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ORIGINAL PAPER

Engaging Families in Supporting the Whole Child: Chicago West Side Parents' Perceptions of Child Health

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Abstract

Schools and districts nationwide have heavily emphasized supporting students' health and wellbeing by engaging families and caregivers to truly support the "whole child," as outlined in the Whole School, Whole Community, Whole Child (WSCC) model. The COVID-19 pandemic only heightened the important role of school and family partnerships in supporting children's health. The Chicago Public Schools (CPS) Healthy CPS initiative is designed to support schools in their compliance with existing health and wellness policies to support child health. This study aimed to explore parents' primary health concerns for their children, characterize these views, explore any alignment with WSCC, and identify recommendations for family engagement in school health promotion. Eleven semi-structured focus groups (seven English, four Spanish) were conducted with CPS parents/caregivers. Groups were conducted in spring 2021 on Chicago's West Side, one of the more historically disinvested communities in the city. Focus groups were recorded, transcribed, and analyzed using constant comparison, incorporating both inductive and deductive approaches. Key themes emerged related to parents' perceptions of schools' role in promoting health including: (1) parents see child health as a shared responsibility between families and schools; and (2) parents identify significant structural barriers and inequities that impede child health, such as racism, community violence, and a lack of community resources in their neighborhoods, and believe schools can do more to address them. Parents' viewed child health and wellbeing as multidimensional and stated that these dimensions must be considered holistically. Their views aligned with WSCC family engagement-related components. Parents recommended that schools employ a variety of strategies to engage families. Findings from this paper have implications for engaging families in school health policy and program development as well as implementation, particularly those in lower income, urban communities that have faced a history of structural inequities.

Keywords Parent engagement · Family engagement · School health and wellness · School-based health · Local school wellness policies · WSCC · Whole child

Highlights

- Chicago Public Schools parents in in this sample see child health as a shared responsibility between families and schools.
- Consistent with the long-standing evidence documenting historic disinvestment on the West Side of Chicago, participating parents identify significant structural barriers and inequities, such as racism, community violence, and a lack of community resources in their neighborhoods, and believe schools can do more to address them.
- Parents recommend schools take a variety of strategies to engage families and recommend more leadership opportunities for parents.

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Introduction

"Schools are the heart of health" in supporting the physical, mental, social and emotional health and wellbeing of all students (Institute of Medicine, 2012). Schools and districts nationwide have long been working to support students' health and wellbeing through school-based health promotion activities including but not limited to linkages to health services, wellness policies governing the school food environment, and fitness and nutrition programs for children and their families. However, schools cannot do this in isolation—it takes working with community partners and agencies, families and caregivers, and other sectors of society (e.g., health care, recreation, transportation, etc.) to truly support the "whole child" (Institute of Medicine, 2012; Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015). The COVID-19 pandemic only heightened the focus on these issues; in particular, the pandemic underscored the important role that school and parent/family partnerships play in supporting healthy growth and development of children (Mapp and Bergman's 2021). Family engagement efforts have been central to schools' work to ensure student success and wellbeing (Garbacz, Herman, Thompson, & Reinke, 2017) long before the pandemic. That said, the shift to virtual learning during the pandemic forced families and caregivers to take on additional, unprecedented roles. There remains an opportunity for exploration as to how school-based health promotion and family engagement efforts can best be aligned, and how schools can foster family engagement in their attempts to support child health and wellbeing (Lee et al., 2019).

Both the disciplines of education and public health have centered on the social ecological theory, which posits that a student's health and learning are influenced by myriad factors at multiple levels. These include the family and peer levels (e.g. parental support and monitoring), the school-level (e.g. teacher support), the community-level (e.g. community cohesion), and the societal-level (e.g. supportive policies and legal frameworks) (Golden, McLeroy, Green, Earp, & Lieberman, 2015). Family engagement, defined as collaboration between families and school personnel that aims to foster student learning, health, and development (Center for Disease Control and Prevention CDC (2019)), sits at the nexus of the family and school levels. Expanding upon the opportunities for overlap across the family and school levels, family engagement theories have postulated that strong home-school relationships can foster benefits through a variety of mechanisms. Communication and participation is theorized to lead to prosocial behavior, motivation to achieve, and language growth (Caspe, Lopez, & Wolos, 2006). Further, consistent two-way communication between school and home is theorized to promote student development (Epstein, 2001). Finally, well-trained educators, culturally-relevant and appropriate communications, a welcoming environment, and shared decision-making is theorized to foster improved exchange between families and schools to further promote student growth and wellbeing (Halgunseth, Peterson, Stark, & Moodie, 2009).

A growing body of empirical research links family engagement with improved child educational and psychosocial adjustment outcomes and shows that there are *many* meaningful ways to engage families. This body of research has motivated legislators, educators, and researchers to call for investment in strategies to promote family engagement in schools (Cheung & Pomerantz, 2012; Hill et al., 2004; Wang & Sheikh-Khalil, 2014; Wong et al., 2018; Wood et al., 2017). However, challenges and barriers— including time and resource constraints (Hornby & Blackwell, 2018; LaRocque, Kleiman, & Darling, 2011), limited skills and training among teachers for working effectively with parents and caregivers (LaRocque et al., 2011), and lack of mutual trust and understanding between families and schools (Henderson, Williams, & Bradshaw, 2020; Hornby & Blackwell, 2018) — have resulted in lower levels of family engagement. There is an opportunity, particularly in low-income settings, to improve family engagement efforts. Research indicates that parental participation in schools is heavily influenced by school staff member's perceptions of parents' backgrounds, such viewing parents as uneducated or undervaluing education. These perceptions have negative equity outcomes on families from nondominant backgrounds in engaging with schools (Baquedano-López, Alexander, & Hernandez, 2013; Langford et al., 2017; Sim et al., 2021). With this understanding, there is a particular need to better comprehend and document successful practices for family engagement. This is especially needed in communities of color, especially lower-income, urban communities that lack mutual trust with schools as some communities have experienced decades of historic disinvestment (Langford et al., 2017; Sim et al., 2021). This includes those on the South and West Sides of Chicago (Lipman & Haines, 2007).

