Parents' perceptions on parental involvement in preparatory secondary vocational school health education

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Research Internship 2	Graduation research. Definite version
Date	02-07-2014
Mentor	Dr. Rob de Leeuw. Julius Centre for Health Science and Primary Care, University Medical Center Utrecht.
Course Tutor	Dr. Janneke de Man
Number of Words	3463
Dutch abstract	296
English abstract	296
Intended Journal	Health Promotion International
	3000 Words for body of text
	250 Words for abstract
	1000 Words for references
	Total of 3 tables or figures (500 words each)
Reference Style	APA 6th edition

Master education KGW. Nursing Science. Utrecht University

1.INTRODUCTION

A common target group for health education programs are adolescents in the age of twelve to nineteen years because many unhealthy lifestyle factors develop during this period. Unhealthy lifestyle factors include use of alcohol, tobacco or illicit drugs, unprotected sexual activity, poor dietary habits and physical inactivity (Currie et al., 2012). Young people can damage their current health by living an unhealthy lifestyle, but their health is also likely to be affected in the long term (Schrijvers & Schoemaker, 2008). Unhealthy lifestyle factors occur more frequently in adolescents with a lower educational level. One large and significant target group where problems could be prevented is that of adolescents attending preparatory secondary vocational education [PSVE] (Hamberg-van Reenen, Meijer, Gils van, & Savelkoul, 2014; Schrijvers & Schoemaker, 2008; Vereecken, Carine Maes, Lea De Bacquer, Dirk, 2004). In general, Dutch youth health has not changed considerably in the last decade. However, some health aspects changed, such as the hospital admissions due to extreme alcohol use and the (mis)use of social media (Hamberg-van Reenen et al., 2014). Secondary school environment has been recognized as an important setting for school health education, which contains health related choices and activities- and projects organized by school. Adolescents spend much time at school, where a health promoting environment can easily be created (Niemeier, Hektner, & Enger, 2012; Van Lippevelde et al., 2011). Stimulating secondary schools to develop policies for exercise and a healthy lifestyle is a key goal in the education program of 2012-2016, supported by the Dutch government (Putten van der, Oostrom van, & Faber, 2012).

Secondary schools' influence on health behavior is increasing, but parents are still considered to have the most important influence on adolescents' lifestyle, mainly because of their function as role model. Parents may also play a receiving role in health education by participating in education programs organized by school (Sormunen, Marjorita Tossavainen, Kerttu Turunen, Hannele, 2013). For example in educational sessions about health related topics. Parental involvement is often advocated as important for secondary school health education (Niemeier et al., 2012; Peters, Kok, Ten Dam, Buijs, & Paulussen, 2009), but parents are not eager to participate in school-based activities, mainly because of their little spare time (Perry, Crockett, & Pirie, 1987). In a study on parents' ideas about parental involvement in primary school, parents proposed to introduce interactive and practical activities to perform with their child. Activities should be cheap, feasible, focused on their child, not theoretical and school or home based (Van Lippevelde et al., 2011).

Another important discussion in parental involvement concerns the role, responsibility and expectations of home and school in health education, on which only limited research has

been performed regarding adolescents (Sormunen et al., 2013). Finnish parents of 10-11 year old children considered health education mainly their responsibility, or a mutual responsibility with the school. Two reviews also show that there is a need for more parental discussion about the values and ideas on parental involvement in school health education (Ouellette, 2008; Petrie, Bunn, & Byrne, 2007). The Dutch government will change policy lines regarding parental involvement, which will be effective in January 2015. An important aspect of this change is stimulation of partnerships between school and parents (Parental involvement; by the dutch department of education, culture and science).

Problem Statement

Parental involvement is often advocated as important for secondary school health education, but parents are not eager to participate in school-based activities. To date, no conclusive evidence is available concerning the effectiveness of involving parents, the perceptions of parents and which role they would like to fulfill in school health education.

2. OBJECTIVES

The present study aimed to get insight in parents' perceptions on parental involvement in PSVE regarding health education. This information may contribute to the development of a theoretic framework that could be used to increase parental involvement. To address this goal, the following research question is formulated: What are parents' perceptions on parental involvement in preparatory secondary vocational health education? Including how they perceive the role and responsibilities of school and parents, current parental involvement and desired involvement in school health education.

3. METHODS

Grounded Theory [GT], a qualitative design, was used in this study. GT moves beyond description and intends to discover a process of interactions or general themes (Strauss & Corbin, 1998). By using focus groups [FGs] more insight was gained in the interactive patterns among group members about the study topic. The flexible questioning increased the likelihood that data was found that would remain uncovered with other methods. Homogeneity was preferred regarding group composition, for instance on gender or ethnicity (Boeije, 2010).

