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ABSTRACT

This paper proposes that local public schools assume the locus of responsibility for providing comprehensive health and mental health services for children and their families. Among the advantages of school based delivery systems are the universality of public education, the availability of physical and human resources, established funding mechanisms and local control of operations. It is suggested that existing program and networks (such as community mental health centers, health agencies, and community education programs) lend themselves to the development of a system of physical and mental health services delivered through the schools with citizen participation in the decision-making process. Current state and federal legislation would require only slight modification to enable services to become school based. Services provided through the school system would vary depending on local values and needs, existence of other community services, cost, the roles of the caregivers and their vested interests, and the availability of technical assistance in implementing the system. The most important consideration is the need to develop varied delivery systems congruent with the divergent needs of urban, rural, and minority groups. (Author/RH)

An Expanded Role for Public Schools: Community-based Delivery of Comprehensive Health and Mental Health Services

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On May 25, 1977, the President's Commission on Mental Health heard testimony from a variety of lay and professional citizens concerning the mental health needs of children and families in the southeastern United States. Two major themes emerged from the day-long hearing. Many speakers emphasized the need to coordinate the existing array of services so that consumers would have a simplified and prompt access to helping agencies and professionals. Other speakers expressed a need for increased consumer participation in decision-making regarding the actual implementation and delivery of services so that community health needs could be met within the framework of regional and national goals. One alternative to meeting these needs for coordination and participation in decision-making is the use of the existing network of public school systems to provide, obtain, or assure preventive and rehabilitative care for children and their families.

At the hearing, three speakers addressed the role of the public schools. Mr. Jerry Boone, president of the Tennessee Psychological Association, called for school-based programs for children and families as a means to reduce the barriers to utilization of services. Mrs. Joseph M. Marshall, president of the East Tennessee chapter of the National Society for Autistic Children, suggested that schools should serve as diagnostic centers for young children (below six years) so that developmental abnormalities could be identified as early as possible. In addition, parent education services and a full-year educational

program for children with special needs were cited as necessary components of the mental health service delivery system. Finally, Mr. Nicholas Hobbs of Vanderbilt University recommended that "the public schools be made responsible for providing, obtaining, or assuring health, mental health, social and recreational services for the children of our nation."

What is the rationale for expanding the role of our nation's public school system? The arguments may be briefly summarized as follows:

1. Schools are where most children are--55,000,000 of them.

2. Schools are accessible, physically and psychologically, to nearly all children and families. Every community has a public school. Schools are more favorably regarded than are the mental health, health, welfare, and law enforcement systems.

3. Schools are staffed by competent, trained people who have dedicated their lives to children. There are 3,000,000 teachers, 60,000 guidance counselors, 20,000 nurses, and 10,000 psychologists working today in public schools. Increased use of paraprofessionals and community volunteers is creating greater manpower resources in public schools than has existed in the past. Bringing together existing school-based resources and fragmented community resources within centralized neighborhood sites (schools) would provide for better coordination and more efficient delivery of services.

4. There is an existing tax base for schools that includes local, state, and federal funds. Mechanisms to fund existing and innovative programs are in place in both state and local education agencies.

5. The schools are the <u>only</u> social institution that provides services to <u>all</u> children on a universal basis. The long-standing tradition of a free public education has meant there is no stigma attached to receiving services from or through the school system, and recipients of services have not been segregated according to income eligibility criteria.

6. Some 250,000 children are currently excluded from schools because the schools do not have personnel or facilities to meet their special health and mental health needs (Children's Defense Fund, 1974).

7. There are numerous state and federal programs, some of which are currently school-based, delivering services to an expanded population group, including preschoolers, adults, and handicapped children. In some states, school services are mandatory for handicapped children from birth to 21 years of age.

8. Schools have a tradition of local control that can serve as a model to the health and mental health delivery systems. Parent involvement in decision-making has increased in some areas through the introduction of community education programs. Expansion of the community education concept will provide for still greater involvement in decision-making.

9. Schools have physical and human resources that are underutilized due to declining birth rates. Empty classrooms in the 91,000 schools in the United States and 200,000 unemployed teachers point to a significant waste of existing resources. In addition, there is a comprehensive record-keeping system in place in public schools that could be expanded to include physical, dental, and mental health records while assuring confidentiality and access by parents.