Family engagement has been considered a key component in the promotion of health and wellness in the field of school health. The Whole School, Whole Community, Whole Child (WSCC) framework, developed by the Centers for Disease Control and Prevention (CDC) and ACSD (formerly known as the Association of Supervision and Curriculum Development), is an integrated and collaborative approach to improving student health and educational outcomes (Basch, 2011) and supporting and engaging the whole child (Chiang, Meagher, & Slade, 2015; Lewallen et al., 2015; Morse & Allensworth, 2015). Beyond family engagement, WSCC includes nine other components linking child and school health and wellness (i.e., health

education, nutrition education and services, physical activity (PA) and physical education (PE), health services) with behavioral/psychosocial supports (i.e., social and emotional climate, counseling and psychological services), the physical school environment, employee wellness, and community involvement (Lewallen et al., 2015). In a study of WSCC component implementation, family engagement was the least-frequently implemented of the ten components (Lee et al., 2019). Both the WSCC framework and socio-ecological theory (Golden et al., 2015) underscore the need to explore how family engagement can be improved. We need to understand how it can better support child health, and how it can be used as a crosscutting strategy in schools' efforts to support all components of child health. Because of compounded historical institutional inequity and racism, there is a particular need to understand how schools can better partner with families in communities experiencing continued disinvestment and continued effects of systemic racism (Mapp and Bergman's 2021). However, to develop this understanding, researchers need to first better understand parents' own views of what child health and wellness means and which components related to child health most resonate with parents.

Chicago Public Schools (CPS), the 4th largest school district in the nation (United States Census Bureau, 2017), provides an opportunity to do so. CPS has long been invested in supporting child health through its Healthy CPS program, an initiative designed to guide schools in complying with over 50 federal, state, and district-level health and wellness policies (Chicago Public Schools, 2020, 2021a). Healthy CPS was not originally based in the WSCC framework but addresses many WSCC components, including family engagement. Healthy CPS requires that a Wellness Team is created at each school that meets regularly and reports annually to the school's parent-led Local School Council (LSC). Despite being a priority, family engagement remains challenging, particularly in parts of Chicago, such as the West Side of the city, that have experienced historical disinvestment and inequity. This study was conducted to inform a pilot project designed to better support schools on Chicago's West Side in their efforts to achieve Healthy CPS.

To this end, this study's goal was to understand how parents of children attending schools on Chicago's West Side conceptualize child health and how they view the role of schools in promoting child health. Focus groups conducted with parents/caregivers aimed to answer the following study questions: (1) What are parents' primary health concerns for their children and how do parents view the role of the school in addressing these concerns?; (2) How can parents' understanding of child health/wellness be characterized and what relationship, if any, does this have with WSCC?; and (3) What recommendations do parents have for family engagement in school health promotion?

Methods

This qualitative study, consisting of focus groups conducted with parents/caregivers of school-aged children, was conducted to explore parent's primary health concerns for their children, to characterize these concerns and their possible relationship to the WSCC model, and to identify their recommendations for family engagement in school health and wellness activities. This study was conducted as part of a research project for the Policy, Practice and Prevention Research Center (P3RC) at University of Illinois Chicago School of Public Health; the P3RC is one of 26 centers funded by the CDC between 2019–2024. The project involves a partnership between the P3RC and CPS.

Setting

As noted above, this study was conducted to inform a pilot project designed to support schools on Chicago's West Side in their efforts to achieve Healthy CPS. Families in this study were recruited from forty-three schools serving nearly 20,000 Kindergarten through 8th grade students. Located on Chicago's Westside, these schools consist of predominantly African-American/Black (62%) and Hispanic/Latinx (35%) students; 78.6% of students quality for free or reduced price meals (Chicago Public Schools, 2021b). These schools and the surrounding communities have been impacted by a long history of legal racial segregation, inequities in citywide resource allocation, and limited retail, business, and social investment (Pappas, 2022). Neighborhood schools in these communities are documented to be under-resourced as compared to other areas of the city (Coffey, 2021; Stovall, 2013).

Participants

Eleven focus groups were conducted, seven in English (32 participants) and four in Spanish (17 participants). In total, 49 parents or caregivers participated in the focus groups. Demographic information across all groups and by Spanish-speaking (4) and English-speaking focus groups (7) are presented in Table 1. Although there were 49 participants, completion of the demographic survey was optional and those who chose not to complete it or identify were recorded. Across all eleven groups, most participants identified as female (77.6%) and as either Black or African American (42.9%) or Hispanic or Latinx (40.98%). The seven English-speaking groups included a majority of participants that identified as Black or African American (62.5%) and

Table 1 Key characteristics of parent focus groups.

