Urban Community Schools: Educator Perceptions of the Effects of Children's Health and Wellness on Learning

Diana J. LaRocco, Beth A. Taylor and Suzanne C. D'Annolfo
University of Hartford

Findings from a participatory action-research project that brought together 11 individuals from five of Hartford's seven community schools to engage in a focus group discussion about the effects of children's health and wellness on learning are presented. The researchers and key personnel from Hartford Public Schools and Achieve Hartford! co-constructed the inquiry. Issues identified as interfering with student learning clustered into themes that include students' and family members' mental, behavioral, nutritional, and domestic/neighborhood health. The results are being used to create a call for translational research proposals for University researchers to address these questions and disseminate findings to Hartford Public Schools and related community partners.

Keywords: community schools, action research, health and wellness

Conceptual Foundation

This paper presents select findings from a participatory action-research project that brought together 11 individuals from five of Hartford's seven community schools to engage in a focus group discussion about the effects of children's health and wellness on learning. The five schools are located in Hartford's most impoverished neighborhoods (Colantonio & Martin, 2013). More specifically, the study aimed to: (a) identify student health issues that discussion participants perceived affect student learning at their schools, (b) identify local strategies that they felt were especially promising in addressing the health issues their students face, and (c) generate related questions that participants would like answered.

Three concepts formed the foundation for this study of the health challenges that confront school and community partner personnel in Hartford's community schools. First, a child's health matters to learning and the longer-term outcomes of college and career readiness (Basch, 2010; Cook & Jeng, 2009). Second, collaborative, community-based approaches work best for overcoming barriers to learning (Dryfoos, 1994, 2005). Third, research is relevant when it is contextualized in its purpose, the

place and time it is conducted, and the people involved (Labaree, 2008).

Child health and educational attainment are linked. Factors known to affect children's health, and consequently, their learning include diet, being underweight or overweight, diabetes, physical activity, chronic diseases, and parent lifestyle and education (Eide, Showalter, & Goldhaber, 2010; Janus & Duku, 2007). Children living in families with limited household resources frequently face limited or uncertain availability of nutritionally adequate and safe foods (Cook & Jeng, 2009). These children are apt to come to school without breakfast, hungry and unprepared to learn (Basch, 2010). Similarly, urban, minority youth whose families have limited financial and health resources often experience health disparities including, among others, under-diagnosis, treatment, and ongoing care of asthma and vision problems (Basch, 2010).

Hartford's children face similar health disparities. Asthma rates among pre-K and kindergarten children were 17.2% during the 2004-2006 school years (Nguyen, 2010). Obesity rates among the city's children ages 6-11 from 1999-2008 were 24%, which was substantially higher than the national average of 17%

(Pachter, 2013). Census data available from the U.S. Department of Commerce (n.d.) reveal that in 2011, child poverty rates were at 47.9%, the highest in the state. Per capita income in Connecticut was $36,775 vs. $16,798 in Hartford. Of the state's residents 25 years of age and older, 35.2% held a Bachelor's degree or higher vs. 13.3% of Hartford's residents. The city's largest racial and ethnic groups are Hispanics or Latinos (43.4%), followed by Blacks (38.7%). Of the nearly 21,000 students enrolled in Hartford Public Schools, 90.3% are from low-income families, 16.9% of students are English language learners, and 91% are students from racial and ethnic minority backgrounds. Hartford has struggled for many years with low achievement and a persistent achievement gap and, until recently, was the lowest performing school district in the state.

Connecticut's high stakes tests under the No Child Left Behind Act of 2001 are the Connecticut Mastery Test (CMT), administered in Grades 3-8, and the Connecticut Academic Performance Test (CAPT), administered in Grade 10. Germane to this study's focus on the effects of children's health and wellness on learning, these tests, which assess essential reading, writing, mathematics, and science skills, serve as a measure of students' *academic learning* within Connecticut's System for Educator Evaluation and Development (SEED; Connecticut State Department of

Education, 2013b). Thus, they are of significant interest to Connecticut's educators. The levels set for student achievement on CMT and CAPT are *below basic*, *basic*, *proficient*, and *advanced*, which is done to provide an accountability system for school districts.