Minzey and LeTarte (1972) summarize these arguments by stating:

> The neighborhood school (is) the one unit that can be utilized as a basis of operations. It is the one facility that all neighborhoods have in common. No other agency or governmental system has a structural framework that approaches that available through the local elementary school, and it is the only governmental agency that exists in neighborhoods all over the country (pp. 6-7).

Community education is a philosophy of education and community involvement which is especially relevant to a discussion of an expanded role for schools. It is a concept that has been in use since the early 1940's in this country (Totten, 1970). Rather than being characterized as a single system or program, community education is best described as a "process that achieves a balance and a use of all institutional forces in the education of all the people of a community" (Seay et al., 1974, p. 3). Community education seeks to relate the school to the community by opening up the schools to all age groups and by using the schools as catalysts for bringing community resources to bear on community problems. Utilizing the leadership of a Coordinator assigned to the "community school," an advisory council is assembled from leaders and citizens in the community. The council then becomes the central element in the process of ongoing community assessment, identification and development of needed services, and community/school decision-making. There are over 1300 community schools in almost 1300 school districts in the U. S. (Seay et al., 1974).

Research on the impact of community education, while scanty, has been generally positive. Field-based studies have found that the programs have been accompanied by decreases in school vandalism, auto thefts, juvenile delinquency, recidivism, and school dropout rates. There are also indications that community education can increase political involvement (as measured by the number of those

voting in school bond elections), student achievement, student participation in curricular and extra-curricular activities, and level of adult participation in school activities (Totten, 1970).

It is important to distinguish between the related but distinct notions of school decentralization, neighborhood schools, and the community school that delivers community education. Decentralization, exemplified by the Ocean Hill-Brownsville experiment in New York City, is an administrative procedure that attempts to set up a middle-level of accountability so that local citizens can have easier access to policy-makers and a greater voice in decision-making concerning their schools. It does not imply an expanded role for the schools per se.

Neighborhood schools have come to connote those schools not affected by interracial busing plans, thus reflecting the ethnic composition of the immediate neighborhood in which they operate. The "quality education" movement among black communities has been an attempt to upgrade neighborhood schools existing in primarily segregated areas (Hamilton, 1968).

With the community school, there is both an expanded role for parents and citizens in policy-making, and an attempt to serve the needs of all those in the neighborhood. However, community schools frequently play an affective role in comprehensive busing plans for racial integration. A community school may serve children and families from both contiguous and distant neighborhoods to improve racial balance.

The community mental health system, established under Public Law 88-164, Section 200, during the Kennedy administration, is an intervention system designed to prevent, manage, or reverse undesired emotional conditions. The intital purpose of the system was,

> to decentralize the provision of mental health care, locating it in a manner which is conveniently accessible to the homes of clients and their families, and to encourage the programs to be accountable to the population served (Miller, 1974, pp. 43-44).

The original goal of establishing a national network of 1500 community mental health centers by 1980 has fallen short. There are about 500 such centers in existence today, most of which are facing significant funding cutbacks as a result of amendments to P.L. 88-164, found in the Special Health Revenue Sharing Act of 1975.

The two systems described here, in conjunction with the public health system, have the potential to complement the existing school system so that comprehensive services are available to children and families. It is not suggested that the health and mental health systems be subsumed under the public school bureaucracy. Rather, community schools could become the service entry point for families using the health systems, the advocate for families not previously in contact with health care providers, and the agency responsible for identifying the unmet needs of the community. We do not suggest the creation of a monolithic service system, but we do see advantages in the creation of an efficient system that will coordinate the numerous services that now exist.

Legislation. There are several state and federal statutes that would facilitate the merger of the community mental health system, public health care, and the community education concept. The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) as amended by the Special Health Revenue Sharing Act of 1975 (P.L. 94-63), establishes comprehensive mental health service centers that are capable of delivering in-patient and out-patient care, transitional care, alcohol and drug abuse counseling, individual and group therapy, family counseling, diagnostic and assessment services, and consultation and education services to the general community. This last category has been the primary mechanism for preventive mental health education programs in schools and other community agencies. P.L. 94-63, Section 201,(D) follows:

"(D) consultation and education services

"(i) are for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities; and

"(ii) include a wide range of activities (other than the provision of direct clinical services) designed to (I) develop effective mental health programs in the center's catchment area, (II) promote the coordination of the provision of mental health services among various entities serving the center's catchment area, (III) increase the awareness of the residents of the center's catchment area of the nature of mental health problems and the types of mental health services available, and (IV) promote the prevention and control of rape and the proper treatment of the victims of rape;

Schools, as public agencies, are eligible to receive money for consultation and education services under this Act.