Characteristic	Parent Focus Group Participants $N = 49$ participants (11 groups)	Spanish Parent Focus Group Participants $N = 17$ participants (4 groups)	English Parent Focus Group Participants $N = 32$ participants (7 groups)
Race/Ethnicity			
White	3 (6.1%)	0 (0.0%)	3 (9.4%)
Black or African-American	21 (42.9%)	1 (5.9%)	20 (62.5%)
Mixed or other race	0 (0.0%)	0 (0.0%)	0 (0.0%)
Hispanic or Latinx	20 (40.8%)	14 (82.3%)	6 (18.7%)
Missing or Prefer Not to Say	5 (10.2%)	2 (11.8%)	3 (9.4%)
Gender			
Female	38 (77.6%)	15 (88.2%)	23 (71.9%)
Male	6 (12.2%)	0 (0.0%)	6 (18.7%)
Missing or Prefer Not to Say	6 (12.2%)	2 (11.8%)	3 (9.4%)

female (71.9%). Only six individuals identified as males and were part of the English focus groups. The four Spanish-speaking groups did not include anyone who identified as male and had a majority of participants identify as Hispanic or Latinx (82.3%). No other sociodemographic characteristics were obtained for the parents.

Instrumentation

A focus group topic guide was developed to explore parents' primary health concerns for their children, their perspectives on the role of the school in addressing these concerns, and their recommendations for family engagement in school health promotion. Topics and prompts on the guide also related to parents' knowledge of specific Healthy CPS initiatives (e.g., health education, healthy snack policies, school gardens, etc.) as well as their knowledge and experience of supports provided during the pandemic. The guide was reviewed with CPS district staff involved in school health and wellness for appropriateness of language, flow, and sequencing (Krueger & Casey, 2014).

Procedure

Parents were recruited for participation in virtual focus groups using two mechanisms. Community-based organizations (CBOs) who sit on the study's advisory committee assisted in distributing recruitment information to parents of children who attend the 43 schools to recruit participants for six groups. Additionally, LSCs, the parent and community governing bodies at each school, were invited to participate and helped to recruit for five groups. Parents were asked to contact a study investigator by phone or email if they were interested in participating. Upon initiating contact, they were asked to confirm that they were parents or full-time caregivers of Kindergarten through 8th grade children in one of the target schools. While this eligibility was assessed, parent versus caregiver status was not recorded. For consistency and brevity, the term "parent" is used throughout to encompass both parents and caregivers.

Virtual focus groups were conducted via Google Meets between February and April of 2021; groups lasted approximately sixty minutes and was guided by the procedures outlined in Krueger & Casey, 2014 (Krueger & Casey, 2014). Groups were conducted in Spanish ($N = 4$) or English ($N = 7$) depending on parent preference. Three study team members were present for each focus group.

Informed consent was obtained prior to starting the focus groups through an electronic survey link using Qualtrics. Participants were encouraged to complete an optional demographic questionnaire after completing the consent form. Groups were digitally recorded and transcribed. Recordings of focus groups with Spanish-speaking parents were translated to English after transcription. Participants received an electronic $50 gift card at the conclusion of their focus group. The study was approved by the University of Illinois Chicago Institutional Review Board (protocol #2019-1161).

Study Team

The study team consisted of individuals with diverse skills, racial/ethnic identities, and languages spoken. Roles during data collection consisted of two lead moderators, two note takers, and a facilitator who had also led recruitment and who checked consent form completion, eligibility, and provided technical support. Analysis consisted of two primary coders and three co-analysts who consulted on

analysis throughout the process. The lead moderator for the Spanish speaking groups is a native Spanish speaker who identities as Latina. The lead moderator for English-speaking focus groups (conducted primarily with participants identifying as Black or African-American) was also one of the co-analysts, and identifies as a Black woman and a parent of a school-age child during the time of the study. One notetaker identifies as a Latina and native Spanish-speaker, the other identifies as a White woman, who also served as a primary coder. The facilitator and other primary coder identifies as a White woman, a non-native Spanish speaker, and the parent of school-aged children. The lead study investigator and co-analyst identifies as a White woman and the lead collaborator from CPS, who also served as a co-analyst, identifies as a Black woman who is also a parent of school-aged children. In summary, this mix of perspectives and backgrounds enriched the study team's ability to build rapport with participants and engage deeply in analysis. That said, differences in education levels and socioeconomic status between parent participants and the study team may have impeded the team's ability to fully understand the perspectives and experiences of parents in this sample. This limitation was mitigated through member checking, described below in the analysis section.

Data Analysis

Audio-recordings of the focus groups were transcribed verbatim, formatted as text files, and inputted into MaxQDA (Software, 2022), a computer program for managing qualitative data. Consistent with constant comparative analysis, an iterative process of inductive and deductive data collection, analysis, and summarization was conducted throughout the study to ensure that theoretical saturation or informational redundancy was reached (Corbin & Strauss, 2015; Padgett, 2012). Initially, entire transcripts were read several times to obtain a clearer understanding of issues discussed within each group. The text was then coded line by line to generate categories that reflected "health concerns," "definition of child health," "perception of school role in health," "recommended strategies," etc. This process consisted of identifying discrete ideas and concepts related to the topic areas; breaking transcripts down into smaller conceptual text units (e.g., sentences and paragraphs), and labeling or coding text units according to their meaning. Transcripts were coded independently by two coders until 80% agreement was reached.