In 2012, Connecticut applied for and received a flexibility waiver from the U.S. Department of Education (Connecticut State Department of Education, 2013a). The waiver allowed the state to establish a new accountability system in which indices are calculated at the student-, subject-, school- and district-levels to assess school performance (Connecticut State Department of Education, 2013a). Under this system, a student's achievement level on the CMT or CAPT is transformed into an index score (i.e., *goal/advanced* = 100, *proficient* = 67, *basic* = 33, *below basic* = 0). The student individual performance index (SIPI) is calculated by first indexing a student's score in each subject on the CMT or CAPT and then averaging those scores. A school's performance index (SPI) is calculated by averaging all the SIPIs. This allows for the evaluation of school performance across all tested grades, subjects, and performance levels on state tests. Similarly, a district performance index (DPI) is calculated by averaging all of the district's SIPIs. The state's benchmark for a DPI is set at 88 "because in a district with a DPI of 88 or above, students will have performed at or above the 'goal' level on the majority of tests" (Connecticut State Department of Education, 2013a, p. 4). Table 1 depicts CMT and CAPT DPIs for Hartford. As can be seen, Hartford's DPIs for the academic year 2012-

Table 1
Hartford Public Schools DPI: CMT and CAPT

School Year	CMT DPI	CAPT DPI
2009–2010	54.2	49.5
2010–2011	56.2	48.9
2011–2012	58.4	49.6
2012–2013	58.1	50.5

Note: Data are from Hartford School District 2012-13 Performance Report (Connecticut State Department of Education, 2013c).

2013 for both the CMT and CAPT fall between proficient and basic. The DPI for the 2012-2013 school year is well below the state's benchmark of a DPI of 88 or above.

Although Hartford Public Schools has achieved significant improvement in students' academic learning since the district committed to a drastic change of course and launched an aggressive education reform initiative over six years ago, it remains among Connecticut's lowest performing districts and has the nation's largest achievement gap relative to suburban schools. The complexity of issues related to child health disparities and educational outcomes are compelling, and addressing them requires a collaborative approach (Sanders, 2006; Stone, Henig, Jones, & Pierannunzi, 2001). School personnel and health professionals must engage families and community service providers to ensure that children and their families receive the services and supports they need to succeed. To this end, and as part of their larger school reform efforts, Hartford Public Schools has developed a portfolio of schools that have features of evidence-based full-service *community schools*, as described by Dryfoos (1994, 2003, 2005). The community school serves as a hub for neighborhood life, providing activities and services for children and their families, as well as the wider community. A lead social service agency partners with schools to plan, implement and sustain on-site services such as health services, youth development and after school programs, and parent enrichment activities.

Finally, the private university in which we work prides itself on its engagement with the community, as does our college, which has a mission of integrating health and education sciences through community engagement. The college has a laser focus on translational research, which "creates a space for collaborative, co-constructed inquiry that values and utilizes the expertise of all stakeholders involved (Smith & Helfenbein, 2009, p. 91). Further, we believe that school personnel know their context and the history of local of efforts towards addressing the challenges they face on a daily basis (Smith & Helfenbein, 2009).

As such, we worked with key personnel from Hartford Public Schools and Achieve Hartford!, an independent non-profit organization designed to catalyze, support, and monitor educational reform in Hartford, to co-construct this inquiry. Our belief was, and remains, the interaction of child health and academic achievement is best understood from the vantage point of those most closely engaged with addressing the issue (Merriam, 2009). We were especially interested in how school and community partner personnel interpreted and made meaning of their experiences (Creswell, 2014; Merriam, 2009). Gaining participants' perspectives on the ways in which health affects student learning at their schools and the strategies they use to target and improve health risk

factors has the potential to inform the development of district wide long-term approaches to improve health risk factors that could have a direct effect on students' educational performance.

Study Design and Methods

The design of this inquiry was action research, an approach in which the aim is to identify "an appropriate solution for the particular dynamics at work in a local specific situations" (Stringer, 2007, p. 5). The dynamic in this study is the interaction between children's health and wellness and learning. The local specific situation is Hartford Public School's community schools. In an effort to understand how and why individuals act as they do, the researcher engages in an inquiry cycle of *looking*, *thinking*, and *acting* (Stringer, 2008). The five main processes in the cycle are: (a) designing the study, (b) collecting data, (c) analyzing data, (d) communicating outcomes, and (e) taking action (Stringer, 2008). How each was carried out in this study is explained next.

