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Regional Issue Brief #43 Spring 2015

A Community Schools Approach to Accessing Services and Improving Neighborhood Outcomes in Manchester, New Hampshire

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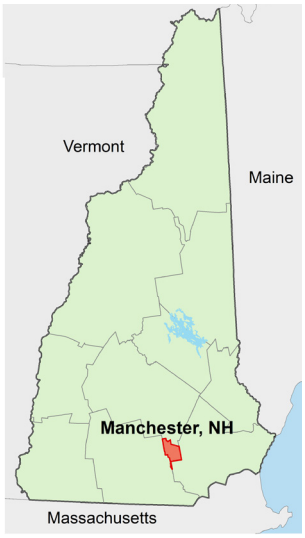


In the several years since the Great Recession, New Hampshire, like the nation, has witnessed and experienced growing economic disadvantage. The state's poverty level stands at 8.4 percent, and child poverty increased from about 8 percent in 2000 to nearly 10 percent in 2012.[1] Some areas of the state have been hit harder than others. In the state's largest city of Manchester, for instance, the poverty rate rose from 10 percent in 2000 to 14 percent in 2012, and within Manchester some neighborhoods have become poorer than others (Figures 1 and 2).[2] Increases in poverty and educational disadvantage are steepest among minorities and immigrants, the city's fastest-growing demographic groups.[3]

The vulnerabilities to which people are exposed as a result of poverty can have devastating consequences. Children living in poverty are less likely to graduate from high school, and they have worse educational outcomes overall; one study found that living in a high-poverty neighborhood is equivalent to missing a year of school.[4] Poverty-afflicted children are also more likely to live in poverty as adults.[5] In an era when a state's economic health depends more than ever on the physical health and educational capital of its residents, stakeholders across New Hampshire have a vested interest in alleviating the growing poverty in Manchester and the wide disparities between Manchester and the rest of the state.

KEY FINDINGS

1/4 One-quarter of residents surveyed in the Manchester neighborhoods of Bakersville, Beech Street, and Gossler Park say that difficulty in finding services is a major hindrance, especially to economic stability, health, and social connectedness.

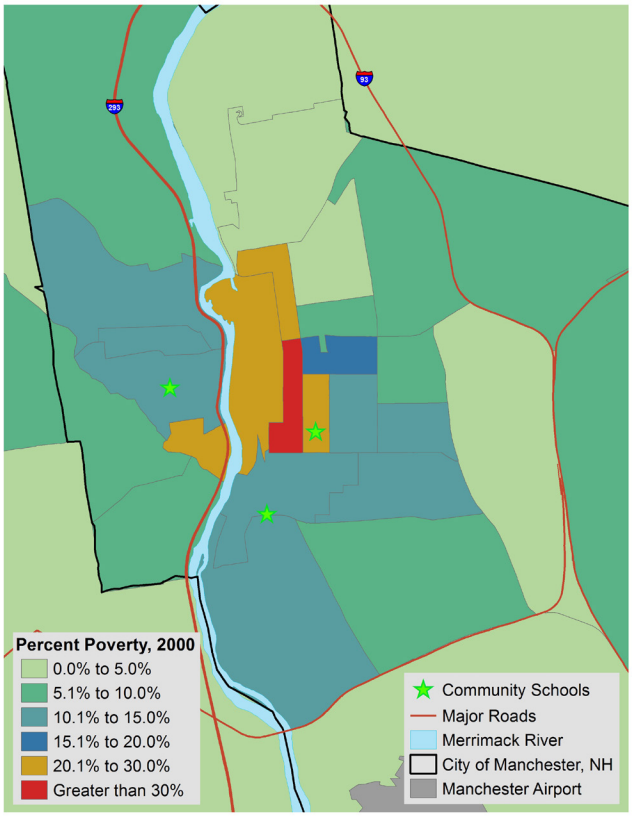
Focus group data suggest that the city's foreign-born residents, especially Hispanics, have the most trouble finding and accessing services.

$ Cost is an obstacle to accessing health care services, and older and younger focus group participants, as well as immigrants, say the cost of transportation is a barrier to accessing services.

