 7.3 sessions during the 18-week study period ($F = 6.36, p < .05$), whereas those who were seen by comparison therapists averaged 5 and 5.9 sessions (for telephone-alone and the usual intake methods, respectively).

In relation to the proportion of sessions scheduled versus the proportion that were kept during the 18-week study period, families who were assigned to the combined engagement intervention attended 74 percent of the sessions—a 25 percent increase over the families who received the telephone intervention alone and a 16 percent increase over the clinic comparison families.

DISCUSSION

One of the most clinically significant findings of this study was that without more intensive engagement efforts, 56 percent of the cases can be lost between the telephone call to request services and the first intake appointment. This figure is alarming, given that the assessment information gathered during the initial telephone call identified these children as in need of mental health services.

The impact of the telephone engagement intervention was limited to attendance rates at initial intake appointments; it did not extend to ongoing rates of engagement, as other studies have suggested (see, for example, Szapocznik et al., 1988).

These findings suggest that the level of the therapists' engagement skills is critical. Therefore, it is not sufficient for therapists to be more responsive to clients during the initial calls to a mental health center; rather, responsiveness and an emphasis on identifying and addressing barriers to the use of services must be continued during face-to-face contact with clients.

The interpretation of the results is limited in several ways. First, the study did not incorporate information from clients about their satisfaction with the agency or the therapists, their motivation to return for future appointments, or the specific barriers that interfered with their use of mental health services. Feedback from the consumers of mental health services is clearly needed to enhance the findings of this study and of the literature on mental health services in general. Feedback from the therapists about the engagement process is also critical if future studies are to specify the complex helping exchanges that occur during early meetings with children and their families. Components of both the telephone intervention and the first interview training were meant to target a range of barriers to help seeking, so more research is clearly required on the types of barriers that are more influential than others in predicting help seeking. Additional refinement and specification of the training are necessary to define more clearly the processes that are more likely to help vulnerable client populations gain access to services.

Another concern regarding the study is the lack of specificity of the clinic comparison therapists' behavior in sessions. Whereas the therapists in the interventions condition were monitored to ensure the integrity of treatment, the therapists in the comparison condition were not. Clearly, a more rigorously designed study is required to replicate the findings of this preliminary evaluation. In future studies, a careful analysis of therapists' behavior in both conditions is needed to gain a better understanding of how such behaviors facilitate or

Table 4. Initial Engagement and Retention Rates for the Three Conditions

	Usual Intake (<i>N</i> = 39)		Telephone Alone (<i>N</i> = 35)		Combined (<i>N</i> = 35)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Families who came at least once	17	44	30	86	31	89
% of sessions attended versus scheduled	101/173	58	151/309	49	241/327	74

block problem solving in relation to specific barriers to help seeking.

Despite these limitations, there is sufficient evidence to suggest that the provision of intensive engagement training to providers of mental health services and alterations in service delivery systems can influence initial engagement and retention rates. Such adjustments are critical if vulnerable low-income children of color are to receive services. Unless barriers to outpatient mental health services can be addressed, urban children and their families will continue to rely on more costly and restrictive services (Wallen, 1992; Zahner, Pawelkiewicz, DeFrancesco, & Adnopoz, 1992). Furthermore, future studies on the effectiveness of child mental health services will rely on the ability to engage children and their caregivers. Therefore, additional thought and research should focus on developing the means to involve children who need such services the most in such efforts. **HSW**

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Section Four: Training Resources

Video Resources – Can be used for parent involvement discussions

Example #1:

0 to 5 – Parent involvement in 30 minutes

<http://www.youtube.com/watch?v=qjl1dVBbJNU>

Example #2:

PBS KIDS & Virtual Pre-K: Importance of Parental Engagement

<http://www.youtube.com/watch?v=4bABLIcqxS8>

Example #3:

Active parenting

http://www.activeparenting.com/FTA_main

Materials to Support the Training of
NYC Early Intervention Program
FAMILIES AS PARTNERS
DOHMH

Training Activities

Family Involvement I. “What are the first words that come to mind when you think about a parent who is “hard to engage”?”

