WATERBURY TRUANCY CLINIC

Judge Thomas Brunnock

Waterbury Regional Children's Probate Court

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WATERBURY
Public Schools

Today's Students, Tomorrow's Leaders

The Truancy Clinic
is a collaborative and systemic
approach to addressing truancy.

Anne Marie Cullinan,
Chief Academic Officer
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and Judge Thomas P. Brunnock

believed that students should be given the tools to support their educational success as early as possible. Thus, the Truancy Clinic was installed at the elementary school level in Waterbury.

- Truancy Clinic fixed itself to the elementary school population

- Truancy Clinic proceeding is initiated against the parent(s)/guardian(s) (hereinafter referred to as "Parent") of the students, and not the students themselves.

- The average elementary school student is 5 to 12 years of age and as a result of their minority, they cannot bear the responsibility of answering for their truancy.

- Their absences are a consequence of their parents' actions, inaction and/or some larger systemic family issue.

•A fundamental difference between the Waterbury Truancy Clinic and the Truancy Courts in other jurisdictions exists.

•The Truancy Courts are a judicial proceeding (i.e., arraignment, drug testing, punishment).

•The Truancy Clinic, however, is non-judicial. A Judge oversees the process but the Truancy Clinic is voluntary, non-punitive and designed to identify and resolve the causes of absences.

•Truancy Clinic operates as a by-product of the Waterbury Regional Children's Probate Court ("WRCPC"). The overall mission of the WRCPC is to more efficiently serve those children under the age of 18 and their families involved in matters of guardianship, termination of parental rights, adoptions, claims for paternity and voluntary admissions to the Department of Children and Families.

•Through a systemic and collaborative approach of mental health, community and educational service providers, the WRCPC works to maintain and support family preservation, to deter the Court's children from future involvement with other Court systems, to mitigate their mental health issues and to encourage their educational success.

•The WRCPC has the distinction of being one of the six regional children's courts in Connecticut.

- Truancy Clinic also engages the collaborative efforts of the local Board of Education,
- Department of Children and Families (DCF),
- Teachers, social workers, truant officers, community resources/services, and most importantly, students and parents in a non-judicial process that addresses the systemic cause of the student's truancy.
- Truancy Clinic returns a once truant child to a positive academic environment armed with self-esteem and personal growth.
- The outcome of the Truancy Clinic is not only a student, but also the student's entire family system, completely vested with and invested in educational success

The Procedure

The Truancy Clinic procedure is simple

•School officials regularly review their attendance records.

•Students with a demonstrated history of unexcused absences are identified as potential Truancy Clinic participants and may be the subject of a referral to the Truancy Clinic.

•Once a referral is deemed necessary and ultimately made by the school, the clerk of the Truancy Clinic will process the referral by first assigning and preparing the Citation and Summons for the Presentment Part I ("P1") date.

•The Clerk will attach the school's referral form to the Citation and Summons and the Parents are then summoned to appear for the initial P1 proceeding before the Truancy Clinic Judge ("Judge") at the school of their truant student.

•During the P1 proceeding, the Judge addresses the Parents in a group setting; he explains the reason for the Summons along with the nature and requirements of participation in the Truancy Clinic.

•Participation in the Truancy Clinic requires that the Parents agree to insure that their child will (1) attend school everyday; (2) be on time; (3) behave; and (4) complete all assigned classroom work and homework.

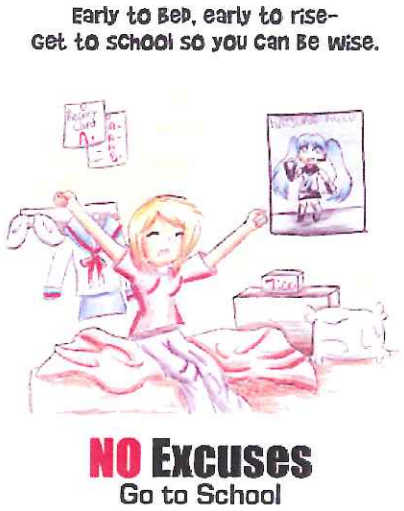
•Further, the Parents are instructed that by participating in the Truancy Clinic they are also agreeing to comply with the school-required protocol regarding sick days.