The codebook was then reviewed and compared to the data many times to determine relationships between constructs. Upon initial examination of the "definition of child health" coded output, it became clear that parents' definitions of child health aligned closely with the WSCC component topic areas, meaning they understood health to constitute a range of dimensions including regular physical activity, proper nutrition, social emotional wellbeing, access to safe and healthy physical environments, etc. While the study's aim was always to characterize how parents viewed child health, the authors chose to use WSCC as a framework to facilitate this characterization. They therefore chose to take a more deductive approach (Padgett, 2012), deriving a priori codes from WSCC. This analysis decision was in alignment with the iterative nature of a hybrid qualitative analysis, drawing from both inductive and deductive approaches (Padgett, 2012).

Therefore, ten additional codes, aligning directly with the ten WSCC framework components, were applied to the data through an additional cycle of coding. These new codes included "Family Engagement," "Nutrition environment and services," "Social and emotional climate," "Physical education and physical activity," etc. This set of codes were applied by the two primary coders and again reviewed to ensure agreement. This was done to answer the second research question, characterizing how parents understood child health, and in particular, exploring how parents' perceptions aligned with WSCC.

After coding was completed, code frequencies were examined and compared across groups to see if there were differences between the groups by Spanish versus English or if there were differences between the groups recruited by CBOs and those recruited by LSCs. Some key differences were found, particularly between the CBO-recruited groups and the LSC-recruited groups and these are reported in the findings.

Data quality was evaluated using the trustworthiness criteria described by Lincoln and Guba (1985), including prolonged engagement, peer debriefing, member checks, progressive subjectivity, and confirmability/dependability audits (Lincoln & Guba, 1985). For example, as alluded to above, authors engaged in a peer debriefing process, whereby the two coders met regularly with the other co-analysists to ensure trustworthiness of the inferences made from the data (Lietz, Langer, & Furman, 2006; Lincoln & Guba, 1985; Patton, 2002). Meetings consisted of reviewing findings, discussing themes, and discussing areas of potential bias, such as where authors may have drawn too heavily on their own experiences as parents, as well as any possible discrepancies in the data. Additionally, member checks were conducted during follow-up interviews by asking participants to confirm and elaborate on issues, ideas, experiences, and practices that came up in the initial interview. Emergent constructs were also discussed with key informants during advisory meetings, etc. Additionally, preliminary findings were shared with a community advisory committee, including parents and CBO representatives, and district representatives to discuss findings and conduct member

checking (Lietz et al., 2006; Lincoln & Guba, 1985; Patton, 2002).

Results

As described above, data were examined to explore parents' primary health concerns for their children and how they view their schools' roles in addressing them. Additionally, this analysis aimed to characterize parents' health concerns and how they relate to WSCC components, as well as what recommendations parents have for family engagement in school health promotion activities. To that end, the findings below are reported under headings aligned with those three aims.

Parents' Health Concerns and their Views of the Role of the School in Addressing Those Concerns

During focus groups, parents were asked "What comes to mind when you think about a 'healthy child'?" and "What should a school's role be when it comes to supporting 'healthy children'?" Reponses in all eleven focus groups reflected a whole child perspective. One parent noted, "…I think health is an umbrella that encompasses many things… nutrition, emotional state, and academic state are important. It's like a puzzle that puts together a little bit of everything, and all the components are equally important" (Group 6). Another commented "Whether it's physical, mental, spiritual, all of those are important when it comes to good health, when it comes to children." (Group 2).

Two themes emerged related to how parents view schools as promoting child health and how they view the school's role in working to address their health concerns. These themes included: (1) Parents see child health as a shared responsibility between families and schools; and (2) Parents identify significant structural barriers and inequities and believe schools can do more to address them.

Child Health is a Shared Responsibility

Parents in all eleven groups articulated a belief that children's health is something that both parents and schools are responsible for cultivating and that a joint approach is needed to accomplish this. As mentioned above, parents perceived the schools to be key sources of emotional and social support for their children and as a safe space where they should be able to learn, build social connections, be physically active, and thrive. Parents described school as a "second home… this is where they get their brains fed, food for the soul… It helps with your social skills, just the whole environment of giving a chance for kids to develop on their own" (Group 8). Parents identified both principals and teachers as playing critical roles in creating and maintaining "a culture of health" within schools. One parent commented, "All the adults in school… the teachers, the assistant principal, almost everyone that works there, it's someone that the kids feel they can trust" (Group 10).

Parents in all groups reported that their schools have an opportunity to strengthen the foundation for a shared responsibility for child health with families. Parents stated that communications could be improved, noting "because there was no communication… there are schools, [where] parents don't even know who the principal is; they have never met them in person… principals should be more like leaders, make themselves more known to students and parents" (Group 3). Another parent went on to say, "You got to [have] a relationship with the community. You got to build relationships with the community and the school, the community's got to feel that they've got a voice in their school" (Group 11). Again, principals were noted as essential in accomplishing this. For example, a parent explained that "with the principal, once they see…like that I'm working. I only have a limited time, but in these five or ten minutes, if you have time to check in with me, let me know what's the main thing I need to have with my kids or concerns… That would be great. That's that one-on-one connection" (Group 2).

Notably, parents in groups recruited by LSCs more often spoke of the efforts being made by school staff to take on this shared responsibility while parents in groups recruited by CBOs spoke more about their aspirations for shared responsibility and shared personal experiences where they had not yet seen evidence of this in reality, such as school staff that offer only reminders of medical forms that have not been submitted rather than resources or linkages to services and supports.

