

## Full Service Schools: Revolution or Fad?

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During the past decade, a plethora of new school-based models for enhancing the life chances of adolescents have emerged. The term *full service schools* encompasses school-based primary health clinics, youth service programs, community schools, and other innovative efforts to improve access to health and social services. These programs have in common the use of school facilities for delivering services through partnerships with community agencies; a shared vision of youth development; and financial support from sources outside school systems, particularly states and foundations. Organizing a school-based initiative requires careful planning to involve school personnel, community agencies, parents, and students. Evaluation is still preliminary; scattered results are encouraging in regard to utilization of and access to needed health and mental health care; dropout, substance abuse, and pregnancy prevention; and improved attendance. This evolving field of school-based intervention creates new opportunities for research on outcomes and impacts, operational components, and cost benefits. Observers see the development of full service schools as a significant step toward the integration of the movements for quality education and the drive for healthy youth development.

Two important strands of social intervention began to come together during the resource-strained 1980s. The drive to meet the urgent health and social support needs of growing numbers of disadvantaged children, youth, and families was linked to the movement toward educational reform that would lead to more successful futures for these people. A variety of new institutional arrangements were created by

innovative practitioners and educators. School-based clinics, school-linked clinics, family resource centers, community schools, caring communities, youth service centers, and such programs as Cities-in-Schools, Schools of the 21st Century, New Beginnings, and Beacons all used school buildings as places for integrating programs to assist poor and troubled people. The term that best describes this emerging phenomenon is *full service schools*, a phrase first encountered in the Florida's innovative legislation to support comprehensive school-based programs (Florida Department of Health and Rehabilitative Services and Department of Education, 1991):

A Full Service School integrates education, medical, social and/or human services that are beneficial to meeting the needs of children and youth and their families on school grounds or in locations that are easily accessible. Full Service Schools provide the types of prevention, treatment, and support services children and families need to succeed ... services that are high quality and comprehensive and are built on interagency partnerships ... among state and local and public and private entities ... [including] education, health care, transportation, job training, child care, housing, employment, and social services. (p. 1)

This article is based on a recently published book by Joy Dryfoos, *Full Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families* (Dryfoos, 1994). Here current research, commentary, and observations about the concept of full service schools are summarized, with particular focus on programs for adolescents. The rationale for the linkage of educational and health efforts is presented along with precedents for bringing support services into school buildings. Various school-based models are reviewed, showing how states and foundations have shaped the development of this emerging field. Consideration is given to organizational issues such as governance, "turf," controversy, and financing. A summary of evaluation research findings is offered along with suggestions about the potential of this field for new studies. Finally, the future prospects for integrated school-based health and social services are addressed. Are full service schools the wave of the future or is the concept merely another fad in demonstration projects that will rapidly be supplanted by something else?

### RATIONALE

Why the accelerated movement toward comprehensive school-based services for adolescents? The plight of young people growing up in inner cities or poor rural areas has been well documented. The dire statistics of the new morbidities—adverse effects of modern-age sex,

drugs, violence, depression, and stress—account for a vast number of youths who will never make it without immediate intervention. My own estimate is that one in four young people growing up in the United States today is in grave jeopardy (Dryfoos, 1990). These disadvantaged young people, living in run-down, resource-poor communities, cannot overcome the odds without substantial assistance. Some lack family nurturing and require individual attention from other caring adults. Many go to schools in which they are expected to fail. Both the health system and the educational system are called upon to respond to these social deficiencies. Thus, the rationale for creating new kinds of institutional arrangements crosses several domains: health, education, and social services integration.

### **Health**

Although adolescents are generally healthy, youth in disadvantaged communities are much less likely to have access to primary health care and more likely to rely on emergency rooms for treatment of illnesses and accidents than their advantaged peers (Office of Technology Assessment [OTA], U.S. Congress, 1991). Even in middle-class communities, few private physicians are equipped to deal with the psychosocial problems that are so prevalent during the teen years. Teenagers, in general, are less likely to be covered by any form of health insurance, and for those poor teenagers eligible for Medicaid, coverage is tied to parental enrollment, reducing the prospects for confidentiality. The OTA, U.S. Congress (1991), when charged by Congress to review the health status of American adolescents and present options for congressional consideration, strongly recommended comprehensive school health clinics as the most promising recent innovation to improve access to health care. They added a note of caution, however, pointing out that systematic evidence that school centers improve health outcomes is limited.

Along with the OTA report, some 25 other major reports have been published recently that address the relation between young people's health status and their educational experience, call for a comprehensive approach to health, and support the placement of health promotion and health service programs in schools (Lavin, Shapiro, & Weill, 1992).