Safety concerns and poor walkability often prohibit residents from engaging in healthier behaviors, focus group participants say; parents with young children say that local parks can be unsafe and that afterschool programs often have long waitlists.

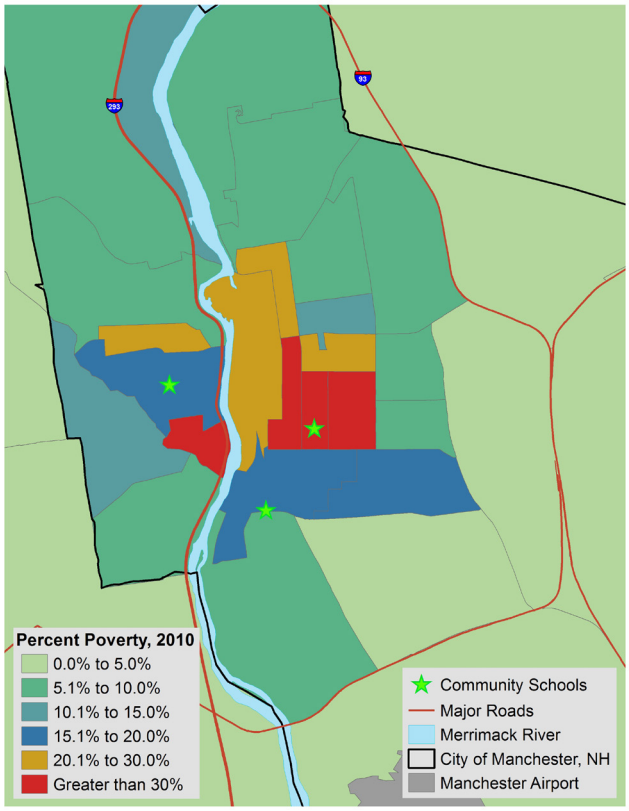
To engage in this challenge, the Manchester Neighborhood Health Improvement Strategy Leadership Team launched the Manchester Community Schools Project (MCSP)—a partnership between the Manchester Health Department, city elementary schools, philanthropists, neighborhood residents, and several nonprofit agencies—to improve and enhance educational achievement, economic well-being, access to health care services, healthy behaviors, social connectedness, safety, and

FIGURE 1. PERCENT BELOW POVERTY IN MANCHESTER BY CENSUS TRACT, 2000



Source: U.S. Decennial Census, 2000

FIGURE 2. PERCENT BELOW POVERTY IN MANCHESTER BY CENSUS TRACT, 2010



Source: U.S. Census Bureau: ACS, 2009–2013

living environments. Efforts are focusing on the Bakersville, Beech Street, and Gossler Park neighborhoods. As Table 1 illustrates, all three neighborhoods are more disadvantaged than the city as a whole on a number of measures. Unemployment rates, for example, are roughly double Manchester's 5.6 percent rate; more elementary school students are enrolled in free and reduced-price meals programs, and incidence of homelessness (with the exception of Bakersville, which is home to one of the city's largest public housing developments) tends to be more common.

Data collected by the Manchester Health Department as part of the MCSP show that residents' needs

TABLE 1. INDICATORS OF SOCIOECONOMIC DISADVANTAGE IN THE BAKERSVILLE, BEECH STREET, AND GOSSLER PARK NEIGHBORHOODS (COMPARED TO MANCHESTER OVERALL)

	BAKERSVILLE	BEECH STREET	GOSSLER PARK	MANCHESTER
UNEMPLOYMENT RATE	10.5%	11.4%	12.1%	5.6%
PERCENTAGE OF RESIDENTS 25 AND OLDER WITH LESS THAN A HIGH SCHOOL EDUCATION	19.6%	27.6%	25.1%	13.4%
POVERTY RATE	24.9%	32.0%	26.4%	14.1%
PERCENTAGE OF ELEMENTARY-SCHOOL STUDENTS ENROLLED IN FREE-OR-REDUCED MEALS PROGRAM	84.3%	89.7%	77.2%	51.1%
PERCENTAGE OF ELEMENTARY-SCHOOL STUDENTS WHO REPORTED BEING HOMELESS AT ANY POINT DURING THE 2012–2013 SCHOOL YEAR	5%	7%	12%	5%