•After the Judge has reviewed the requirements of the clinic, the Parents are then excused and instructed to return the following week; same day, time and place for the Presentment Part II ("P2") proceeding.

• As the Parents leave, they are given the Participation Agreement (which details the requirements of participation in the program) and a Release of Confidential Information (which provides for the mutual sharing of student related information).

•Every week, on the same day of the week, at the same time and in the same place, the Truancy Clinic operates. This consistent stable scheduling has been a key to the success of the Truancy Clinic.

• There are Spanish and Albanian translations of the forms available for those who require a language other than English. Spanish and Albanian translators are also available at all proceedings.



•During the P2, each Parent meets individually with the Judge and states whether they intend to participate.

•If they agree to participate they are excused and given a date and time for the following week to appear for the next stage of the proceeding, the Review. (A parent who agrees to participate does so for a twelve (12) month period of time; e.g., if the participation commenced in January 2013, then the termination occurs in January 2014).

•At the time of each Review, the Parents meet with the Judge individually.

•This Review process is the real life of the Truancy Clinic.

•During these Review meetings, the Parents and Judge engage in a dialogue about what they understand to be the cause of the unexcused absences.

• This process is designed to be non-adversarial, provide an assessment of the dynamics of the truancy and to develop, in collaboration with school officials, an understanding of and a pragmatic resolution to the unexcused absences.

•Since October 2011, DCF has assigned a social worker to each of the schools. The parents are told that DCF is a participant to the Clinic to help identify issues and offer services to families on a voluntary basis. Once a plan is established, the Parents return to weekly, or as needed, reviews.

II. Linkage and Coordination

•In an effort to provide appropriate linkages to related programs, the Truancy Clinic utilizes all school department professionals including teachers, social workers, guidance counselors and administrators.

•Because truancy is such a dynamic issue, there is a need to have a diverse array of program services to meet the needs of the students and their families.

- The Truancy Clinic has been in operation since January 2008.
- One of the most significant recent developments has been the participation of the Department of Children and Families (DCF) in the Clinic.
- A DCF social worker is assigned to each of the (2) Truancy Clinic elementary schools.
- The social worker's role is to assist families who request assistance, e.g. referrals have been made for IICAPS services, individual therapy, transportation assistance, etc.
- With this skeleton presentation of the clinic's procedures as a background, we will now look at some of the statistical data of two (2) schools at which the Clinic presently operates.

MARGARET M. GENERALI ELEMENTARY SCHOOL

Generali school is a K-5 elementary school with approximately five hundred fifty (550)

•Students of whom almost seventy-three (73) percent are eligible for free or reduced price meals.
•The ethnicity of the student population is approximately thirty-two (32) percent White, twenty-nine (29) percent Black, and thirty-eight (38) percent Hispanic.
• Approximately fifty-five (55) percent of the kindergarten students attended preschool, nursery school or Head Start.
• Over thirty (30) percent of the students above entry grade level attended a different school the previous year.

•Between September 2011 and February 2013, there have been thirty-seven (37) students referred to the Clinic.
• Twenty-two (22) have not been in the Clinic for twelve calendar months so they are not included in the following analysis.
• In addition, one student transferred within two months of being referred to the Clinic and therefore, is not included in this analysis.