### **Education**

Schools cannot educate children who are too "stressed out" to concentrate. Teachers are not trained as social workers and cannot possibly attend to their jobs if they must spend all of their time trying to remedy problems. The challenge for schools is to be allowed to concentrate on

teaching. Even if all the necessary support services are in place, disadvantaged young people cannot succeed unless they attend schools with quality educational programs. Educational experts have excellent ideas about how to improve the educational outcomes of disadvantaged children, with extensive research and demonstration models that work in low-income communities (Comer, 1989; Slavin, Karweit, & Wasik, 1994; Wehlage, Rutter, Smith, Lesko, & Fernandez, 1989). Consensus is building among educators about the importance of bringing support services into schools that will strengthen their efforts at restructuring (United States Government Accounting Office, 1993; Usdan, 1994). Organizations such as the National Association of State Boards of Education, the National Association of School Boards, and the Council of Chief State School Officers have been in the vanguard of task forces and commissions that call for comprehensive school-based service programs.

### **Need for Integrated Services**

*Service integration*—the establishment of linkages between agencies—is a hardy perennial that reappears whenever there are a plethora of categorical programs and overwhelming needs but little new money to address the problem. The subject is of interest to advocates of full service schools because of the necessity of welding together fragmented health and social service agencies with educational systems, often a challenging experience. Much has been written about the fragmentation that results from the development of specialized programs to address each category of need as it gains visibility in a very competitive funding and media environment (Schorr, 1988). This categorization has been particularly marked in regard to adolescent problems, with each year's crisis ending in a new wave of limited grants and program development: delinquency, substance abuse, teen pregnancy, HIV/AIDS, and the latest, violence/conflict resolution. But families also experience difficulty gaining access to health, social, welfare, housing, and employment services that are operated separately with different regulations, eligibility, and geographic location.

Growing recognition based on recent research findings that these categorical programs have only limited and short-term effects has fed the demand for integration of services, reducing the fragmentation of existing service systems for families (Kahn & Kammerman, 1992). Many of the new family-centered programs are being placed in schools to facilitate "one-stop-shopping" for whatever families and their children need to overcome the enormous odds they are up against in disadvantaged communities. Much of the service integration rhetoric

calls for *systems changes*—new ways of organizing administrative structures that are more responsive to consumers (Melaville, Blank, & Asayesh, 1993). In this literature, considerable attention is being directed toward the involvement of the community and the importance of a sense of ownership by parents and other residents, recalling the language of the community action programs of the 1960s.

### Historical Precedents

The idea of bringing health and social services into schools has been around for more than a century. At the turn of the century, settlement house workers and social activists led the movement toward attending to the critical needs of disadvantaged immigrants pouring into city schools. Both the demand and the supply have fluctuated over the years, reflecting changing social conditions and social attitudes. In periods of poverty, epidemics, and unrest, provision of school-based primary health services and extensive health inspection by physicians has been allowed, but whenever school services have loomed as competition to the private sector, approval has been withdrawn.

The history of social services in schools mirrors that of health services. Early on, social activists stimulated the development of vocational guidance, home visiting, vacation schools, school breakfasts and lunches, and after-school recreation programs, largely through voluntary efforts. As these initiatives formalized, schools began to become the employers and providers, and the programs were left to the vagaries and budgets of school boards and electorates. After World War II, school systems generally incorporated more pupil personnel services, including guidance counselors, social workers, and psychologists, but the primary thrust came from middle-class families who wanted assurance that their children would do well and get into college. Beginning in 1975, with the passage of legislation that called for special education, schools were made responsible for caring for physically and emotionally handicapped children, including everything from physical and speech therapy and psychological services to intensive nursing care and case management. Today, almost half of school workers are noninstructional employees (Tyack, 1992). Yet school systems cannot meet all the needs of their students with the existing personnel. During the final decade of this century, the pendulum is swinging back to bringing outside health and social service programs into schools in response to contemporary crises growing from poverty, immigration, and community decay. Currently, every major national social and health organization supports the concept that community agencies should bring services into schools.

## VISION OF A FULL SERVICE SCHOOL

My vision of a full service school integrates the best of school reform with all other services that children, youth, and their families need, most of which can be located in a school building. This concept expands the Florida (1991) definition and, like a big umbrella, encompasses the educational mandate that places responsibility on school systems to reorganize and innovate. Restructured schools attend to individual differences, give staff a wide range of choices regarding teaching methods, organize curricula that are stimulating and relevant, and eliminate tracking and suspensions. The charge to community agencies is to bring the support side into the school: health, mental health, family planning, employment services, child care, parent education, case management, recreation, cultural events, welfare, community policing, and whatever else may fit into the picture. The result is a new kind of "seamless" institution, a community school with a joint governance structure that allows maximum responsiveness to families and communities and promotes accessibility and continuity for those most in need of services.