Setting and participants

The study population included parents of adolescents attending PSVE in the middle of the Netherlands. Parent councils of PSVE schools were approached. Subsequently, a convenience sampling method was used (Creswell, 2007). First, the managing director of the school was approached. When he or she agreed with involvement, the chairperson of the parent councils discussed participation in the study in the next parent council meeting. Additionally, the parents received written information about the study and gave informed consent prior to the FGs. A target number of three to four FGs was used, each including six to eight parents, which is in accordance with the manual focus group by the Dutch quality institution of healthcare (Manual focusgroup research by the Dutch quality institution for healthcare, 2004). In total, eleven PSVE schools were approached, of which three parent councils decided to participate. From the eight schools that refused participation, two parent council groups were too small to form a focus group. The other six schools refused because of a lack of time due to new developments in education, full agendas and the large amount of requests to participate in research. The three included city schools had a mixed western and non-western population. All parents who agreed to participate were included. Twenty Parents (sixteen mothers and four fathers) participated in three FGs consisting of nine, five and six parents. For characteristics of parents and their children attending PSVE see Table 1.

The study was conducted according to the principles of the Declaration of Helsinki (59th WMA General Assembly, Seoul, Korea, Oktober 2008) and the Dutch code for ‘Proper behavior‘ (2th Gedragscode Gezondheidsonderzoek, Rotterdam FMWV 2005). The research proposal was approved by the Utrecht University Medical Research Ethics Committee (MREC), for not being subject to the Medical Research Involving Human Subjects Act (WMO).

Data Collection

FGs were conducted in March and April of 2014 in planned council meetings at school. Each session took between 40 and 55 min. FGs were conducted without attendance of the managing director, with the aim of creating an open and safe environment. To obtain standardization in procedure, an interview guide was developed. This guide was critically checked after each FG and questions were added and changed if necessary. It contained the following topics: 1. Parents opinions about the role and responsibilities of school and parents in school health education 2. Current parental involvement and desired involvement 3. General perceptions on parental involvement in school health education. Each session was facilitated by a moderator [BMK] and assisted by a co-moderator [GFK or KvK] taking notes during the discussion. After each FG session the two moderators debriefed by summing up the most interesting discussions. The analysis was made more transparent by using memos to record and explain interpretations and conclusions.

Analysis

All FGs were tape-recorded and anonymous transcripts were made in Dutch. During analysis, two supplementary intertwined strategies were used, that is coding and constant comparison (Boeije, 2010). Coding was supported by the software program MAXQDA 11 (Version 11. VERBI GmbH). Coding started with open- and axial coding in order to break up the data into smaller parts, and then proceeded to selective coding which facilitates reassembly of the data (Boeije, 2010; Strauss & Corbin, 1998). The attention to meaning was enlarged by active coding, facilitating interpretative results that fits the perceptions of the respondents (Boeije, 2010). The process of analyzing the data was to a large extent done by one researcher [BMK]. One team member [KvK] individually read one transcript and double coded this transcript to enhance validity. During a meeting the team worked towards consensus about the interpretations, considering possible meanings. Peer review was performed by supervision of the project leader [JRJL] of the Utrecht Health study, the network in which this study is conducted.

4. RESULTS

Parents' opinions about the role and responsibility of school and parents.

Quotes used in the results have been slightly edited to increase readability.

All parents reported that the responsibility for adolescents' health lies with parents. Secondary school has a supporting role, also described as a supervising role. One mother described the following with regard to the distribution of responsibility by parents and school, respectively:

> *'I am in favor of a 70%, 30% distribution because we do not see our children all day. The children spent more time at school than at home, therefore a part of the responsibility should be placed with school'.*

During the sessions, parents discussed the boundaries of schools' responsibility and their own, mainly focused on bullying. When adolescents attend school under supervision of teachers, they show 'perfect' non bullying behavior. When they step outside schools borders the bullying escalates, mostly influenced by social media. Parents gave examples like ignoring each other in group text messages and bullying on social media. When the cause of bullying behavior is originated in school, parents suggested a combined responsibility. Parents did admit that it is difficult to establish where the cause of bullying is originated.

According to parents, family has an important role in creating an open and safe environment to talk about health problems. Parents suggest that school should offer a curriculum where different health related topics are frequently discussed in a creative way. The parents point out that a confrontational approach works best in creating a sense of understanding in adolescents and creating discussion at home. In general, the use of mobile phones and social media was considered to be the most important problem of this time. A large group of parents complained about the role of media, group pressure and 'external temptations', such as offered food, because they find it difficult to withstand or balance these influences. Some parents mentioned the responsibility of providing information by specific organizations, such as the Dutch Association for Public Health and Security (GGD) and the municipality. A small group of parents expressed that the responsibility of adolescents themselves should not be ignored. Furthermore, the influence of teachers and mentors was considered important by many parents as they can signal and observe problems, and act on this. Some parents assigned a function of role model to the teachers.