- Goals of Exercise: Become more aware of explicit and implicit beliefs about “hard to engage” parents.
- Activity based on Staff Building Training for Building Family Partnerships, NHSA, “ENHANCING PARENT INVOLVEMENT” (1997). *Special acknowledgement to Dr. Faith Lamb-Parker, Columbia University for the development of original activities on parent involvement.*

Activity Required Participants to write down words that immediately come to mind when staff thinks of parents who are hard to engage in EI services.

Participants are then asked, ‘what are the strategies you use to engage parents who do not seem to want to be engaged?’

Family Involvement II: *Life Load & Family Involvement*

- This activity required that each pair of participants in the room have a paper bag, and a cup of dried beans of two sizes (we had pinto beans (large) and black beans (small)). We explained the concept of the ‘life load’ and how each parent is dealing with a particular set of stressors and supports. The life load is defined as all the stressors minus the supports.
- Goals of Exercise: Increase knowledge about the demands and challenges that families face and inform our work with families.
- Instructions: (This exercise was done twice- once with each person in the group in the lead role.) *Think about the stressors associated with having a child. Consider other stressors in the families’ lives. Consider additional aspects of life: health, work, home, relationships, finances, etc. Create a hypothetical family in your program or think about your own life. For each stressor put bean(s) in the bag to represent its amount (small beans signify less of an amount than the bigger beans). When all stressors have been ‘collected and accounted for’, then begin to consider the supports that your hypothetical family or you may have. Consider all the categories again and think about the relief that each support or resource brings. Take out beans from the bag for each support or resource. At the end of this*

exercise one group member has their 'life load'. Discussion focused on individual differences in the patterns of stressors and supports for each family.

- Group activities based on Staff Building Training for Building Family Partnerships, NHSA, "ENHANCING PARENT INVOLVEMENT" (1997). *Special acknowledgement to Dr. Faith Lamb-Parker, Columbia University for the development of original activities on parent involvement.*

Video Clips

Just Being Kids (produced by US Dept of Ed, Office of Special Education Programs, Maternal and Child Health Bureau, Administration on Developmental Disabilities)

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Bailey, D.B., Jr. (2001) Evaluating parent involvement and family support in early intervention and preschool programs. *Journal of Early Intervention*, 24 (1), 1-14.

Brotherson, M.J. (2001) The role of families in accountability. *Journal of Early Intervention*, 24(1), 22-24.

VIDEOS AND OTHER RESOURCES:

Resource Guide: Selected Early Childhood / Early Intervention Training Materials (compiled and previewed by C. Catlett, P. Winton, A. Mitchell) FPG Child Development Institute. Available online: <http://www.fpg.unc.edu/Publications/Rguide/rguide.pdf>

RECOMMENDED BOOKS:

Bailey, D.B., Jr., McWilliam, R.A., Winton, P.J. & Simeonsoon, R.J. (1992) *Implementing family-centered services in early intervention: A team-based model for change*. Cambridge, MA: Brookline Books

Dunst, C.J., Trivette, C.M. & Deal, A.G. (Eds.). *Supporting and Strengthening Families Vol. 1. Methods, Strategies and Practices*. Cambridge, MA: Brookline Books.

Hanson, M.J. & Krentz, M.S. *Supporting Parent-Child Interaction: A Guide for Early*

Intervention Program Personnel [Handbook] (Full of case studies that could be used for <http://128.174.128.220/cgi-bin/classSearch/viewitem.cgi?id=769>)

Roberts, R., Rule, S. & Innocenti, M. (1998) *Strengthening the family professional partnership in services for young children.* Baltimore: MD: Paul H. Brookes Publishing. (Focus is on how to develop collaborations between professionals and families. Emphasis on taking into consideration families' individuals needs.

Landy, S. & Menna, R. (2005) *Early intervention with multi-risk families.* Baltimore:Brookes.