Fourteen (14) students in Clinic for one full year.	Twelve months prior to Clinic	Twelve months in Clinic	
Total unexcused absences	181	44	Reduction of 76%
Total excused absences	41	23	Reduction of 44%
Total unexcused tardies	77	42	Reduction of 46%

• The next sub-group was what the Clinic refers to as "non-participating participants" (NPP) i.e.. parents who did not attend Truancy Clinic regularly or more importantly, did not engage in their child's educational process. This group represents four (4) families with five (5) children. The statistics are as follows:

•Of the fourteen (14) students, two families had two students each. Two parents refused to sign on, but their attendance was still tracked and the results are as follows: Their combined unexcused absences were reduced from 17 to 0, their excused absences were reduced from 6 to 0, and their tardies went from 14 to 2.

	Twelve months prior to Clinic	Twelve months in Clinic	
Total unexcused absences	65	38	Reduction of 42%
Total excused absences	28	12	Reduction of 58%
Total unexcused tardies	39	12	Reduction of 70%

•A brief profile of this group is two (2) of the four families have DCF histories. One family with two students included a kindergarten student who had twenty-one (21) absences, and a sibling who was an eight year old second grader who had averaged twenty-seven (27) absences a year.

• All students in this group were reading below grade level. One mother refused to attend a PPT meeting at the school for her child who was already receiving special educational services. One mother did finally enroll her children in the after-school program and although as of January 2013 was still almost one full year below reading level, the student had started to make "marked improvement" per his teacher.

•The remaining seven (7) students represent six families. The statistical analysis is as follows:

Seven students in Clinic for one full year	Twelve months prior to Clinic	Twelve months in Clinic	
Total unexcused absences	93	4	Reduction of 96%
Total excused absences	12	9	Reduction of 25%
Total unexcused tardies	22	10	Reduction of 55%

Chase Elementary School

Chase Elementary School is the largest K-5 elementary school in Waterbury with approximately eight hundred fifty (850) students.

•About eighty (80%) per cent of the students are eligible for free or reduced price meals.

• The ethnicity of the student population is approximately thirty (30%) per cent white and seventy (70%) per cent minority with twenty four (24%) per cent black and forty three point five (43.5%) per cent Hispanic.

•Only fifty (50%) per cent of the kindergarten students have attended preschool, nursery school or head start.

•Over forty (40%) per cent of the students above entry grade level attended a different school the previous year.

•Between September 2011 and February 13, 2013, there have been 36 students referred to the Clinic. Two students have not been in the Clinic for twelve calendar months so they are not included in the following analysis. In addition, nine students transferred within a short time of being referred to the Clinic and therefore are not included in the following analysis.

•Out of the remaining twenty-five students, seven parents refused to sign on to the Clinic. Two of these families have DCF histories. One of these students has been absent fifty (50) days in the previous three years. In the year of referral, he had been absent nineteen (19) days as of April of this school year!! Three of the students were receiving special educational services from the school. Almost all were reading below grade level. The individual students in this group averaged from sixteen (16) to twenty-seven (27) absences a year. One student had a total of eighty-six (86) absences in her first four years of schooling.

•As indicated in the prior analysis there were parents who although they signed on to the Clinic , are labeled "non-participating", that is, they did not attend the Clinic sessions or more importantly did not participate in the educational process of their child. There are three families who fall into that category.

Three students in Clinic for one full year	Twelve months prior to Clinic	Twelve months in Clinic	
Total unexcused absences	34	19	Reduction of 45%
Total excused absences	6	25	Increased by 450%
Total unexcused tardies	41	30	Reduction of 27%

•One of the students had in the prior three academic school year averaged thirteen absences per year and now has six (6) in the Clinic, and his tardies were reduced from twenty (20) down to nine (9). Another student received special services from school, has major asthma issues, is reading below grade level, and the parent had been completely non-cooperative with school interventions. Prior to Clinic, this student had a total of thirty absences (6 excused, 24 unexcused) and in Clinic, had twenty-eight (28) absences (19 excused, 9 non-excused). In the first three years of school, this child has missed 92 days of school-one half of a school year!!

•We will now look at the statistics of the fifteen students whose parents participated in the Clinic for one year.