Table 1 presents an idealized model of the full service school, listing in the left column some of the components that might be incorporated

TABLE 1  
Components of Full Service Schools Institutions

| <i>Quality Education<br/>Provided by Schools</i> | <i>Services Provided by Schools<br/>or Community Agencies</i> | <i>Support Services Provided<br/>by Community Agencies</i> |
|--|---|--|
| Effective basic skills                           | Comprehensive health education                                | Health screening and services                              |
| Individualized instruction                       | Health promotion  | Dental services  |
| Team teaching                                    | Social skills training  | Family planning  |
| Cooperative learning                             | Preparation for the world of work (life planning)             | Individual counseling                                      |
| School-based management                          |   | Substance abuse treatment                                  |
| Healthy school climate                           |   | Mental health services                                     |
| Alternatives to tracking                         |   | Nutrition/weight management                                |
| Parent involvement                               |   | Referral with follow-up                                    |
| Effective discipline                             |   | Basic services: Housing, food, clothes                     |
|  |   | Recreation, sports, culture                                |
|  |   | Mentoring  |
|  |   | Family welfare services                                    |
|  |   | Parent education, literacy                                 |
|  |   | Child care   |
|  |   | Employment training/jobs                                   |
|  |   | Case management  |
|  |   | Crisis intervention  |
|  |   | Community policing   |

into a quality education initiative and, in the right column, those support services that could be provided by community agencies. The support items are drawn from research on the common components of successful prevention programs in the separate fields of substance abuse, teen pregnancy, delinquency, and school failure (Dryfoos, 1990) or based on observations of school-based services demonstration projects (Cahill, 1993; Children's Aid Society, 1993; Florida Department of Health and Rehabilitative Services and Department of Education, 1991). Several components, such as social skills training, health education and promotion, and career training, could be placed in either column. Whereas these health education efforts are currently implemented by school systems, it is also feasible for community agency staff on the support side of the model to provide those services in the school.

### CURRENT STATUS

Everywhere in the United States, the school house doors have opened. At least 40 different types of personnel have been identified in school-based programs, including nurse practitioners, substance abuse counselors, mediation trainers, legal advisors, volunteer senior citizens, case managers, community police, and clergy. Almost none of these people are paid by school systems; rather, they work for health departments, neighborhood health centers, mental health and social service agencies, hospital/medical schools, youth agencies, mayors' offices, employment agencies, labor unions, or universities. The funds for these programs derive from an assortment of state and federal categorical funding sources, foundation grants, and local contributions. With few exceptions, schools do not lay out their own scarce resources for these support services.

Many different models of full service schools are being promoted by states, foundations, universities, and individual practitioners. School-based and school-linked health clinics have been organized by all of those entities. However, some states have also developed comprehensive school-based services programs for youth in which health services are only one of many components. Other states have supported youth centers in schools that are primarily for the purposes of coordination and that do not include health clinics. Several states have initiatives that give school districts a choice from a menu of on-site and referral services, and the result is a mixture of models. Finally, around the country, a few models have been identified that appear to be on the way to fulfilling the vision of the full service school, with attention to both sides of the education/support services equation.

One further distinction is between family-focused initiatives and those that center on adolescents. My concern here is with the latter, with heavy emphasis on changing the school environment to enable students to learn. Whereas parental involvement is one objective, it is not always possible or feasible. However, within the domain of full service schools are many different family-centered programs that begin with the needs of parents, helping them get their children off to a good start. Head Start programs are moving in this direction, extending their hours and adding more services. Excellent family-centered programs are emerging at the elementary-school level. The two prototypes intersect in middle schools, during the developmental stage for young adolescents prior to separation from family influences. I do not focus on family service centers here; however, their importance in the movement toward the development of full service schools must not be overlooked.

### School-Based Clinics

A school-based clinic is a primary medical care facility located in a school building typically operated by a health agency, hospital, or other community group. (School-linked clinics are located near schools and connected to them through formal referral systems.) The model is more easily described than other kinds of full service schools (such as family resource centers) because practitioners have made an effort to standardize it. Most recently, a national working group of providers and foundations has produced a set of principals of operation and standards of service provision. They have called for a multidisciplinary team to provide comprehensive medical, social, mental health, and health education services in a well-equipped school clinic with assurance of 24-hr backup by a medical institution.<sup>1</sup> A typical clinic in a large high school might employ two nurse practitioners (or physician assistants), two or more social workers, a health educator, a receptionist, and a part-time physician. In school clinics, the most heavily utilized services are for acute illnesses and accidents, mental health counseling, and physical examinations and screenings, but clinics may also provide family planning; treatment for sexually transmitted diseases; dental care; counseling regarding nutrition, substance abuse, and chronic disease management; immunizations; treatment for acne; prenatal and postnatal care; and child care. A survey of school-based

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<sup>1</sup>Information provided by the National Work Group on School-Based Health Care, Columbia University School of Public Health, Center for Population and Family Health.

and school-linked health centers showed that 70% offer on-site individual counseling, over 30% provide group counseling, and more than half currently offer health information and prevention education within the classroom regarding substance abuse, reproductive health care, nutrition, and HIV/AIDS (McKinney & Peak, 1994).