Designing the Study

In action research, designing the study encompasses identifying an issue worthy of investigation and developing a quality plan (ethical and trustworthy) for conducting the study (Stringer, 2007, 2008). The importance of the issues under investigation was explained earlier. The focus of the study, its design, and the research materials were developed collaboratively and through a process of consensus by the authors and key personnel from Hartford Public Schools and Achieve Hartford!, over three months and a series of four meetings. The University's Human Subjects Committee for the conduct of ethical research approved the study. The remainder of this section provides a description of how the study was conducted. The outcomes of the study are shared in the section on results, and broad recommendations for action are provided in the final section of the article.

Collecting the Data

Data collection, which is the *look* part of the inquiry cycle (Stringer, 2007, 2008), began with participant recruitment. The sample for this study was purposefully drawn from Hartford's seven community schools. The principal and community school director each received an e-mail from the lead author inviting them to attend a dinner and facilitated discussion. The e-mail contained a description of the purpose of the evening and asked the recipients to identify up to two additional individuals (e.g., nurse and teacher) that would attend the dinner and discussion. An invitation to the event was also posted to the Outlook calendar that is internal to Hartford Public Schools. Once the principal or community school director identified school personnel that would attend, the individuals received an e-mail invitation, explaining the purpose of the evening and the voluntary nature of participation along with a copy of the informed consent

Table 2
Distribution of Attendees by School and Position

School	Grades	Principal/AP	Community School Director	Teacher
A	PreK - 8	X	X	—
B	PreK - 8	X	X	X
C	PreK - 8	X	X	—
D	6 - 11	X	X	X
E	PreK - 8	X	—	—

form. The dinner, which was funded by the University, took place on the campus in the early evening, to accommodate potential participants' work schedules. The University campus borders Hartford.

Eleven individuals representing five of Hartford's seven community schools attended the dinner and participated in the discussion. The sample was comprised of four principals, four community school directors, two physical education teachers, and one assistant principal. Table 2 depicts the type of school and distribution of attendees across schools by position.

The method for collecting data was a facilitated, focus group discussion. Focus groups are a qualitative interview method for obtaining participants' perceptions on a defined topic of interest in an open, nonthreatening environment (Krueger & Casey, 2009). Using Krueger and Casey's (2009) focus group recommendations as a guide, the discussion was structured as follows: (a) welcome, (b) overview of the topic, (c) review of ground rules, and (d) the questions.

The lead author facilitated the discussion, which lasted two hours. During the welcome, participants were thanked for attending the focus group and the purpose of the project and the evening's logistics were reviewed. Then, ground rules for the conversation were covered. The main questions that framed the discussion were as follows.

1. What are the health issues that you perceive affect student learning at your school?
2. What are the local strategies that you feel are especially promising in addressing the health issues your students face?
3. What are the related research questions that you would like to answer on this topic?

Each participant was invited in turn to give input and express opinions to ensure that varying points of view were obtained. Active listening techniques were employed and follow-up questions primarily took the form of elaboration probes, to elicit more information,

and clarifying probes, to check for understanding and clear up any confusion (Rubin & Rubin, 2012). The discussion was digitally transcribed, verbatim, in real-time during the evening using word processing software and a laptop computer. The second author recorded field notes on a computer and the third author served as scribe, recording notes on chart paper.

Analyzing the Data

Data analysis, which is the *think* part of inquiry cycle (Stringer, 2007, 2008), was carried out as follows. A verbatim transcript served as the data set for analysis. Procedures commonly used in qualitative research were applied (Marshall & Rossman, 2011; Merriam, 2009). To enhance credibility, the data were examined and re-examined several times throughout the analysis process. First, the lead and second author independently read the focus group transcript and took notes in the form of memos to capture initial impressions made and emerging themes. Sections of text (e.g., words, phrases) were marked and coded (i.e., labeled), by hand or using word processing features including comment and highlight. With each reading, themes, categories, and corresponding coding were refined and modified as necessary. Then, the independent data analyses were compared, and the first and second authors came to consensus on the themes.

Results

The presentation of results are organized according to the issues identified as interfering with student learning, the local strategies perceived as especially promising in addressing these issues, and the research questions that participants want answered. Related themes that emerged through the data analysis are presented along with quotes that are representative of participants' responses.