Source: Unemployment, education, and poverty figures are derived from the American Community Survey (ACS), Five-Year Estimates (2008–2012); data on free and reduced meal enrollment are provided by the New Hampshire Department of Education (2013); data on homelessness, also from the State Department of Education, are through March 2013.

and the strategies residents use to overcome barriers to well-being differ across demographic lines and by neighborhood. This brief uses data from focus groups and a survey of residents in the Bakersville, Beech Street, and Gossler Park neighborhoods to provide information about how barriers to various dimensions of well-being differ by place and also across race/ethnicity, foreign-born status, and age. Survey data and focus groups gave residents a voice in the implementation of the MCSP.

Data and Methods

This research draws on data collected by the Manchester Health Department and analyzed by the Carsey School of Public Policy. In the summer and fall of 2013, the Health Department conducted two surveys of residents in the Bakersville, Beech Street, and Gossler Park areas—the location of the city's most socioeconomically disadvantaged neighborhood schools. This brief uses data from the second of these two surveys, which focused on service needs and barriers to well-being. A total of 264 individuals (33 from Bakersville, 135 from Beech Street, and 96 from Gossler Park) completed the survey, which was sent home to parents of children attending schools in these neighborhoods. Survey respondents were directed to answer questions only about the services and program areas that were most important to them. The differences discussed in this brief are significant at the $p<.05$ level.

The Health Department and the Carsey School also conducted six focus groups (with a total of thirty-seven participants) in these three neighborhoods. Four focus groups were conducted in English, one in Spanish, and one in Arabic, the latter two with the assistance of interpreters. The focus groups provided important feedback on how individuals access particular services and overcome barriers, and the diversity of experiences across demographic groups (for example, older residents compared to young adults). Among the six focus groups, two included participants age 50 and older, two focused on young adults age 18 to 24, and another two were conducted with foreign-born residents whose primary language was not English. The demographic characteristics of focus group participants are presented in Table 2. To avoid confusion between survey findings and those from focus groups, "respondents" is used to refer to survey data, while "participants" signifies data gleaned from focus groups.

Persistent Barriers to Well-Being

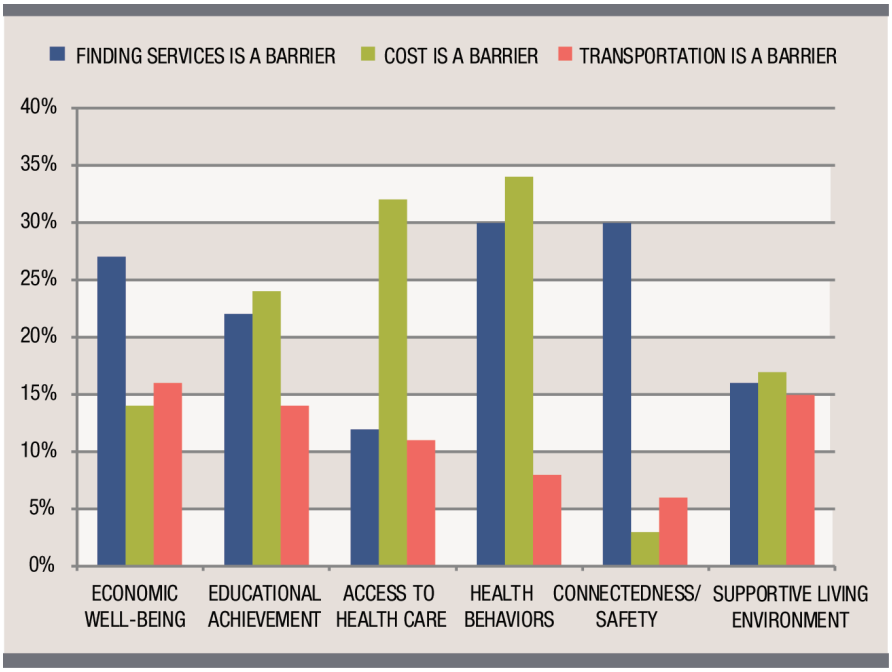
Survey respondents identified barriers related to six dimensions of social/physical health: economic well-being, educational achievement, health care access, healthier behaviors, connectedness/safety, and supportive living environments. Consistently, the top barriers across all these dimensions were (1) a lack of knowledge about where to find services, (2) the cost of services, and (3) transportation (Figure 3).[6] Focus group participants also identified a lack of safety/walkability as a barrier. Responses varied little by neighborhood except with regard to health behaviors, including diet and exercise (data not shown). In this case, about 75 percent of