In 1984, only 10 school-based clinics could be identified. Today, more than 600 school-based clinics have been organized, mostly in junior and senior high schools in low-income communities. The most significant support for school-based clinics has come from state budgets and from Maternal and Child Health departments in at least 20 states that have made the decision to use federal block granted funds to support local school health initiatives. For example, in Connecticut, a state Adolescent Health Coordinator actively works with schools and community groups to plan and maintain clinics in schools covering most parts of the state. New York uses state funds to support 140 school-based primary health clinics in inner city and poor rural neighborhoods. Across the country, at least 35 school clinics have been organized by community health centers with support from the Bureau of Primary Health Care in Washington.

### Youth Service Centers

New Jersey's School-Based Youth Services Program is frequently cited as the model for the nation. Beginning in 1986, grants were awarded by the Department of Human Services for proposals that combined the resources of schools and community agencies to prevent teen pregnancy, dropout, and other high-risk behaviors. Each of the 29 school-based programs has a different configuration. Local community mental health centers are the operators of five of the school-based efforts, bringing mental health counselors into the school center along with other prevention, health, and recreational activities. New York City's Beacons are "lighted" schools kept open all hours with additional services offered by local community-based organizations. Each program is different depending on the capabilities of the local groups to address neighborhood interests.

In Kentucky, every school with more than 20% of the students eligible for free lunch can apply for a grant to open a Youth Service Center or a Family Resource Center. Several hundred junior and senior high schools have received funds to designate a space in the school as a center, staffed by a full-time coordinator, who develops a menu of ancillary services depending on an assessment of the needs of the students and the resources in the community. Employment counseling

and job placement, after-school recreation, family counseling, and referral for health services are typically provided.

In California's Healthy Start initiative, the Department of Education is empowered to award grants to low-income school districts to create innovative, comprehensive, school-based or school-linked health, social, and academic support services. To receive funding, school systems must submit evidence of a working collaborative partnership with health, mental health, social services, drug and alcohol, probation, and other public and nonprofit agencies.

The range in size of grants is significant. In Kentucky, the average grant is about \$75,000, only enough to fund a full-time coordinator, whereas New Jersey's annual grants have been about \$250,000, adequate to contract for center staff and professional services. In Florida, full service schools are receiving as much as \$400,000 a year, and, in some communities, new building grants for comprehensive centers equal more than a million dollars.

### **Full Service Schools**

Only a few schools have been identified that could be labeled "full service," covering all the components listed in Table 1. Yet across the country, one finds remarkable examples of very comprehensive demonstration models. In New York City and Modesta, California are two, quite similar innovative schools that provide quality educational experiences to disadvantaged junior high school students and bring in everything else that is needed to lead toward successful achievement. In New York City, the Children's Aid Society, in conjunction with Community School District 6 has created a true settlement house in a school (Children's Aid Society, 1993). The Hanshaw Middle School in Modesta, California is also open most of the time to serve the needs of a deprived, largely Hispanic neighborhood (Hanshaw Middle School, 1992). With support from California's Healthy Start initiative, a center has been constructed on the campus to house an interagency case management team and a primary health care and dental clinic. The Hanshaw program results from many partnerships between the school system and mental health, social services, public assistance, public health, and nonprofit health and service agencies.

### **Foundations**

In 1987, the Robert Wood Johnson Foundation awarded grants to launch health centers in 24 schools and, building on that experience, has created the Making the Grade initiative, supporting 10 states to

create state-level offices for school-based services and model clinics in two local sites. The Carnegie Corporation is supporting states in its Turning Point initiative to help middle schools link students to comprehensive health and social services as one component of middle-school reorganization. The Hogg Foundation for Mental Health has been instrumental in creating The Schools of the Future, changing schools into primary neighborhood institutions for promoting child and family development, building on the Comer School Development Program, Zigler's Schools of the 21st Century, school-based clinics, programs for community renewal, and family preservation.

A major new foundation-supported effort will attempt to reproduce in elementary schools the thrust of school-based initiatives for adolescents. Under the auspices of the National Health/Education Consortium (1993), a national demonstration project will be undertaken with 50 elementary school-based health centers in five geographic areas. Grants will be awarded to replicate a demonstrational model based on research in existing elementary school clinics.