Parents Identify Significant Structural Barriers and Inequities

In commenting on the ways in which schools can and do promote health, parents expressed their experiences of how racism impacts the schools' ability to provide services, programming, and connections to community resources for students and families. While parents in both English-speaking and Spanish-speaking groups articulated this concern, this was discussed more consistently and more profoundly within the English-speaking groups, consisting primarily of Black/African-American parents. Parents in English-speaking groups specifically described their perceptions that schools on the city's more well-resourced North Side likely have a greater capacity to implement more health and wellness programs and activities than those on the city's West Side, where the parents in this sample reside. As one parent noted, "Because what's going on in the North

Side -- what's going on, there. It's not going on over [here in our community]. For some reason, we are redlined out. It was because of our color. We are left out" (Group 11).

Parents in all groups noted a lack of resources manifest in a variety of ways. Parents commented on the lack of adequate staffing for PE teachers, nurses, and counselors to adequately support physical and mental health in their children's schools. Responses included "perhaps there are just too many kids for one teacher" (Group 5), "they won't have a nurse [if a child is sick]. So… thinking about how disproportionate we are as a community, we don't have those basic services for our children" (Group 4), and "schools have only one counselor, so, one counselor for more than a thousand students, it honestly doesn't work" (Group 5). Parents also commented on a lack of physical resources and structures (i.e., gymnasium space, outdoor recreation space, etc.).

Again, parents in English-speaking groups specifically linked this lack of resources to larger inequities across the city. Parents noted such inequities related to available space for children to play, park district classes and activities, mental health services, and access to fresh fruits and vegetables. Community violence and structural barriers within the built environment were recognized as a result of historic inequities in resource allocation and racism in Chicago and highlighted as particularly detrimental to the mental and socioemotional wellbeing of children. Parents also noted how these inequities had exacerbated the effects of the pandemic – with magnified impacts on food, financial, and housing insecurity.

Characterization of Parents' View of Child Health and Corresponding WSCC Component Alignment

As noted in the methods section, it became evident that our analysis revealed the way parents conceptualized child health appeared to align with the WSCC components. Therefore, an additional layer of analysis was conducted to more rigorously assess this alignment. Indeed, this analysis revealed that parents' responses touched on all ten WSCC components, as shown in Table 2. Staff wellness was only mentioned once; likely because child health was the focus of the groups. The initial responses to the question about a school's role in supporting health related most directly to "Physical Education and Physical Activity" and "Nutrition Environment and Services." As the conversations in the focus groups progressed, parents moved to a variety of additional WSCC topics including "Social Emotional Climate," "Physical Environment," and others. "Family Engagement" and "Community Engagement" were often mentioned in tandem with other components, such as the value in engaging community organizations to provide opportunities for physical activity or nutrition education for children and families.

The way that parents discussed WSCC component topics aligned with the themes described above. "Family Engagement" (mentioned in all eleven groups) was typically discussed in conjunction with other WSCC components, such as "Nutrition Environment and Services," (also mentioned in all groups) and discussed as a shared responsibility between schools and families. Parents described ways in which schools and parents can work together to ensure that children have access to healthy foods both at home and at school. Examples given included family access to school meals during the summer and pandemic, healthy eating tips sent home in school newsletters, and the school's ability and willingness to connect families to nutrition-related community services and resources (e.g., food banks, community gardens, etc.).

Similarly, when discussing "Social Emotional Climate" (mentioned in all groups), "Physical Education and Physical Activity" (mentioned in ten of the eleven groups), and "Health Education" (mentioned in six groups) parents emphasized that these are essential elements of overall child health and described the important role that schools can play alongside parents in addressing both. One parent stated, "The school can make a difference and it has made a difference, teachers sometimes make a difference by supporting kids too, not just learning math or letters, but that they can feel that they're appreciated and that they have a special place inside the school, and not just a child who is passing by" (Group 5). Health education, including topics related to both nutrition and sexual health, were the areas in which parents saw themselves playing a dual role with the schools in teaching students about these topics.

Additional WSCC components were mentioned in the context of parents' discussion of structural barriers and inequities, as described above. The "Physical Environment" of the school (mentioned in ten groups) was emphasized as having a significant impact on student's mental and physical health, with parents noting community safety in the area surrounding schools and larger neighborhoods. Regarding "Health Services" (mentioned in nine groups), parents viewed the school as a coordinator of resources and as a facilitator of access to physicals, dental appointments, and hearing exams; lack of services within the community was recognized by parents as a barrier to some schools in being able to provide these services. "Community Involvement" (mentioned in nine groups) was seen as related to family engagement but was something that was limited by pandemic. Parents saw engagement of the community as a key piece in holistically supporting student health and stressed a need for greater synergies between schools, families, and the broader community. Finally, "Counseling, Psychological and Social Services," (mentioned in five groups) were

Table 2 WSCC Components, Associated Themes, and Illustrative Quotations.