TABLE 2. DEMOGRAPHIC CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS

		TOTAL	PERCENT
NEIGHBORHOOD	BAKERSVILLE	8	22%
	BEECH STREET	18	49%
	GOSSLER PARK	11	30%
RACE/ETHNICITY	WHITE	27	73%
	BLACK/AFRICAN	3	8%
	HISPANIC (ANY RACE)	3	8%
	OTHER/MULTIRACIAL	4	11%
NATIVITY	NATIVE BORN	29	78%
	FOREIGN BORN	8	22%
PRIMARY LANGUAGE SPOKEN AT HOME	ENGLISH	22	59%
	OTHER THAN ENGLISH	7	19%
	NOT REPORTED	8	22%
AGE	18–29	12	32%
	30–39	3	8%
	40–49	3	8%
	50–59	3	8%
	60+	16	43%
GENDER	MALE	12	32%
	FEMALE	23	62%
	NOT REPORTED	2	5%

Note: To protect the confidentiality of participants, we do not break down these demographic figures by focus group.

FIGURE 3. BARRIERS TO SPECIFIC DIMENSIONS OF WELL-BEING



respondents in Bakersville said that cost was a barrier, compared to only about a quarter of respondents in Beech Street and Gossler Park.

Lack of knowledge about where to find services related to healthier behaviors (services like fitness programs or nutrition classes) was greater in Bakersville and Gossler Park than in Beech Street. Focus group data suggest that a higher availability of services in the Beech Street area might help to explain this gap: Beech Street focus group participants said that many programs are within walking distance. As one interpreter noted, several Hispanic residents participating in the focus groups said that, "They wanted to get into this area [neighborhood] because they said it is easy to get to.…You know, the bus comes here, Market Basket is right there. They can get to a bunch of services by walking." Why cost is more prohibitive among Bakersville residents when it comes to healthier behaviors remains unclear, however.

Any attempts to provide services and improve well-being in Manchester must contend with barriers residents face when attempting to improve one's well-being. Focus group data suggest that these barriers are experienced differently among native- and foreign-born participants, as well as by age.

Lack of Knowledge About Where to Find Services

A top area of concern that arose from the survey data was unfamiliarity about where to get services. However, this varied from one dimension of well-being to the next (Figure 3). Survey respondents reported that finding services was most difficult when it came to economic well-being, health behaviors, and social connectedness/safety. Lack of knowledge about services did not appear to be as much of a barrier to accessing health care or supportive living environments.

Knowledge about where to find services also varied from one focus group to the next. In focus groups with refugees and Hispanic immigrants, for example, participants cited a lack of familiarity with the structure of various services/benefit programs and eligibility for them. Both Spanish- and Arabic-speaking focus group participants said that a dearth of translators was problematic, and that language barriers made numerous day-to-day tasks difficult. Service providers should consider partnering to increase access to English as a second language (ESL) programs, particularly those that focus on completing legal documents and/or job applications, which focus group participants said were especially difficult tasks.