Health Issues Perceived to Affect Student Learning

When asked to describe the health issues that they perceived affected students' learning, focus group participants described multiple stressors experienced by the children in their schools. Participants' stories revolved around the interaction between children and their

immediate environment—families, neighborhoods, and schools. The stressors described centered on the challenges faced in meeting children's basic needs, including access to adequate food, housing, and healthcare and safeguarding against environmental threats. Participants perceived the stressors negatively affected students' overall physical, emotional, and social health and wellness. Adverse consequences, participants explained, were observed in children's behavior and academic outcomes.

The child's health and wellness. Participants talked about students' families and neighborhoods and described the effects these environments had on the children's physical wellbeing and mental health. A teacher stated:

> [Students] have so much going on in their lives that when you bring them to the school, it's hard for them to differentiate between home, school . . . that affects their learning, their intellectual learning, which is mental health. That affects their physical health. That affects their social health. That affects everything. (T1)

Students' mental health was a significant concern for several of the participants. While students are receiving services and supports through their Individualized Education Programs (IEP) and 504 plans under the U.S. Rehabilitation Act, participants perceived the services were not meeting the students' needs. A principal shared, "you know, last year I recall we had three specific students where they were really heavy-duty children, always with a lot of mental health issues. They have so many services, but I just feel it wasn't helping them." (P3)

Likewise, children's physical wellbeing worried the participants. In particular, access to quality health care posed problems. Many of the children in Hartford's community schools are covered by state or federal health insurance (Medicaid/CHIP). The limits of the policies were described as posing barriers for children (e.g., coverage for glasses, medications). A community school director explained:

> Having access to the proper health care to manage some of the issues that they have. . . . Several students that have asthma might miss days on end of school, again, because they may not have the correct access to the health care to manage that type of problem. (C1)

Similarly, another community school director talked about the need for better access to eye care and insurance to cover the cost of glasses:

> For the last two years, teachers have been talking about how students can't see the board. Trying to figure out how to address the vision issues and seeing if we can bring in resources

to help identify what those resources are to take care of those issues.

> But the other thing, too, is if students have state insurance, and they're only allotted one pair of glasses a year, they're students, they're kids, what happens when their glasses break? They go for a year without any glasses to help support them. That affects their learning. (C3)

Participants also discussed students' understanding of their own physical and emotional development and the need to provide ongoing guidance and education. Students were described as lacking basic health information about personal hygiene and sexuality. A community school director shared, "We have high schoolers at our school, conversations and knowing about sexual activity and STDs, health issues that are becoming aware to us" (C4). Similarly, participants were concerned about middle school students' and even the younger children's understanding of how "their body . . . operates". As one principal explained:

> When you look at our middle school students, when it comes to health, the things they need to know at a certain age, developmentally. When they get to talk about sexual things or you hear things that [are] not appropriate for that age group. There's a lack of education, period. (P1)

In sum, participants shared concerns about how students' emotional and physical health affected learning and overall wellbeing. The lack of access to adequate health care services and insurance as well as students own understanding of their developing bodies were highlighted as two factors that were having a negative effect on student's health. Nevertheless, participants' stories about the health issues that they perceived affected student learning at their schools largely centered on the interaction between the developing child and the family environment, and these emergent themes are presented next.

The family environment. Virtually every participant shared concerns about the interaction between the developing child and the family environment or system (Turnbull, Turnbull, Erwin, Soodak, & Shogren, 2011). Participants described whole family (e.g., culture, socioeconomic status) and individual family member characteristics (e.g., health, coping) that in turn affected students' health and learning. Examples of the disadvantages children's families were said to experience clustered around family members' health, education and understanding of their children's health issues, involvement in domestic violence, and values and beliefs, including those based in culture and religion. These issues were characterized as placing a strain on families' capacities to meet their basic needs and those of their children.