WSCC Component	Number of Focus Group Transcripts	Themes	Illustrative Quotations
Family Engagement	11/11	Parents noted incentives/motivations, a variety of opportunities for parent engagement and parent leadership, and the importance of trust and relationship building as essential to family engagement	*"To engage…they need to be doing more contact, like phone calls, more emails to the parents to make sure…they'll be invested…I think there could be more constant communication from the school.'"* – Group 1 *"The whole thing is that you get parents to talk to other parents. It's all about building relationships."* – Group 11 *"When you ask a parent, 'What do you need?' How can I help you?' You'll get an honest answer."* – Group 8
Nutrition Environment and Services	11/11	Parents reported the quality of school meals, student preferences, healthy food options, nutrition classes/ education, and food insecurity as key factors related to nutrition	*"The environment in which one lives is very important in a person's health. Food also has a lot to do with it… in the school, I have noticed the progress that has been made."* – Group 6 *"They have to be nourished. They have to be able to focus. So none of us can focus when we're hungry."* – Group 10 *"Our school needs a food pantry…If parents were able to come and pick up a bag of fresh vegetables, a bag of fruit… Cause a lot of our parents don't cook vegetables, don't eat that much fruit.* –Group 8
Social and Emotional Climate	11/11	Parents commented on the impact of the physical environment, bullying, community violence, and pandemic on child wellbeing as well as on how school staff acted as key supports	*"When the kid goes to school, they find friends, they find a mother…they find a person to look up to."* – Group 8 *"Bullying…that's a big concern…with the peer pressure…the role of the teacher, principal, school…can support the child's emotional needs as well."* – Group 2 *"The school's role is to be those extra eyes… because they see us more than they see their families…You identify these things that they're doing…[to] uplift and encourage them."* – Group 10
Physical Education and Physical Activity	10/11	Parents tied nutrition to mental health and commented on built environment constraints and the use of innovative strategies to overcome challenges	*"I don't have a space for them to do some of the activities that they want."* –Group 10 *"Even though we can't get those minutes for PE, [the PE teacher] finds ways for students to move constantly throughout the building. We have movement breaks."* – Group 7 *"If a child is not doing exercise well or is not getting good grades…both are important."* – Group 4
Physical Environment	10/11	Parents discussed the physical environment's impact on mental and physical health as well as resource constraints, safety concerns, and housing insecurity.	*"There are schools in wealthy neighborhoods in which their schools even have a swimming pool. So, those of us living in poor neighborhoods…we walk into a small gym and with the least amount of money."* – Group 5 *"I don't take them outside because I'm worried about what's happening outside…It's violent…it happens in front of the schools. It happens in front of their houses. This messes with our children's minds."* – Group 11
Health Services	9/11	Parents recognized the school as a coordinator of resources and facilitator of access to physicals, dental appointments, and	*"They used to offer services like vision…if you gave your consent for your child to have a vision exam."* –Group 5

Table 2 (continued)

WSCC Component	Number of Focus Group Transcripts	Themes	Illustrative Quotations
		hearing exams and the impact of the lack of services in community	*"We are lacking…we have less access…then the pandemic hits, and now we're just at a loss. So now we are really scrambling to find doctors that will service our children…or even take a chance on servicing them…The school has to make a huge effort when we are already at a deficit because of the community we're in."* – Group 8
Community Involvement	9/11	Parents discussed this in relation to parent engagement and as something that was limited by the pandemic and could be improved upon	*"This is a community that needs to come together. You know, one person can't do this all…so we're not focusing on one things and that's a good thing."* – Group 9 *"The school can only do so much…when I grew up, it took a whole community to raise kids and it doesn't just start with the parents."* – Group 2 *"Let's get the parents in the community to help teach our community, to help be a voice in our community to help get our schools better, help get our neighborhoods better."* – Group 11
Health Education	6/11	Parents focused on sex education, nutrition education and healthy eating, and the school garden as part of health education.	*"So as far as the things of sex education, that was the one thing that I was like, no, I will be the one responsible letting my son know about this part of his life and development…I didn't want the school to take on that responsibility."* –Group 2 *"Being a parent, I just think that it helps me with bringing on the conversation for my two boys…it also helps pave the way so we could start having those big boy conversations [about sex education.]"* – Group 2 *"I think nutrition is essential to establish a good habit for all children. Sometimes it's difficult because a student does not understand the importance of nutrition, so they want to eat what they should not*." – Group 6
Counseling, Psychological and Social Services	5/11	Parents highlighted a lack of adequate supports in schools and communities and a need for schools to enable improved access to services	*"I think that schools really need to teach meditation…to experience the reduction of anxiety, stress, and depression."* – Group 5 *"Most of the CPS schools have only one counselor. There are so many children who need a lot of psychological help…[because of] trauma in children."* – Group 5 *"We will need a lot of assistance, especially mental assistance…I think schools should focus more on that, on the students' mental health."* – Group 4
Employee Wellness	1/11	N/A	This code only came up once in the context of a yoga class available to school staff and was not probed on during the discussion.

described as scarce supports, both within schools and the community. However, there was still an expectation from parents that schools should enable improved access to these services.

Recommendations for Family Engagement in School Health Promotion

To address the third research question, parents recommend schools take a variety of strategies to engage families. Parents noted seeing the inequities across schools as an opportunity to speak out and demand that their schools receive the programs, resources, and opportunities that other schools are getting. Parents expressed desires for greater engagement from the district, not just their schools, and from the Networks, the district's regional units which provide oversight to all schools in a given community or neighborhood. Some parents noted that recent efforts to promote safety, including background checks for all parent volunteers entering the school, had resulted in sending the message that parents are unwelcome. Parents also noted that the pandemic had intensified these feelings, with parents unable to enter school buildings, attend events, etc. Parents in groups recruited by CBOs spoke about how this led to a lack of trust between schools and families. Parents in these CBO-recruited groups, as well as parents in Spanish-speaking groups more often noted the importance and need for more opportunities for two-way communication and engagement that offers parents the opportunity to provide feedback and share their concerns as well as suggestions and ideas.