Among the most important findings from the focus groups were the disparate experiences of refugees compared to Hispanic immigrants. Those who arrived in the United States as refugees often cited ties with local organizations, such as the International Institute, which had provided assistance with services like job placement. These services lasted only a few months, though, and several said this length of time was not enough to help them complete their transition. One participant said that when she first arrived in Manchester, an interpreter often assisted her at doctor's appointments and sometimes provided transportation and other forms of aid, but that these services did not last long. Participants in the

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Hispanic focus group described a somewhat different situation, one derived from a lack of a formal center or agency to assist immigrants from Latin America. Indeed, while a Latino Center used to exist in the city, a translator noted that it closed several years ago due to lack of funding. This means that Hispanic residents must often rely on informal channels to help one another, a point that Hispanic participants reiterated. The reinstitution of such a center could potentially improve numerous outcomes among Hispanics—the second-largest and fastest-growing racial/ethnic group in Manchester.[7]

Lack of knowledge about services appeared to be much less problematic among focus group participants 50 and older. They said flyers, brochures, and other literature were plentiful. Several said they contacted ServiceLink (an agency that provides contact information for various services) when they did not know whether a particular service existed or they needed help overcoming an obstacle like cost. Many senior residents said that service providers regularly came to their living facilities to provide care or services such as meals, cleaning, and blood-pressure monitoring.

Participants in the young adult (18–24) focus groups, much like the Hispanic residents we talked to, often cited a reliance on word-of-mouth when it came to finding services or searching for work. Young adult participants also said they had someone like a parent or former teacher/guidance counselor who could assist them with services such as GED classes or job-seeking programs. Even when residents know where to find resources, however, they often are unable to obtain transportation or cover necessary costs.

Cost As an Impediment

The cost of health care, education, and transportation affects residents in numerous aspects of their lives. Survey respondents did not appear as concerned about transportation costs as they were about the costs of various programs. About a quarter of survey respondents identified cost as a barrier to educational achievement, while a third said it was a barrier to access to health care and health behaviors (Figure 3). However, during focus groups, participants often specified that the cost of transportation was an obstacle. For example, some residents said they had issues paying for private transportation, like taxis, to medical appointments and similar health services. Due to the cost of transportation to services and the cost of services themselves are difficult to disentangle, they are discussed in this section simultaneously.

Among survey respondents who said educational achievement was a top area of concern, nearly a quarter identified cost as an impediment (Figure 3). During focus groups, younger residents were especially likely to say that they had issues with paying for college or GED classes. A related barrier—the cost of child care—was also especially problematic for young adults. One mother, for example, said that she had trouble paying for child care, and child care made it difficult to work the hours she needed.

Transportation was a greater barrier to some services (like economic well-being and educational achievement) than others (for example, social connectedness), according to survey data (Figure 3). Despite the demographic differences in the composition of each of the six focus groups, transportation arose as an issue during each discussion, though for different reasons. Older residents only sparingly cited transportation as problematic when it came to medical appointments. Some said they were not quite old enough to meet age requirements of various transportation programs (or did not know what the requirements were). Others reported having to rearrange their budgets after unexpected needs arose (such as having to take a taxi after a medical procedure). Foreign-born residents said that transportation to and from medical appointments was an issue. An Iraqi participant said that her "son missed two appointments just because of transportation." Hispanic respondents described a number of issues using private transportation, such as drivers being unwilling to take vouchers or not showing up on time.

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Focus group participants also said that cost prohibited them from participating in a number of fitness activities. Their concerns are in line with those of survey respondents, a third of whom said cost was a barrier to healthier behaviors. As one older resident noted, "Last year they passed out gym memberships [to residents in his complex] and then this year they took them all back. That was very handy to have, to go to exercise." In addition to cost, safety issues and lack of walkability also made it difficult for focus group participants to engage in a variety of fitness activities, including walking to stores and parks in the neighborhood.

Lack of safe spaces for children and adults alike to exercise is a major impediment to engaging in healthful behaviors. As survey findings suggest, respondents are highly interested in fitness and stress-reduction classes, perhaps because their neighborhoods are not conducive to pursuing such activities in local parks or playgrounds. Tackling barriers like neighborhood safety, in addition to affordability and accessibility, will require Manchester's numerous service providers and schools to work together to help residents solve local problems and find needed resources.