## ORGANIZATIONAL ISSUES

### Governance

The concept of full service schools calls for a joint governance structure whereby partners agree to pursue a shared vision and have common goals, expect to share resources, participate in joint decision making, and use their personal and institutional power to change systems (Melaville et al., 1993). This implies a formal process that leads to the establishment of a new kind of governing body, such as a nonprofit coordinating agency or a new mayor's office initiative with the authority to oversee the whole comprehensive program. Program experience to date has shown little structural change. More typically, partners—schools and community agencies—have agreed on goals and signed contracts or memoranda of understanding that leave the status quo of the organizations entirely intact. The agreement may specify policies regarding fiscal responsibility, client-student data collection, confidentiality, and other administrative issues.

Most school-based health clinics are funded by grants directly to health agencies who then contract with school systems to provide services. This is a matter of policy for some state health departments and foundations who believe that the school system should not be burdened with the responsibility for providing primary health and social services to the students. Observers of the Robert Wood Johnson

initiative concluded that the way to strengthen health services provided in schools was to make those services an integral part of a community's health care delivery system (Lear, Gleicher, St. Germaine, & Porter, 1991). Community health agencies are already positioned to collect third party reimbursements (Medicaid), carry their own liability insurance, arrange medical referrals, protect medical confidentiality, and provide medical backup when the school health centers are closed.

In states with initiatives that start with school restructuring, such as Kentucky, the grants go directly to school systems with the proviso that they collaborate with human services providers at the local level. In Florida, where the grants also go to the school system, the proposals must show evidence of formal partnerships with community agencies, particularly the local public health agency. Whether the school or the health agency takes the fiscal lead in the development of a full service school project, whatever transpires in a school building must be approved by the school authorities.

### **Moving Into a School**

Whereas the superintendent and the school board must sign off on arrangements and policies for full service schools, the building principal facilitates the partnership with extensive planning for obtaining parental consent and releasing students from classrooms for clinic appointments, arranging hours of operation, and dealing with emergencies. Existing school personnel may perceive the transaction as the school environment being infiltrated with a new staff who work for a different organization, often with a higher pay scale and always with a different union. Scarce space, classrooms, or the old band room is converted into a primary care facility with freshly painted walls, new furniture, and attractive posters. Or, as in Florida, prefab units are added to the campus.

Full service school programs often encounter opposition from teachers and others who are not convinced that health and social services should be provided on school sites (even though the school system is rarely the actual provider). Competition often arises between existing pupil personnel services (school nurses, guidance counselors, social workers, school psychologists) and full service staff over the question of who is in charge of working with the student and the family. School-based clinics have accommodated school nurses by incorporating their services into the new delivery system and discerning principals create student service teams to coordinate the work of the school personnel and the clinic personnel. It has been observed that within a short

period of time, all parties agree that the growing needs of troubled students and their families far outweigh the joint capacities of the partnerships and they join together to advocate for additional services.

Full service school coordinators are a new category of personnel. Often nurse practitioners or social workers, they must know how to integrate with school personnel and promote a sense of "ownership" throughout the school community. Programs report increasing referrals from teachers who want help in dealing with problems. School-based practitioners, because they are heavily exposed to the day-to-day stresses of urban schools, perceive that schools must undergo dramatic changes if they are to improve the outcomes for the students. They can help school administrators move toward restructuring by arranging for consultants, conducting staff retreats, fostering continuing education, and joining in the dialogue about healthy school environments.

### Controversy

The phrase *school-based clinic* is like a red flag for conservative groups waiting for an excuse to raise community tensions over sexuality issues. The most highly publicized school-based clinics in the early 1980s were heralded as pregnancy prevention programs, leading to attacks from the opposition that schools were opening sex clinics and abortion mills. When later replications of these models were shown to have little effect on pregnancy rates because they did not include family planning services, the attack shifted and the opposition organized against bringing any kind of services into school buildings, even into elementary schools. At the time that the Kentucky Youth and Family Service Centers were first proposed, the Eagle Forum put out brochures referring to the program proponents as child snatchers. In reality, few programs have been suppressed because of organized opposition. In accounts of these events, parents and medical providers invariably surface as the most articulate and credible advocates for school-based services (Rienzo & Button, 1993).

Many of the state programs were authorized by legislation that prohibited the distribution of contraceptives and referral for abortions on school premises. Other "comprehensive" programs issued from the school-community planning process, with the distribution of birth control omitted—the price for avoiding controversy. As a result, only about 20% of all school-based health clinics provide contraceptives, although most conduct reproductive health care examinations and referral, pregnancy tests, and screening and treatment for sexually transmitted diseases (McKinney & Peak, 1994). Nationally, only 10% to

20% of visits to school-based clinics are for family planning, suggesting that the expectation of controversy has a cooling effect on service provision. In the few clinics that have more assertive efforts to provide sexuality education and counseling, and offer contraceptives, the utilization rates for family planning are much higher (Kirby & Waszak, 1989). In recent years, school systems have been changing their policies to allow the distribution of condoms in schools, as long as parents do not object. Typically, the local health department comes into the school to hand out the condoms, relieving the school system of the responsibility (Samuels & Smith, 1993).