Current parental participation

In general, parents were satisfied with the schools' approach in informing parents and handling health related problems. Information and feedback was given to parents by the mentor, via contact letters, or it was provided using websites. Parents were aware that school initiated promotion of a healthier lifestyle by providing healthy food, education lessons about the consequences of social media and the use of drugs and alcohol etc. However, some parents stated that more efforts could still be made.

Most parents did not feel that they were involved in decision making in school health related topics. They did not regard their opinion being decisive. Because of the attendance in parent councils, they did feel more heard and were given the chance to discuss health topics. All parents expressed difficulties in reaching a high attendance in parents in school health education. Many examples of low-visited parent evenings were mentioned. One mother expressed the following:

> *'The parents that you want to reach, because of problem behavior started by their children, are always the ones that do not attend school meetings. They usually do not care whether their children work in the local supermarket, as long as he or she finishes school.'*

According to the interviewed parents, the challenge of involving parents is part of a social problem. There are groups of parents that do not recognize health problems, do not show the 'right' example for their children, or are difficult to reach because of a language barrier. When talking about potential solutions in reaching more parents, the parents pointed out that these groups are almost impossible to reach. Futhermore, they agreed that school is not responsible for this social problem, the Dutch government is.

Desired involvement in school health education

A small group of parents would like to be more involved in the decision-making of school health related topics. According to the parents, this could be realized by discussing these topics and stimulating shared decision making in parent council groups. Parents acknowledge that involving all parents is impossible.

The majority of parents did not feel the need to be more involved in the decision-making of school health related topics. They felt that their ideas are in line with the schools vision on health related topics and trust the school in taking the right decisions. Mixed opinions existed about schools' role in forwarding information on unhealthy behavior of adolescents to parents. Most parents indicated that school should not interfere in this, mainly because the

trust of the adolescent in their mentor should not be breached by the school by forwarding information to parents. Some parents wished to have a more extensive feedback system from school to parents in order to be more aware of their children's behavior at school.

All parents liked the possibility of attending school education programs for parents. One parent expressed:

> *'…If you want to educate children about health, you should also educate parents in order to let the education successfully reach children'.*

Some parents endorsed that organizing educational programs for parents and adolescents simultaneously would not be successful. Adolescents could feel ashamed of their parents and would not be free to talk. Educating the adolescents first, followed by an education program for parents, would enable discussing adolescents' perceptions in the parental education.

According to parents, current school initiatives in parental education sessions are low because of difficulties in involving parents. By discussing successful parental education sessions provided by other organizations parents indicated to prefer: a personal approach in the invitation, a relevant and appealing topic, a course teacher with knowhow, interactive (role plays) and confronting sessions. Positive experiences with parental education addressed topics such as 'the impact of social media' and 'the brain of the adolescent'.

5. Discussion

This article presents findings from focus group research related to parents perceptions on parental involvement in preparatory secondary vocational health education. Parents believe that the responsibility for adolescents health lies with parents, with the secondary school as supervisor. The majority of parents did not feel the need to be more involved in the decision-making of school health related topics

Regarding adolescents' health, parents mentioned 70% responsibility for parents and 30% responsibility for schools. This corresponds with the perception of Finnish parents towards the role of parents and school. They stated that child's health education was perceived as the mutual responsibility of home and school by parents (Sormunen et al, 2013). The present study also shows that bullying via social media is currently a major problem. This is also acknowledged by the rapport 'Growing up Healthy' 2014, commissioned by the Dutch Ministry of Health, Wealth and Sport (Hamberg-van Reenen et al., 2014).

We found that parents are satisfied with the schools' approach in informing parents, and they were aware of the organization of initiatives to promote a healthy lifestyle. The Dutch Monitor

advises parental involvement in the form of an educational partnership in primary-, preparatory secondary-, and secondary vocational school. It states that the involvement of parents, in particular exchange of information, is increased in the last years, (Bruin de, Linden van de, Vegt van de, & Aa van der, 2012). In our study, some parents still wish a more extensive feedback system resulting in an awareness of their children's unhealthy behavior. Other parents experience this feedback as interference. A previous study describes that parents mainly struggle with interference from school about health education. Half of the parents agree with the statement that school is allowed to appeal on health education at home (Herwijer, Vogels, & Andriessen, 2013). In our study most of the parents would not appreciate this interference.