Safety and Walkability

Another barrier that emerged from focus groups (but was not asked about in surveys) was safety and walkability. In the focus group discussions with residents age 50 and older, participants described the absence or deterioration of sidewalks (which made the use of a scooter or wheelchair difficult) and drivers ignoring pedestrian crosswalks as issues with which they struggled on a daily basis. While senior residents described a great deal of success using service-provided transportation such as Step-Savers, they preferred not to rely entirely on such services. One woman said that, while "we like to go to the drug store and things on our own, we need a safe way, and there isn't because the sidewalks are horrible." Unplowed or icy sidewalks also decrease walkability in the winter months, some said.

Safety was an issue not only in terms of traffic and walkability but also crime. Many residents 50 and older said they would not go outside at night for fear of being victimized. As one woman said, "You don't feel at ease. We [she and other residents in her building] would go outside and sit sometimes, but you have to watch your back all the time." A number of focus group participants also said that there were issues within the buildings in which they lived that made it difficult to get to know other residents or to even feel secure within their own apartments.

Park safety was a pressing issue, especially for focus group participants with young children. Several parents said they often try to take their children to parks in other neighborhoods. Discarded needles were one issue that parents said drove them away from local parks. Focus group participants with children sometimes said they want places for their children and even themselves to exercise, though they are often wary of sending their kids outside alone. One parent added that afterschool programs are popular, but "there are so many kids who apply that they cannot take everyone."

A Community Schools Approach to Breaking Barriers and Improving Outcomes

Rising socioeconomic disadvantage in Manchester and particularly in some of its neighborhoods has consequences not only for the city's most vulnerable residents, including many of its children, but also for all residents of the city and New Hampshire statewide. Growing disadvantage and the toll it takes on educational achievement, economic well-being, and other areas of social life suggest a need for place-based interventions.

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A key element of the Manchester Community Schools Project is to make elementary schools in the Bakersville, Beech Street, and Gossler Park neighborhoods centerpieces of community life for all residents, not just those with children.[8] By allowing schools to serve as community centers (housing a variety of civic-related activities like block parties and watch groups), residents can more easily build social ties to one another, school personnel, and their neighborhoods more broadly. Schools also house community care coordinators who can direct residents to agencies related to the dimensions of health and well-being discussed in this

brief. These coordinators can work one-on-one with residents, helping them connect to the programs and services they need, thereby improving residents' knowledge of where to find services (a commonly cited barrier to well-being). Serving residents directly in the schools in their own neighborhoods can also reduce transportation-related issues. Another dimension of the MCSP—linking nonprofits and public-sector leaders to one another—will help stakeholders work together. Such collaboratives may allow these groups to leverage current resources, such as translators, or create new ones presently lacking, including ESL programs. Additionally, the MCSP is beginning to provide no-cost health and fitness programs, leadership development opportunities for youth and adults, and no-cost financial literacy and employability trainings in the Community Schools.

The community schools model has already been implemented in cities like Chicago, Los Angeles, Cincinnati, and Tulsa, Oklahoma. This approach has been shown to improve a variety of outcomes, including school attendance rates, graduation rates (coupled with lower high school dropout rates), parental involvement, and healthy behaviors among both students and adults.[9] Congress is considering legislation that would increase grant funding for community schools.[10]

The MCSP is employing an outcomes-based approach to ensure that programs and agencies involved achieve intended results and are working together to have a collective impact. The surveys and focus groups analyzed here illustrate the data-driven approach that the MCPS is utilizing. This includes partnering with service providers to establish templates that measure the success of interventions beyond simple indicators like number of clients served. Organizations can then use these data to alter their practices as needed.

The neighborhood in which one lives shapes a variety of outcomes related to well-being. A place-based approach like the community schools model can improve outcomes not only for residents of the Bakersville, Beech Street, and Gossler Park areas but for all Manchester residents. To learn more about the Manchester Neighborhood Health Improvement Strategy, please visit www.manchesternh.gov/health/neighborhood-healthimprovementstrategy.pdf.

Endnotes

1. Data from 2000 are based on figures from the U.S. decennial census; 2010 refers to five-year estimates from the American Community Survey (ACS), 2008–2012. Year-to-year changes (for example, 2008 to 2009) from the ACS are not referenced here, as the margins of error for Manchester are too large to establish reliable estimates with the one-year data.