In the area of public health, the Public Health Service Act of 1944, as amended by P.L. 94-317, the National Consumer Health Information and Health Promotion Act of 1976, establishses community health programs aimed at the development of new and innovative preventive and primary care systems in schools, day care centers, and other community settings. Section 1703 reads, in part:

"SEC. 1703. (a) The Secretary is authorized to conduct and support by grant or contract (and encourage others to support) new and innovative programs in health information and health promotion, preventive health services, and education in the appropriate use of health care, and may specifically—

"(1) support demonstration and training programs in such matters which programs (A) are in hospitals, ambulatory care settings, home care settings, schools, day care programs for children, and other appropriate settings representative of broad cross sections of the population, and include public education activities of voluntary health agencies, professional medical societies, and other private nonprofit health organizations, (B) focus on objectives that are measurable, and (C) emphasize the prevention or moderation of illness or accidents that appear controllable through individual knowledge and behavior;

"(2) provide consultation and technical assistance to organizations that request help in planning, operating, or evaluating programs in such matters;

"(3) develop health information and health promotion materials and teaching programs including (A) model curriculums for the training of educational and health professionals and paraprofessionals in health education by medical, dental, and nursing schools, schools of public health, and other institutions engaged in training of educational or health professionals, (B) model curriculums to be used in elementary and secondary schools and institutions of higher learning, (C) materials and programs for the continuing education of health professionals and paraprofessionals in the health education of their patients, (D) materials for public service use by the printed and broadcast media, and (E) materials and programs to assist providers of health care in providing health education to their patients; and

"(4) support demonstration and evaluation programs for individual and group self-help programs designed to assist the participant in using his individual capacities to deal with health problems, including programs concerned with obesity, hypertension, and diabetes.

The third legislative element in the proposed merger of caring systems involves P.L. 93-380, the Education Amendments of 1974 of the Elementary and Secondary Education Act. Section 405 reads, in part:

> Sec. 405. (a) This section may be cited as the "Community Schools Act".
>
> (b) In recognition of the fact that the school, as the prime educational institution of the community, is most effective when the school involves the people of that community in a program designed to fulfill their education needs, and that community education promotes a more efficient use of public education facilities through an extension of school buildings and equipment, it is the purpose of this section to provide educational, recreational, cultural, and other related community services, in accordance with the needs, interests, and concerns of the community, through the establishment of the community education program as a center for such activities in cooperation with other community groups.
>
> (c) For purposes of this section and subparagraph (C) of section 402(b)(3), a "community education program" is a program in which a public building, including but not limited to a public elementary or secondary school or a community or junior college, is used as a community center operated in conjunction with other groups in the community, community organizations, and local governmental agencies, to provide educational, recreational, cultural, and other related community services for the community that center serves in accordance with the needs, interests, and concerns of that community. Nothing in this section shall be construed to prohibit any applicant under this section from carrying out any activity with funds derived from other sources.
>
> (d)(1) In order to carry out the purposes and provisions of this section, the Commissioner is authorized to make grants to State educational agencies and to local educational agencies to pay the Federal share of the cost of planning, establishing, expanding, and operating community education programs.

A fourth item of legislation, P.L. 94-142, the Education of All Handicapped Children Act, is presently mandating expanded services within public school settings for children with special needs from 3 to 21 years of age. Although this Act is comprehensive in addressing the individual health and developmental needs of exceptional children, and in calling for due process, parent involvement in decision-making, normalization, and deinstitutionalization, no dollars are provided for health treatment or supervision within the scope of the Act.

It appears that there is sufficient legislation in place to facilitate an expanded role for schools in the health and mental health delivery systems. Closer scrutiny may reveal specific areas that will need amendment or increased federal financial support to enable the proposed coordination of services to occur. There will be a need to develop guidelines for local communities that wish to provide school-based health and mental health services. In addition, technical assistance from state and federal agencies should be available at little or no cost to aid school districts in this process.