That said, some parents noted that their children's schools were making creative, concerted efforts to meet parents where they are at and reach out to parents, despite these challenges. These anecdotes were shared more often by parents in groups recruited through LSCs. For example, to overcome the challenge of parents needing background checks, one parent shared that their school has a separate entrance and space cut off from students for parents to use for parent meetings and workshops, circumventing the need for all entering during the school day to have undergone a background check. Many parents noted increased accessibility through virtual meetings and workshops. Some noted this has allowed parents who are not yet well-connected to engage for the first time. Still others noted that since the onset of the pandemic they had received frequent check-in calls from office staff to see how their families were doing, "…I do have someone at the school that calls me weekly… She's my little supportive system. She calls me every week to check up on me and my kids to make sure things are right or everything is stable…" (Group 2). Parents expressed appreciation for these engagement efforts.

Additionally, parents talked about engagement going beyond communications and extending to include opportunities for parents to take on leadership roles. Parents provided examples of ways in which parents had stepped up to advocate for their children (i.e., in instances of bullying) as well as more formal programs and mechanisms for parents to take on leadership roles within their schools. For example, one parent explained that their school had a "Parent Advisory Committee and Bilingual Advisory Committee parent program…[that] worked well because there were approximately 15 parents…who participated continuously in different things…Since it was something small, so intimate, there was the opportunity to talk, to ask questions, to take advantage of those things that sometimes you can't do when it's a big group." (Group 6). Additionally, as part of more informal efforts to engage parents, one LSC member explained that their school has "parent meetings…at the beginning and in the middle of the year, we talk about data and explain to[the parents] exactly what it means…and we've invited parents to come out and talk (or not talk) and just meet with them and explain…if they want to be a part of our community, there is a thousand percent something that they can be a part of and they are always invited to" (Group 9).

Finally, parents discussed different incentives that schools have used in the past to increase their engagement (i.e., raffles). In sharing these previously used strategies they also noted activities they would like to see the schools facilitate in the future (i.e., after school activities for students and spaces for parents to share their feedback), as well as their own motivations for wanting to be involved (i.e., to better support their own child's health and learning). Parents emphasized the importance of teachers and school staff engaging parents beyond requests or reminders, so that relationships were built, and trust was established. Parents recruited by CBOs talked about how this needs to come from the principal. For instance, one parent explained that "it starts with the principals…[who] want to start relationships with the parents, especially with the parents that they know can't be up there…even if you can't be there physically, or you drop your kids off, that five minutes, the principal will try to pull you in and talk to you just to see. And just the simple checking in" (Group 2). Parents in groups recruited by LSCs shared that this extends beyond the principal to other school staff as well. One LSC member shared that the message from school staff is that they "really value parent relationships. It makes it easier on both ends. Just a really quick message. Like, 'Hey, so-and-so had a really, really good day. I just needed to tell you that.' And sometimes…you get something back. Sometimes you won't get anything, but you can see that they read it. And that's, what's the main important thing you want them to know that their son or daughter's doing really well" (Group 9).

Discussion

Data from this study elucidate how parents define their children's health and wellness and the role of the school in health promotion. Parents in this study endorse a holistic view of their children's health and they view health and wellbeing as a shared responsibility between schools and families. They seek increased opportunities for collaboration between families and schools. Associated implications of this are outlined below. This study's findings echo dynamics that have been reported elsewhere in the literature as related to family engagement in education more generally (Centers for Disease Control and Prevention, 2012; Garbacz et al., 2017; Hornby & Blackwell, 2018; Sim et al., 2021), yet adds detail to the specific ways in which the role of child health functions as part of schools' efforts to engage families. More detail is described below.

Parents in this study desired more opportunities for engagement and identified opportunities for parents to take on increased leadership roles within their children's schools. Unfortunately, parents in this study shared their perceptions that schools had become less welcoming to parents in recent years, due in part to the pandemic. Parents from some schools however, noted creative solutions such as formal parent mentoring programs and parent leadership programs convened by community based-organizations as well as robust school-facilitated opportunities for virtual parent engagement. Parents noted that even after the pandemic, these types of opportunities should remain available and that leadership opportunities should be expanded and replicated.

Notably, parents also expressed a desire for multiple forms of engagement and communication from the school. Not all parents are able to participate in workshops, meetings, and formal leadership roles. Some parents noted the importance of a phone call from the school to check-in. Others noted the importance of a 5-minute conversation with the principal, simply to touch base and strengthen relationships. This aligns with evidence in the literature citing the need to re-envision our definition of parent involvement (Mapp and Bergman's 2021); it does not always look like parent teacher meetings and fundraisers. It can also look like quick conversations to check-in with one another, text messages with parents, and parents feeling welcome to enter the school and be a part of their children's school community (Mapp and Bergman's 2021). Spanish-speaking parents noted a need for more opportunities for two-way communications. While some of the literature reviewed for this study indicated a need for concerted efforts to engage parents in lower-income communities (Centers for Disease Control and Prevention, 2012), including a need to ensure cultural competence (Centers for Disease Control and Prevention, 2012; Sim et al., 2021), few discussed specific needs within specific populations and this study helps to elucidate what kinds of strategies this specific population of parents desire.