Public acceptance of the concept of full service schools is much higher than might be expected. The 1992 Gallup Poll reported that 77% of respondents favored using public school buildings in their communities to provide health and social services to students, administered and coordinated by various government agencies (Elam, Gallup, & Rose, 1992). Contrary to the conventional wisdom about how conservative the American public is, a majority of respondents (68%) approved of condom distribution in their local public schools, although one in four of them would require parental consent. A 1993 sample survey of North Carolina registered voters showed that 73% believe that health care centers offering prevention services should be located at high schools—with the strongest support from African-Americans and 18 to 34 year olds—and no differences by gender, religion, or parental status. More than 60% favored providing birth control at the centers (The North Carolina Coalition on Adolescent Pregnancy, 1993).

## Financing

In every discussion of full service schools, the proverbial bottom line is money. Where will the resources come from to support the wide replication of these various models? Program development thus far has been heavily dependent on state initiatives and a few foundation efforts. Many agreements have been made between schools and public health, mental health, and social services agencies to relocate staff in school centers, resulting in substantial amounts of "in-kind" contributions from local agencies. A few communities have passed special taxes to support school-health services. In addition, knowledgeable program developers have found ways to tap into categorical funding sources that fit into a menu of comprehensive services. The most frequently mentioned sources are Drug Free Schools, Chapter 1 (Elementary and Secondary School Funds), Title X Family Planning, special mental health, and juvenile delinquency initiatives (Dryfoos, 1994). However, categorical funding is difficult to access; each has its own funding

periods, accountability procedures, regulations, and administrative bodies. No program has permanence. Finally, a few school-based programs have attempted to establish a fee structure, charging small amounts for services rendered, but, generally, this has not proven efficient because collections are low and needy students are deterred from utilization. As a result, almost all of the programs are free.

It is not anticipated that many states can significantly increase their level of participation in light of continuing budget squeezes in state governments. Prior to the talk of health reform and managed care, Medicaid was looked to as a funding solution, with the goal of certifying low-income schools as eligible for reimbursement from medical assistance. A few schools are already partners with managed care providers, and others are devising ways to operate under the proposed health reform.

Practitioners, educators, and advocates are now looking to the federal government to play a role in moving these initiatives from demonstration projects in a few school communities to broad institutionalization across the country. Does this mean a center in every school? One estimate of the potential demand for full service schools can be based on the number of schools where more than 50% of the students are eligible for free lunch. About 1 in 5 of the 80,000 public elementary and secondary schools fall into that category, suggesting that as many as 16,000 sites should be set up as rapidly as possible. However, the concept of full service schools applies to every school in which the present staff cannot attend to all the needs of the student population. Community agencies can be invited in to fill the gaps.

The prospects for an expanded role in the advancement of full service schools would have been greatly enhanced by the Clinton administration's health reform proposals. Funds were included for community partnerships in disadvantaged areas to provide school-based health and social services and health education (103rd Congress, 1993). The 1994 Crime Bill also contained provisions for supporting community-schools, modeled after the Beacon program (Portner, 1994). With the advent of the 104th Congress in early 1995, the outlook is less optimistic. The issue of health reform has been bypassed by budget-cutting, with responsibility for such issues as adolescent health promotion and crime prevention remanded to states and localities. Nevertheless, the first federal grants for school-based clinics were awarded under a "Healthy Schools, Healthy Communities" program through the Bureau of Primary Health Care ("News in Brief," 1994). The administration's educational reform package does require state education agencies to demonstrate how they will coordinate access to social services, health care, nutrition, and child care. Reauthorization

of Chapter 1—the Elementary and Secondary Education Act—calls for similar actions at the local school level which will help light up schools in disadvantaged communities and bring in needed support services (Independent Commission on Chapter 1, 1994).

## EVALUATION AND RESEARCH

The first question that is raised by researchers is “do full service schools work?” Do they make any difference in the outcomes for adolescents, specifically, do schools with clinics and other support services have lower dropout and teen pregnancy rates, higher attendance and achievement? The answer is a tentative *yes*. A review of the data currently available about school-based clinics and full service schools suggests that these new programs have shown some potential.<sup>2</sup> Both the quality and the quantity of the research to date have severe limitations, but scattered returns from preliminary studies are encouraging. In addition to studies of behavioral change, several research efforts have been directed toward analyzing the process of organizing and implementing school-based programs.