Fifteen students in Clinic for one full year	Twelve months prior to Clinic	Twelve months in Clinic	
Total unexcused absences	190	48	Reduction of 75%
Total excused absences	63	34	Reduction of 47%
Total unexcused tardies	116	82	Reduction of 30%

III. QUALITATIVE ANALYSIS

Now that the statistical data has been presented, it is appropriate to explain the "why" and "how" of the approaches the Clinic took to achieve the reductions in truancy.

The experience of the Clinic has found certain major issues involved in truancy.

1. Issues related to Truancy in the clinic

A. Mental/Behavioral Health- The importance of DCF involvement is to assist the schools and the families address these issues with needed services.

B. Approximately 12-15% of the absences are asthma related. This correlation between truancy and asthma was usually established by the parent during the first weekly Clinic review.

C. One time issues – for example, extended vacations, late sign-up in the beginning of the school year due to failure to have the required pre-school medical examination by a physician.

D. Transportation – out of district school bus problems, walkers to school who arrive late either because parents bring their children late or they are "slow walkers." Some students are late 20, 30 or 40 times out of 180 school days. This causes a serious disruption to the educational process of the individual students and class.

E. Family Issues – e.g., parents work 3 p.m. to 11 p.m. caregivers cannot assist with school work, language impairments, etc.

F. Hard-Core Truant – as indicated in the footnotes to the statistical analysis given above, it is obvious that some students/families present a situation wherein the parent has refused all voluntary services offered by the school and clinic and their child(ren) continue on a down-hill spiral of truancy, ultimately leading to educational failure and school dropout.

2. Approaches

A. As indicated earlier, once the parent voluntarily enters the clinic and has signed the participation agreement and release of confidential information, Judge Brunnock and the Clinic team then meet with each parent individually.

B. The first step is to have the parent(s) describe what they think is the cause of truancy. Once the parent responds with the cause, such as "asthma," the engagement process begins and the parent becomes invested in the resolution of truancy. The response is never to the parent "Well, Mrs. X, you know that asthma is no excuse for being absent from school." The parent is then asked who the treating physician is, what medications have been prescribed, did the treating physician give the medically prescribed prescription to the school nurse who then can give the child medications in school (e.g., nebulizer, inhaler, etc.). Parents are urged to have current assessments of their child so that proper medications and evaluations are made.

C. The Parents are urged to provide the school with updated medical information regarding their child and to also get updated assessments from the child's treating physician.

D. While no one response can be labeled the most successful, the clinic's after-school program has had the most profound effect on the Clinic students. School officials report that homework problems are lessened and academics improve for those students who participate in the after-school Clinic program.

E. The after-school clinic program gives each student one and one half (1-1/2) hours of extra tutorial help three (3) afternoons a week. The students are fed a snack and are bused to their homes each day. The after-school program has provided some much needed educational assistance to students. Many of the bi-lingual

students' parents are not fluent enough in English to give homework assistance to the students in spelling or reading. Many parents work the second shift (3 p.m. – 11 p.m.) and the child's caregiver does not provide help with homework. Some students need extra assistance with one or more subject matters. The after-school program provides the child the opportunity to achieve academic improvement and success. Almost 100% of the parents have their children participate in the after-school program.

F. The success of the after school program is also evidenced by the fact that at the beginning of each semester (September and January) the parents are asking when does the after-school program start. The added dimension of the after-school program is that often, students who, although they "love" the after-school program, are at times behavioral problems in their classrooms during the day. Teachers have successfully used the after school program as a behavioral modification tool by telling the student that "good behavior" is rewarded with attendance in the after school program.

G. This brief description of the issues and the collaborative approach to addressing these issues has led to some very dramatic results. What is needed now is to address the truancy issue on a city-wide basis for a multi-year period of time, which would include twenty (20) elementary schools and at least three (3) middle schools. By addressing truancy in this manner, the clinic model can be appropriately tested.

QUESTIONS?