Our findings align with recommendations made by researchers and practitioners in both the peer-reviewed literature and gray literature. These include recommendations to use a wider array of nontraditional communication approaches (texting, apps, community events, etc.) and the need for staff to better understand how to engage with parents in ways that foster collaborative design of engagement approaches in alignment with local and culturally-specific needs. In these ways, the this study's findings also mirror the literature in terms of what parents said they needed from principals, teachers, and staff (Centers for Disease Control and Prevention, 2012; LaRocque et al., 2011; Sim et al., 2021; Wang & Sheikh-Khalil, 2014; Wong et al., 2018). Mapp and Bergman's 2021 "liberatory approach to family engagement" is aligned with what parents in our sample recommended. Our findings showing that perceptions of inequities and experiences of racism strongly influence the school-parent relationship. These findings echo the need to move beyond parent involvement as something only parents do to something that schools facilitate. Flores and Kyere's (2021) equity-based parent engagement model is also aligned with what parents in our sample recommended. The liberatory approach and the equity-based engagement model recommend a transparent, bidirectional communications strategy for family engagement that is co-created by parent leaders alongside school leaders, all of which were recommended and discussed by parents in this study. As data in this study reveals, there remains an opportunity for schools to be more intentional in facilitating such engagement. An avenue for future research would be to explore ways in which these models, in addition to WSCC, resonate specifically with parents.

Although the intent of this study was not to assess parents' perspectives of the WSCC model specifically, an opportunity arose to use WSCC as a vehicle for exploring the study's aim to characterize parents' broad understandings of their children's health. Indeed, their understandings are aligned with the WSCC model. As discussed, there were strong areas of alignment between the WSCC elements and the ways parents articulated their understanding of child health and wellbeing vis-à-vis the school context. This study underscores that many parents value whole child and holistic approaches and that parents articulate health as consisting of multi-faceted dimensions that align with the WSCC components. Common health concerns such as nutrition, physical activity, and mental health were more frequently mentioned by parents but notably, all WSCC elements were mentioned by at least some parents in this sample. This alignment brings up an opportunity for future research that would more robustly

explore parents' perspectives on WSCC, its utility, its value, and its resonance. This could include asking parents' their perspectives on WSCC, as well as the examination of current communications materials and parent-facing resources to explore whether and how WSCC may add value to such communications and engagement approaches.

The WSCC model development team recognized the need to align the model with the role that social determinants such as education play in the lifelong health of individuals and of populations (Lewallen et al., 2015). They therefore intentionally incorporated economic stability, education, social and community context, health and health care, and neighborhood and built environment into the WSCC model's theoretical foundation. This also closely aligns with what parents articulated as their concerns and needs when it comes to their children's healthy growth and development. As noted above, parents in this study cited community violence, racism in the city and in the school district, as well as institutional barriers to needed services, resources, and programs for their families. Parents want their schools and the district to allocate resources to neighborhoods that continue to receive fewer resources. And yet, they also recognized that these inequities are entrenched in centuries of institutional racism that cannot be addressed by the district or schools alone. However, parents did have recommendations for things schools can do within their locus of control, including increased opportunities for parent engagement.

Limitations

As with any study, this one was not without its limitations. Purposive sampling was used to ensure a variety of parents by age, geography, race/ethnicity, and language spoken were included. As described above parents were recruited through local school councils as well as though community-based organizations in local neighborhoods. However, we likely included parents who are already connected to services, the school, and community resources. If we had been able to engage with parents who were less connected, their responses may have been distinct and the identification of barriers even more pronounced. Of the parents who participated, it is also important to note that a majority identified as female, suggesting that the findings of this paper likely do not fully represent the perspectives of parents who identify as male.

Additionally, we prioritized having moderators with like identities to our participants, meaning we had two different moderators, based primarily on language. While each moderator is highly experienced and trained and used the same topic guide, each likely probed slightly differently and may have spent varying amounts of time on specific topics based on participant interest. While these variations can occur even with the same moderator across groups, the inclusion of two moderators introduces greater likelihood for such variation.

Finally, these focus groups were conducted in winter and spring of 2021. This was a time during which most CPS schools were still offering primarily remote instruction during the COVID-19 pandemic. These circumstances were of course top of mind for parents and likely influenced parents' responses. However, many parents were able to contextualize their responses and share how their current perceptions had changed or not changed since before the pandemic's onset.

Conclusion

This study reveals that parents recognize student health as a shared responsibility between families and schools and they conceptualize health as multi-faceted and holistic, both in the ways that they articulated definitions of health that align with the ten components of the WSCC model and in the ways they their definitions aligned with the concepts of whole child thinking. They perceive the school as having an opportunity to address the structural barriers that impact student health, despite schools being situated in larger systems that perpetuate inequities. Parents recommended key strategies to engage parents, re-envision what parent involvement can look like, and foster parent leadership within school communities. With family engagement being a core component of the WSCC model, findings from this paper inform what this could like in schools, particularly in lower income, urban communities that are faced with a legacy of inequity.

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Compliance with Ethical Standards

Conflict of Interest The authors declare no competing interests.

Ethical Approval This study was approved by the Institutional Review Board (#2019-1161) at the [university name].

Informed Consent All participants in this study completed an informed consent form that was approved by the IRB.

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