### Utilization and Outcomes

Based on the current state of the art, a number of observations can be made about school-based health clinics. Programs are generally located in the communities and schools with the greatest needs. A number of studies confirm that school clinics are being utilized most by the highest risk students who report the greatest number of problems. Practitioners report early detection of physical problems, such as heart murmurs and asthma, and frequent identification of psychosocial problems resulting from sexual abuse, neglect, and parental drug abuse. Utilization figures show that the characteristics of students who use the centers mirror the school population, with slightly higher usage by female students, younger students, and African-American students. Many of the school health clinic users have no other source of routine medical care and no health insurance. Use of emergency

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<sup>2</sup>In my book, *Full Service Schools* (1994), Chapter 6 is devoted to evaluation findings. More than 30 different sources are cited. For this article, I have referenced only the research studies that were not included in Chapter 6.

rooms has declined in areas with school clinics. Because minor illnesses, such as headaches, menstrual cramps, and accidents on school property, can be treated in school, absences and excuses to go home have decreased in schools with on-site health services.

In centers with mental health personnel, substantial numbers of students and their families are gaining access to psychosocial counseling that was not available to them within the community. The demand is overwhelming. Scattered evidence shows that a few school-based clinics have had an impact on delaying the initiation of intercourse, upgrading the quality of contraceptive use, and lowering pregnancy rates, but only in programs that offer comprehensive family planning services. Programs are just beginning to produce data on other effects. Clinic users in a few schools have been shown to have lower substance use and dropout rates and better school attendance. School-based clinics have the capacity to respond to particular needs in a community, to conduct immunization campaigns or do screening for tuberculosis.

In addition to individual counseling, center staff have an impact on students' behavior through health education and health promotion in classrooms and group counseling covering a range of youth problems, such as substance use, family relations, sexuality, nutrition, conflict resolution, and peer relationships. Students, parents, teachers, and school personnel report a high level of satisfaction with school clinics and centers and appreciate their accessibility, convenience, and caring attitudes. Students particularly value confidentiality. The Office of the Inspector General (1993) recently surveyed state health officials and reported "overwhelming" (p. 8) agreement that school-based health centers improved access to health care by going "where the kids are" (p. 8). They also found that, in addition to primary health care, the centers were providing specialized services aimed at adolescents, not only in clinics but in classrooms and through outreach. This quality was attributed to the presence of staff who were specially trained in attending to adolescents.

Brindis, Morales, McCarter, Dobrin, and Wolfe (1993) reported on a cost-benefit analysis of three California school-based clinics comparing the costs for the school services with the estimated cost in the absence of the school clinic. They factored in reduced emergency room use, pregnancies avoided, early pregnancy detection, and detection and treatment of chlamydia, a prevalent sexually transmitted disease. The ratios of savings to costs ranged from \$1.38 to \$2.00 in savings per \$1.00 costs, suggesting that the school clinic services were a good investment for the health system.

Almost all of the research compiled has been conducted in school-based health and social service settings. We can only speculate about

the potential impact of a thoroughly implemented full service school based on preliminary observations of a few demonstration projects. The two schools mentioned earlier (IS218 and Hanshaw), after their first years, are reporting very high attendance rates, improved achievement, and a vastly improved school climate. Visits to exceptional schools can leave powerful impressions, encouraging the viewer to believe that it is possible to create new kinds of responsive institutions that are full of light and the joy of learning. As one student said, "Everybody here treats you with respect" (Dryfoos, 1994, p. 119).

### **Common Attributes of Full Service Schools**

Although the models mentioned here (clinics, centers, community schools) have many differences, research on the support side (health, mental health, and social services) has yielded a number of common components of successful programs (Brellochs & Fothergill, 1993; Brindis et al., 1993; Godin, Woodhouse, Livingwood, & Jacobs, 1993; The School-Based Adolescent Health Care Program, 1993):

1. A planning process starts off with a needs assessment to insure that the design of the new institutional arrangements are responsive to the requirements of the students and their families.
2. The configuration of support services brought in from the outside is dependent on what already exists in the school in the way of health, social services, and counseling.
3. An Advisory Board includes school and agency personnel, parents and community leaders (and occasionally students). Parental consent is required for receipt of services.
4. If primary health care is to be provided, adequate space is designated in or near a school building for a medical clinic with examining rooms, a lab, an area for confidential counseling, and arrangements for record keeping and referrals.
5. If medical services are not provided on site, a special space is designated within the school as a center for individual and group counseling, parent education, career information, offices for case managers, kitchen, play space, clothes/food distribution, and arrangements for referrals.
6. The building principal is instrumental in the implementation and smooth operation of full service schools. Schools provide space, maintenance, and security.
7. School doors are open before and after school, weekends, and over the summer. Classrooms, gyms, and computer facilities are open for community use.

8. A full-time coordinator or program director runs the support services in conjunction with school and community agencies. Personnel are trained to be sensitive to issues related to youth development and cultural diversity.
9. A data system is in place, preferably a computerized management information system that can process record keeping and billing as well as evaluation data.