2. Because census tract boundaries often change from one decade to the next, the tracts displayed in these maps have been standardized using data downloaded from the US2010 Project, available at www.s4.brown.edu/us2010/Researcher/Bridging.htm. For technical documentation on the standardization of census tracts, see John R. Logan, Zengwang Xu, and Brian Stults, "Interpolating U.S. Decennial Census Tract Data From as Early as 1970 to 2010: A Longitudinal Tract Database," *Professional Geographer* 66(3): 412–20 (2012).

3. Sally K. Ward, Justin R. Young, and Curt Grimm, "Immigration to Manchester, New Hampshire: History, Trends, and Implications," Regional Issue Brief No. 39 (Durham, NH: Carsey Institute, University of New Hampshire, 2014), http://scholars.unh.edu/cgi/viewcontent.cgi?article=1212&context=carsey.

4. Robert J. Sampson, Patrick Sharkey, and Stephen W. Raudenbush, "Durable Effects of Concentrated Disadvantage on Verbal Ability Among African-American Children," *Proceedings of the National Academy of Sciences* 105(3): 845–52 (2008).

5. Jeanne Brooks-Gunn and Greg T. Duncan, "The Effects of Poverty on Children," *Children and Poverty* 7(2): 55–71 (1997).

6. Survey respondents were asked which dimensions of well-being were of most concern to them, and were then prompted to answer further questions about those particular areas. In Figure 3, therefore, only respondents who identified each topic area as one of concern are included in these estimates. About half of respondents said that all these areas were of concern to them, and subsequently answered questions in all six topic areas.

7. See Kenneth M. Johnson and Robert Macieski, "Demographic Trends in the Manchester–Nashua Metropolitan Area," New England Issue Brief No. 16 (Durham, NH: Carsey Institute, University of New Hampshire, 2009), http://scholars.unh.edu/cgi/viewcontent.cgi?article=1084&context=carsey.

8. Manchester's Neighborhood Health Improvement Strategy (2014) is available at www.manchesternh.gov/health/NeighborhoodHealthImprovementStrategy.pdf.

9. Martin J. Blank, Atelia Melaville, and Bela P. Shah, "Making the Difference: Research and Practice in Community Schools" (Washington, DC: Coalition for Community Schools, 2003), www.communityschools.org/assets/1/page/ccsfullreport.pdf. For an evaluation of one community school project, see "Comprehensive Evaluation of the Full-Service Community Schools Model in Washington: Showalter Middle School" (2005), a report prepared for the Eisenhower Foundation by LaFrance Associates, available at: www.eisenhowerfoundation.org/docs/Showalter2.pdf.

10. See Steny H. Hoyer and Aaron Schock, "A Bipartisan Argument for Full-Service Community Schools," *Education Week*, July 28, 2004, www.edweek.org/ew/articles/2014/07/28/37hoyer.h33.html.

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Funding

This work was supported by the Manchester Roadmaps to Health Initiative, with funding provided by the Robert Wood Johnson Foundation, U.S. Office of the Assistant Secretary of Health, Granite United Way, NH Charitable Foundation, Endowment for Health, and the Cogswell Benevolent Trust.

Acknowledgements

The author wishes to thank Anna Thomas and Jaime Hoebeke at the Manchester Health Department, as well as Michele Dillon, Michael Ettlinger, Curt Grimm, Eleanor Jaffee, Laurel Lloyd, and Patrick Watson for their assistance. Thank you to Barbara Cook and Luke Rogers, who created the poverty maps for this brief. Thank you also to the participants, interpreters, and representatives from various agencies and schools who helped to facilitate the focus groups; your input is vital to the success of the Manchester Community Schools Project.

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This work was supported by the Manchester Roadmaps to Health Initiative, with funding provided by the Robert Wood Johnson Foundation, U.S. Office of the Assistant Secretary of Health, Granite United Way, NH Charitable Foundation, Endowment for Health, and the Cogswell Benevolent Trust.

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