Services. Below is a partial listing of services that schools already provide or could provide, either directly or indirectly, to children and families. This list comes largely from the report of the Joint Commission on the Mental Health of Children published in 1969. The feasibility of providing any or all or these services is an empirical question that requires examination of current innovative community health and education systems. Several hundred communities, including Galveston, New Orleans, Cambridge, Flint, Nashville, St. Louis, and Jacksonville are presently delivering limited health care for mothers and children, providing expanded child care before and after regular school hours, and/or including lay adults and senior citizens in their educational programs. It is assumed that local communities will identify their own needs and develop school-based programs congruent with those local needs. Options for services include:

A. Prenatal care

1. Maternal and child health care
2. Outreach educational services
3. Homemaking services
4. Nutritional information and supplements
5. Prepregnancy immunizations
6. Mental health consultation for obstetrical workers
7. Psychotherapeutic intervention for postpartum psychosis
8. Continuing educational opportunities for pregnant school-age children

B. Family planning

1. Education in human reproduction
2. Contraceptive devices, techniques, and/or counseling
3. Genetic counseling

C. Pediatric and mental health services for children under six years

1. Identification of potential handicapping conditions and follow-up treatment and care
2. Mental health consultation for mothers suffering adverse reactions to premature or impaired infants
3. Parenting education programs to enhance normal parent-child social interaction and their mutual physical and intellectual development
4. Immunization programs
5. Nutrition education and supplements
6. Preschool home training programs for disturbed or impaired children

D. Services for school-aged children

1. Mental health consultation available for parents, teachers, and other staff to enable them to meet their own psychological needs while serving children
2. Direct treatment and rehabilitation within school settings for children exhibiting problematic physical, emotional, and intellectual development
3. Curricula in family living, human development, and interpersonal relations for late adolescents
4. Nutrition education and supplements
5. Pediatric screening and referral services

E. Community-wide information and referral systems

1. School liaison personnel to link families with community health and mental health service providers
2. Compilation and dissemination of resource lists on community services for the public, including 24-hour phone lines for i and r services
3. Community resource libraries within public schools, available to any person seeking community services

F. Supplemental child care and development programs

1. Day care services for preschool children of working families
2. Before and after-school care for school-aged children of working families
3. Respite care for children of abusing parents, for handicapped children whose parents require time away from the pressures associated with such a child, or for families in crisis
4. Transitional care for children moving from institutional settings back into their own communities

G. Employment and training opportunities

1. Late adolescents guided and placed in potential career roles while still in school
2. Training and placement of mothers who had previously not participated in the labor market
3. Career opportunities for paraprofessionals within the schools related to classroom teaching, medical care, mental health care, child development, nutritional services, community organizations, etc.
4. Internship opportunities for professionals in the areas of teaching, pediatrics, psychology, social work, nutrition, recreation, law enforcement, etc.
5. Part-time placement for community volunteer agencies such as VISTA, foster grandparents, RSVP, etc.

H. Other services

1. Adult Basic Education
2. Court diversion programs
3. Sponsors of Parents Anonymous chapters
4. Big Brothers/Big Sisters programs
5. Senior citizen hot meal programs

Barriers to implementation. A primary obstacle to overcome in expanding the role of the nation's school system is the long-standing tradition of non-federal involvement in the educational system. Although federal expenditures for education have increased markedly over the past two decades, dollars have generally gone to categorical areas related to economically disadvantaged regions and groups. Federal aid has not been available for comprehensive services provided by the public schools. The major financial share for supporting schools still comes from local and state tax revenues. This separation of state and federal governments has been viewed as a positive relationship because of varying needs in a pluralistic society and the importance of local control over our primary institutional culture bearer. However, the interface between school districts and federal agencies will need to be renegotiated as attempts are made to simplify and coordinate health and mental health services. A balance must be struck between the overarching needs of society as a whole and the particular needs of thousands of local communities.