The family's basic needs. Participants talked

about the "challenge" of meeting students' "basic needs" and their effects on students' "mental health, behavior health, and social health". Participants explained that students in Hartford's community schools frequently experience housing and food insecurity. They shared stories about how many of the students' families struggle with gaining access to and maintaining safe, affordable housing. Some families are chronically homeless, and others might be episodically homeless. Still other families commonly move from neighborhood to neighborhood within the city limits. In turn, children frequently change schools, and this poses a barrier to learning. A principal explained, "The more times they move, the higher the rate of their academic failure. It's harder for their success. . . . These children, you know, not just four times moving, they're moving schools continually." (P2) A community school director expressed similar concerns:

> From day to day, they may not always know, tomorrow, 'Am I returning to the same school? Am I going to a completely different place? Will we be at the shelter tonight?' Those are the types of things that they bring to the table that impairs learning. . . . If the alarm clock didn't go off at the shelter, I'm late for school. By the time my day's started, I've had a level of stress that I now bring into the classroom. That does really impair how well they learn. (C1)

Along with dealing with the stressor of not knowing where they might be living at any given moment, students in Hartford's community schools live in households with inadequate, insecure access to food. Participants described how children are apt to come to school hungry. A teacher stated, "We notice that some of our students K-2 come to the building in the morning late and are hungry. They've missed the whole breakfast time, and they haven't had breakfast at home, which affects their learning, obviously." (T1) A community school director talked about how the free and reduced meals they provided were not sufficient to address the pervasiveness of the problem:

> We offer breakfast. In our after school program, there's dinner, but that's at 4:00 PM. If there's a long gap in eating, by the end of school day energy levels are down. It's hard for them to concentrate. You might find them trying to take another breakfast because they want to have something else to eat. The basic needs play into the mental health, behavior health, and social health. (C1)

Participants acknowledged the likely challenges to accessing an adequate supply of food as financial constraints, transportation, family functioning, caregivers' health, and the well-known problem of a near absence of grocery stores in Hartford's inner city neighborhoods.

Family members' physical and emotional health. Several participants described how individual family members struggled with their own mental or physical health. These issues were characterized as placing a strain on families' capacities to meet their basic needs and being visible in how students behaved in school. A principal explained, "When you meet the parents of those particular students, they were having major issues also, sometimes, mental health issues, sometimes just physical regular sickness. The kids, they do pick up a lot of the behaviors." (P1) Similarly, a teacher noted, "Parents seem to have mental health problems that aren't addressed. The students carry, you know, similar traits of the parents to the building, maybe it's because they've learned that from their parents. It's very difficult to handle those situations." (T2) Family members' physical health also affects some children "because they're either worried about the parents or the parents have medical conditions that they need to take care of or, you know, have disabilities because of the diabetes and things." (P2)

The family's education, understanding, and follow through. Participants perceived that some caregivers did not seem to be educated about or have a full understanding of their children's physical and emotional health issues. A principal talked about how children's "mental health issues were really going unrecognized and . . . not necessarily accepted at the parental level, so the children aren't being treated." (P3) The principal went on to explain, "I think it stems from a lack of awareness of mental health issues. Parents are quite often reluctant to admit that these things exist, for whatever the reason may be, the stigma associated with it." (P3)

Some participants also expressed concerns that parents seemed to lack a "full understanding" or be "uninformed or unaware of all of the proper protocols" (C2) to manage particular physical health problems like asthma or epilepsy. When it's cold outside, a parent might not let a child walk to school because the child has asthma. Participants noted that other families seemed to not have the capacity to follow through with getting their children needed health services or medications.

> Students labeled as ADD or ADHD and are receiving medication through the community health agency, they only get one month of prescription at a time. If you don't make your appointment and get there at the right date, the children go for a couple of days a week or a week and a half or two weeks without medication until the parent can get back to the place to get the medication. (AP1)

Family members' interactions and violence in the home. A few participants talked about their concerns regarding family members' interactions in the home. Some children witness physical (e.g., hitting, punching) or verbal abuse (e.g., name calling, foul language). In turn, the participants explained, those children are apt to

act out in those same ways at school, displaying aggression, anger, or disobedience, for example. A principal shared:

> A few of my moms talked about the domestic violence happening within the home. . . . . Then you see that behavior exhibited, especially the younger ones. You see them acting out because they see how it's handled at home with the punching and the hitting and the language, little first graders. (P2)

Similarly, an assistant principal reflected, "I think the children are exposed to a lot of experiences that they should not be exposed to. There's a lot of language that comes out from the parents or the adults in their lives." (AP1) The sense expressed was that families do not necessarily understand the consequences of "what goes on in the home" on children's learning and emotional health.