Most parents did not feel involved in the decision-making in school health related topics. This corresponds with findings from the Parental Involvement Monitor which stated that parents are moderately positive about parental involvement in councils. More than half of the parents think they have some influence in decision-making, the other part doubts this. Schools declare to appreciate the opinions of parents, especially concerning school policy, quality of education and lifestyle themes like bullying (Bruin de et al., 2012). In contrast to the expected, the majority of parents in our study did not feel the need to be more involved in the decision-making of school health related topics. They feel that their ideas are in line with schools vision on health related topics. According to Herweijer et al. 2013 this could be explained by having shared perceptions. When parents and school have shared perceptions on health education, the fencing off responsibility should not be a problem. When both parties have different visions, sharing responsibility is more difficult, the need to fence off responsibilities is more necessary (Herwijer et al., 2013).

The present study showed that parents prefer attending school education programs for parents. Unlike previously research, we found that parents did not want to participate in these education programs with their child simultaneously. This conflicts with the perceptions of parents of primary school children, which prefer education activities with parents and child. (Van Lippevelde et al., 2011). These differential findings are probably due to differences in age, as adolescents are usually more autonomously. Parents expressed preferences in parental education such as: a personal approach, a relevant and appealing subject, a course tutor with knowhow and interactive and confronting sessions. This adds new knowledge to the existing literature because this topic is limited studied in adolescents.

A strength of our study is that the focus groups were conducted in three homogeneous groups with regard to age and ethnicity. The advantage of a focus group format is that it generates discussion and dialogue and exposes processes that would remain uncovered

otherwise. Another strength is that the focus group sessions were moderated by one researcher [BMK] accompanied by a co-moderator, which ensures reliability in questioning and interview style. A Limitation of our study is the failure to form more than three groups. Interviewing more groups with homogeneity regarding other ethnicities and male gender would have been preferable. As a consequence, mainly western and maternal views of parental involvement were gathered. Because of the recruitment in parent council groups, a relatively 'involved' group of parents was included in the focus groups. However, we believe that our analysis captures parental perceptions in similar educational situations.

The present study identified numerous perceptions of parents which should be kept in mind when developing new interventions. Because of the Dutch tendency to stimulate the interaction between parents and school, these findings could be used to help schools setting up future plans in the involvement of parents. Therefore, the results could be seen as a first step in the development of a theoretic framework to increase parental involvement and create an educational partnership with shared perceptions.

6. Conclusion

Our findings revealed that parents of, preparatory secondary vocational education, adolescents consider the responsibility for adolescents health to lie with parents. School should have a supporting role. Furthermore, when the cause of the health problem lies within school, a combined responsibility is suitable. Most parents do not feel involved in decision making in school health related topics, but they also do not feel the need for this. This is probably due to having shared perceptions on health education. The majority of parents do not prefer a role of school in forwarding information about unhealthy behavior of adolescents as they saw this as an interference. An interesting finding because of the Dutch governments' interest in increasing partnerships between parents and schools regarding health. Parents do like the possibility of attending school education programs for parents.

Recommendations

Future investigations are warranted to achieve broader representation of socioeconomic and ethnic groups and increased efforts in reaching parents that are less involved and may hold different perceptions. Secondly, a discussion is needed about the interpretation of an increased (educational) partnership between parents and school with specific attention paid to the boundaries of responsibilities.

Acknowledgements

The authors thank the secondary schools and parents for participating in the study and providing an interesting discussion in the focus groups. We also thank Kirsten van Kouwenhoven en Gerthe Kerkhof for performing the task of co-moderator and for their supporting role.

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Table 1. Characteristics of the Respondents

Characteristics of parents (N=20)	**N**	**%**
Gender		
Male	4	20
Female	16	80
Age		
30-40	4	20
40-50	11	55
>50	5	25
Education		
Low*	11	55
Middle*	3	15
High*	6	30
Marital Status		
Married/cohabiting	18	90
Divorced/not cohabiting	2	10
Native Country		
Netherlands	18	90
Other	2	10
Number of children		
1	2	10
2-4	18	90
>4	0	
Characteristics of adolescents# (N=23)	**N**	**%**
Gender		
Male	9	39
Female	14	61
Age		
12-14	16	70
15-16	7	30
>16	0	
School Year		
1	11	48
2	7	30
3	3	13
4	2	9

*Low: primary school, lower secondary general, lower vocational; Middle: higher secondary general education, intermediate vocational education; High: higher vocational education, university.

#Characteristics of adolescent children following preparatory secondary vocational education.