Consideration should be given to divergent needs of urban and rural populations because of geographic, social, and historical factors. There is evidence that the rural community views the local school in a manner different from that of urban areas. Although rural communities place a high value on formal education, introduction of expanded roles for the school, experimental curricula, value-laden subjects, and increased expenditures have been resisted in rural areas (Gehlen, 1969). The homogeneous nature of rural populations has been shown to inhibit educational change contrasted with openness to such change in heterogenous urban communities (Kreitlow & Butterfield, 1966). An additional consideration in rural areas is the lack of a comprehensive infrastructure of services, institutions, businesses, and community organizations, a problem that the former governor of Kentucky, Edward Breathitt (1969) has called a "system problem." These problems, combined with sparsely distributed populations, traditional value systems (Matthews, 1966), depressed tax bases (Donohew & Parker, 1970), and lower paid and less trained teachers in rural areas (Coleman, Campbell, et al., 1966), all indicate a need to develop different implementation strategies depending on geographic region and the availability of other supporting resources.

In addition to urban/rural considerations, it will be necessary to consider differing needs of ethnic and racial groups. Schools have functioned both to assimilate subgroups into the larger society and to aggravate racial and ethnic differences. Hamilton (1968) noted that many black communities have not seen the educational system as a viable institution for meeting the needs of black citizens. However, Hamilton suggests not that we do away with schools or restrict their scope, but rather that we expand their role. "The educational system should be concerned with the entire family, not simply the children" (Hamilton, 1968,p. 682). He recommends the development of Comprehensive Family-Community-School Plans that recognize parents as teachers and assure local control of educational policies.

At this point, it is impossible to predict either savings or costs resulting from school-based health and mental health services. Those programs that now operate are quite diverse in their administrative structures, funding sources, and comprehensiveness of services. It does not appear that massive new dollars will need to be generated if existing services are coordinated through the schools. Some rural areas, lacking social services now enjoyed in urban regions, may need additional state and federal support before expanding the role of the schools. Some cities, such as Galveston, Texas, and New Orleans have used a combination of tax dollars, federal grants, third-party payments, and foundation support to operate school-based health services.

Other barriers to implementation include a lack of commitment on the part of state education departments to health education, the need to retrain school nurses as pediatric nurse practitioners, conflicting jurisdictional regulations and practices regarding the control of health services for school-aged children, the lack of any coordinating mechanisms at the federal level, inadequate record-keeping in some public school systems, and the lack of empirical data as to effective implementation metholologies and cost effectiveness of various service delivery arrangements.

Finally, although schools do have a tradition of local control, they have generally neglected the role of the parent as a teacher and decision-maker in the education of children. In 1974, a national task force for high school reform (Task Force '74) developed nineteen recommendations for solving pressing problems in American schools. Their primary recommendation was that local citizens and community groups immediately increase their political participation so that consumers and lay people were more deeply involved in school governance. Etzioni (1969), Berube (1971), Dokecki (in press), and others call for increased parent participation in decision-making in order for schools to meet the comprehensive social

needs of their communities. The federal statutes cited earlier all mandate the use of local advisory councils of lay and professional citizens, including consumers, to administer social action programs. Thus, the historical role of parents as policy-makers has been less than it could be, but current social and legislative trends are granting parents greater decision-making powers.

Summary. It has been proposed that local schools assume the locus of responsibility for providing, obtaining, or assuring comprehensive health and mental health services to children and their families. Citing the need for better coordination of services, easier access by consumers, and greater control over services by local communities, advocates of an expanded role for schools point to the universality of public education, the presence of physical and human resources, established funding mechanisms, and local control as the advantages of a school-based delivery system.

Existing caring networks and innovative programs, including community mental health centers, health agencies, and community education programs lend themselves to the development of a system of health and mental health services delivered through the schools with citizen participation in the decision-making process. Current state and federal legislation would require a minimum of modification to enable services to become school-based.

There are a variety of service options that could be provided through the school system. Which ones can be adopted depend on local values and needs, existence of other community services, cost, the role of the care-givers and their vested interests, and the availability of technical assistance in implementing the system. The most important consideration, and the one perhaps least responsive to legislative regulation, is the need to develop varied delivery systems that are congruent with the divergent needs of urban, rural, and minority groups. It is essential that parents and other citizens be given a major role in defining the options for solving these problems.

Further research on questions implicit in this paper must be conducted before recommendations for policy options are made. The appendix contains an outline of issues that must be addressed in the process.

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