The family's culture, religion, values, and beliefs. Family cultural background was also cited as a factor that had an effect on children's emotional and social health. Participants mentioned the challenges in working with families from various cultural and ethnic backgrounds, especially those who were recent immigrants. They emphasized the struggle of juggling different values, rituals, practices, and expectations related to gender, children, and education. A principal shared several examples, highlighting the complexity of family culture, both micro and macro:

> Gender issues, where . . . a 14 year old is able to tell his mom what goes on in the house when he's not the best student, and how do you have that conversation? . . . Then we have the girls who are in these households who come to school very depressed because, yes, they're being pushed down, you know, terrorized. . . .
>
> There's the whole mentality of the boys get away with a lot and the girls are asked to do so much of helping out in the household, of being trained to be the supporter. They come to school very angry sometimes, 'I don't want to be responsible for the younger person.' That translates into all these frustrations that affect their learning. They can't focus. . . .
>
> We're dealing with the fact that we have two students whose mom just died. . . . from that culture, my understanding is the dead person stays at home, they do a lot of rituals, the kids were sent to school. We didn't find out from the parents that there was a death. We found out from a conversation with a second grader who is saying, 'This is the worst day of my life, my mom just died.' The third grader is giving information, bits and pieces, we are

trying to piece it together. That child is not in the moment at all. (P1)

To summarize, focus group participants identified numerous issues that they perceived were inhibiting families' capacities to meet their basic needs. These issues encompassed health, coping, education, violence in the home, and aspects of families' culture.

The neighborhood environment. Participants shared that physical safety was a significant issue for many of the children that attend Hartford's community schools. The students live in unsafe neighborhoods, with high rates of gang activity and crime (e.g., drugs, muggings, shootings). A teacher explained:

> [Students] may have to walk through gang or drug areas to get to school. . . . Our neighborhood isn't conducive to a friendly environment where parents can feel comfortable letting their children play outside. The parks are there, but they're not monitored as well as they probably could be. (T1)

More worrisome, one principal recalled, "We've had like a stabbing in East Hartford; was one of our kids' parents. The violence, not just the domestic violence in the household, but also community violence and death related to that." (P2)

In sum, the neighborhoods in which the children live with their families presented significant concerns for the focus group participants, and they perceived the violence was having an effect on students learning and wellbeing.

Local Strategies Perceived to be Effective

When asked to describe the local strategies that they felt were especially promising in addressing the health issues were affecting students' learning, participants described making significant efforts to build true community schools, such as those described by Dryfoos (1994, 2003, 2005) and others (Blank, 2005; Blank, Melaville, & Shah, 2003; Sanders, 2001, 2006). As explained by one principal:

> The model is to be a full service school to make sure that you meet the needs, all the needs of the students. I know we're looking to renovate our building. Built into the plans are a home medical suite, mental health suite, dental suite. We designed the building with that in mind. The whole first floor will be dedicated to students, children, and families based on what their needs are. (P3)

Another principal reflected:

> We want to make the school like a hub. The parents are comfortable going there. The idea is if we can help the parents have, you know, educational success, success with health, emotion, everything, then, that will filter into the students, too. I feel like we're building a

great partnership with the families. Those are things that they've identified that they are interested in. (P2)

Notably, virtually every participant talked about the ways in which they were authentically engaging families and trying to meet their expressed needs for support and education. Participants described how they had set up parent resource centers, hired parent coordinators, and engaged parents in the work of a community school. A principal shared:

One of the things that our parents have identified they would really like are the domestic violence or like a women's group. That's something that they have told me, so that's something we will work for next year. The other thing, they really want [are] GED classes. If you look at our demographics in our neighborhood, 50 percent of our adults do not have a high school diploma. We have a list. One of the parents, we were talking about it, I said, 'You're in charge.' She wrote a flyer. She has 50 parents interested in GED classes in Spanish. (P2)

Similarly, a community school director explained, "We have a fathers group that meets every Wednesday mornings from 9:00 to 11:00. They're called 24/7 Dads. That's another program we have for fathers so they can get together to help women." (C3) Another community school director noted, "We have a financial department center where we're trying to just help our families budget correctly, learn to be money savvy, to help them budget correctly for the future." (C2)

With the assistance of various community partners, participants had established mental health clinics, dental clinics, food pantries, and clothing pantries in their schools. They explained how they had made concerted efforts to expand collaborations beyond the immediate partnerships. Participants described engaging community organizations and state agencies to provide students and their families needed supports and services. Those mentioned included Planned Parenthood, the Department of Public Health, Catholic Charities, and local colleges. The partnerships with local colleges included the use of interns who might focus on the younger children that need additional attention. A community school director recounted:

We have a partnership with the local college where we have college interns who come in to facilitate small group programming to help empower some of our younger students, the more harder-to-engage students who are having some challenges behaving well or can't sit still through a class. They get a break from being in the room with 20 other students, which can be helpful, walk around the building with them. (C2)

Participants also spoke about the various curricula and programs they had established in their schools to meet students' developing needs. These included teen outreach programs that were primarily a pregnancy prevention programs focused on "building self esteem," truancy prevention programs with academic and home visiting components, to identify "what's going on at the home." Participants also described "gender based programs for students in a variety of grades."

To address students' challenging behaviors while promoting prosocial behaviors school personnel were embedding behavioral programs and interventions into the school day. A principal emphasized the progress they were making with a character education program that emerged from the students' expressed needs:

We're now using the second step. Previously, what we did was to have a person from Catholic Charities going into the classrooms to actually find out from the students what their needs are and to do those topics. A lot of them want to find out about just growing up to be healthy teenagers. Some of those topics were generated from students and [were] taught to them. (P4)

School personnel, families, and students were being trained in techniques such as mindfulness with the aim of improving the overall school climate. A principal shared:

One of the things we brought in last year in the school is the idea of mindfulness in education. We want the kids knowing all the challenges they walk into the door with, we want them to be able to drop it and be in the present in spite of what's going on. I start with the adults. We want the adults to know about mindfulness and then teach it to the kids.

Additionally, personnel with specific disciplinary expertise had been hired to address students' challenging behaviors. A community school director explained how they had put two behavioral interventionists in place.

They get there at 7:30, they facilitate cycle educational groups, one of them is called Breakfast Buddies. The students do a check in. We have a listing of students that may have had a rough day the day before, so we can grab the students, have a check in, touch point, and kind of frame them for the day. If need be, then you have another check in maybe at lunch. There's a separate group that, we don't like to call it Lunch Buddies, we haven't come up with a name yet. It helps to keep behavior to a minimum. It addresses the social piece, the emotional piece. That is definitely one strategy. In all the community schools, that's something at the forefront.

Research Questions Participants Would Like to Explore

The research questions participants were interested in exploring covered a variety of topics. A principal wondered, "Why we're not using all the scientifically-based research that we know how the brain works, how children and adults learn, why are we so against following it?" (P1) Another principal was interested in learning, "How does full inclusion positively or negatively affect both the SPED [special education] and non-SPED students?" (P3)

Participants wondered about students' perspectives on what it was like attending a community school and receiving the various services and supports afforded them. They wanted data on the effects of the interventions. In this regard, a principal wanted to know, "What impact is providing mental health services for those students or supports for them? How does that impact not only their learning but the learning of the other students in the classroom?" (P2) Also interested in students' perspectives, a community school director stated:

> A burning one for me, what is the effect of in-school suspension, out-of-school suspension on students that we know are already in a frame of mind or have the emotional issues, the social implications. You know, is there another strategy? Really, what is the effect? What are we saying to them? (C1)

Participants were interested in learning about how domestic and community violence affected students and their families, from their perspectives. They also wanted data on students' homelessness and migration among neighborhoods.

Implications for Practice and Action Steps

This paper presents the results of the data collection phase of a co-constructed action-research project that brought together 11 individuals from five of Hartford's seven community schools. The topics of discussion were the health issues that participants perceived affected student learning, the local strategies that they felt were especially promising, and the research questions that they would like answered. This paper represents a first step in the *act* part of the inquiry cycle—communicating the outcomes of the study (Stringer, 2007, 2008). The major findings from the current study are predominantly focused on the role that the child's environment plays on his or her health and wellbeing, and subsequent learning. For example, children in the Hartford community schools are exposed to a variety of stressors external to the school environment. These include food insecurity, poverty, family mental health issues, negative family cultural influences, transient housing situations, lack of parental education on myriad health issues, and exposure to unsafe neighborhoods and domestic or gang violence. It should first be noted that

these findings, on a local level, reproduce what has been published nationally regarding environmental stressors and their impact on a child's educational attainment. For example, health disparities in the treatment of asthma and availability of breakfast are significant health indicators that are known to influence academic success (Basch, 2010). Similarly, improving access to mental health services in schools has been identified as a critical factor for ameliorating gaps in academic achievement among high-poverty, urban students (Atkins et al., 2006). Therefore, we can conclude that the problems that face the children attending Hartford's community schools, and their effects on learning, are in agreement with national data suggesting that children who live in urban, relatively poor areas face unique and substantial obstacles to academic achievement that include inadequate fulfillment of the most basic needs.

The second major focus of this paper is the local strategies used by the community schools to target the various obstacles to learning associated with students' health and wellbeing. These include myriad student programs, social supports, parent groups, teacher and administrator initiatives, and behavioral techniques. These initiatives vary from school to school, and are typically need-based, meaning that they have been designed to respond to a community need identified by the teachers and the administrators (or, in certain instances, the parents and students). This aspect of the community schools highlights one of their critical purposes: They must be responsive to the needs of the community, which includes students, parents, extended families, and community stakeholders. This puts community schools in a unique position in which they must function as both a community organization and an educational institution. This is seen in stark contrast to the magnet and charter schools that also comprise the Hartford Public School system. Therefore, when standardized test scores are used as the basis on which student progress and school performance are assessed, what is missed are the significant, life contributions community make towards addressing health and environmental factors that negatively influence students' learning are often overlooked.

The third major focus of this paper is to present the research questions that educators and administrators develop through their daily interaction with students and families. It is notable that these differ widely from the types of research questions designed and developed by investigators in higher education or outside research and advocacy groups. For example, recent scholarly publications involving the Hartford Public School system have focused on teacher recruitment and retention (Cohen et al., 2013), continuity of individual student data points within the Hartford Public School system (Zannoni, Dougherty, Rudy, & Sternberg, 2013), and an analysis of district choice applications across the system (DelConte, Trivedi, Zannoni, & Dougherty, 2012). By contrast, the

types of questions developed by the focus group participants investigated the impact of various policies (e.g., suspension, inclusion) as they applied to students, or the effect of environmental factors (e.g., presence of other magnet schools, domestic violence) on student learning and behavior. Consequently, the need for translational research inquiry—that originates from and addresses the educational needs of the teachers and administrators most directly involved with the students—will be valuable in providing efficacious policy and instructional guidance for the school system going forward.

In sum, the results of this study are being used to create a call for proposals for University researchers to address these questions and disseminate findings to Hartford Public Schools and related community partners. This will form the second step in the *act* part of the inquiry cycle: taking action (Stringer, 2007, 2008). The authors of the current study, as well as partners in Hartford Public Schools and at Achieve Hartford!, will provide input on the specific research areas that will be emphasized in the call for proposals. These will include research into some of the health factors that influence academic performance (Question 1), as well as assessing the efficacy and characteristics of some of the strategies used to target these factors (Question 2). The hope is that the research projects will be a starting point for better assessing and improving the interaction between children's health and learning within the context of Hartford Public Schools. Such information could prove valuable in identifying long-term strategies to improve health risk factors that could have a direct effect on educational performance.

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Author Notes

Diana J. LaRocco, Ed.D.
Institute for Translational Research
College of Education, Nursing and Health Professions
University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117
dlarocco@hartford.edu

Diana is faculty in the Doctoral Program in Educational Leadership at the University of Hartford. In addition to supervising doctoral-level research, she teaches research courses. She directs the University-charted Center for Leadership in Education and Health within the Institute for Translational Research at the University of Hartford. She is also the University Coordinator of Assessment.

Beth A. Taylor, Ph.D.
Institute for Translational Research
College of Education, Nursing and Health Professions
University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117

Beth is an Assistant Professor in the Department of Health Sciences and Nursing at the University of Hartford. She directs the University-charted Center for Health, Care and Well-Being within the Institute for Translational Research. She is also the Director of Exercise Physiology Research at Hartford Hospital. Her research focuses on age and sex differences in vascular function and cardiovascular responses to exercise.

Suzanne C. D'Annolfo, Ed.D.
Institute for Translational Research
College of Education, Nursing and Health Professions
University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117

Suzi is an Assistant Professor and Coordinator of School Partnerships in the Department of Education. She is interested in two streams of work that focus on practical application: (a) the effect of brain-based learning on student engagement and learning and (b) implementing communities of practice with teachers to benefit students and inform practice.

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