### **Needed Research**

The emergence of these diverse school-based programs creates a rich territory for researchers interested in tracking complex models. However, they should be wary of the many pitfalls in the search for causal explanations and measures of long-term program effectiveness. Cook, Anson, and Walchli (1993) called for adolescent health studies that are based on strong theoretical constructs, random assignment, valid outcome measures, long time periods, powerful and well-defined interventions, high statistical power, and large heterogeneous samples. Millstein (1988), in an earlier monograph on school-linked services, summarized the methodological problems in conducting school-based research dealing with high-risk populations. First, the difficulty in establishing appropriate comparison groups was emphasized, particularly in light of the sizable attrition rate in many inner city schools. If an appropriate matching school cannot be found, she suggests doing cohort analyses, comparing ninth graders in Year 1, prior to the program, to ninth graders in Year 2, after the program has been implemented. Millstein also notes the limited effects that can be measured in small samples and warns against using an entire school population as a base when only a small proportion of the students actually utilize the services. Few of these problems have been addressed in the evaluations completed to date. The cost for such research would be high, and it is probably not possible to assign students to school service programs randomly. Nevertheless, evaluation should clearly receive high priority, to gain a more consistent fix on outcomes, and to track the longitudinal effects of these efforts. Millstein (1988) called for a major evaluation study, including comparison schools and matched subjects.

Operational research on full service schools is also a challenging area, for example, studies of the cost effectiveness of providing health and social services in schools compared to other means of providing services to adolescents, such as private physicians' offices, community health centers, health maintenance organizations, hospital outpatient and emergency departments, and cost-benefits of providing preven-

tive and health promotion services in schools compared to not providing those services anywhere. Much more needs to be known about the operational management of school-based centers, including the most efficient staffing mix, costs and financing, the appropriate roles of pediatricians, nurse practitioners, social workers, physician's assistants, psychologists, health educators, aides, and other personnel, and the most efficient scheduling and arrangements between backup referral agencies and school centers. Studies are needed on the quality of the services and follow-up provided and how well they measure up to the standards being promulgated by advocacy and practitioner groups. We must dig into school systems and determine the appropriate delineation of responsibilities between schools and outside organizations; for example, who should conduct health education and health promotion?

One important research tool, *School Health Care—Online* (Kaplan, 1994), developed by David Kaplan of the University of Colorado School of Medicine, was designed as a data collection and management information tool for school-based clinics. Currently, the software program is designed to collect individual physical and mental health, health screening, risk behaviors, epidemiologic, administrative, billing, and program outcome data. The computer system is set up to produce over 100 preprogrammed reports including "tickler" files listing referrals and follow-up information and statistical reports on users, immunizations, case management, and health screening. Several hundred providers are using this system, but no central clearinghouse has been designated to process and analyze the reports. It would greatly enhance our understanding of the potential of full service schools if a comprehensive census could be conducted along with data collection that would help define the different models and their capabilities. Inclusion of questions about utilization of school-based health and social services in national surveys, such as the National Health Interview, National Youth Risk Behavior Survey, and other such instruments, would also strengthen this research.

The United States Government Accounting Office (GAO; 1993) was recently asked by Senator Ted Kennedy of Massachusetts to review studies and evaluations of multiservice, school-linked programs. The GAO reported that some comprehensive school-linked programs prevent dropout through effects on absenteeism and academic achievement. However, they asserted that among the research issues yet to be addressed are the short- and long-term costs and benefits of various types of school-linked programs and the relative cost effectiveness of these programs compared with other prevention strategies. The report strongly urged the federal government to provide funding for plan-

ning comprehensive school-linked programs, long-term program support, and technical assistance with developing and evaluating programs.

## DISCUSSION

The proliferation of models that fit under the full service schools umbrella has resulted from many forces: demand from school systems for help in dealing with the "new morbidities," recognition of the necessity to shelter children for longer hours, bubbling up of unique creative models for working with high-risk youth, dedication of youth workers to bringing their services into the schools, movement at the community level to integrate services, commitment of foundations to the creation of comprehensive service systems, and support from innovative state government initiatives.

Does all of this activity add up to a revolution? Implementation of the concept of full service schools would surely lead to a major transformation in the use of school facilities for improving the lives of disadvantaged children, youth, and families. This metamorphosis is still in an early stage. However, programs exist whereby requisite services are located together in one place, in a school-based center that welcomes its clientele, promises them confidential and caring services, and demonstrates a high level of concern about what happens to them. In today's beleaguered communities, this is a profound departure from the fragmented nonsystems upon which people are expected to rely to help them get through their troubled lives. Even in middle-class communities, young people experience stressful circumstances and appreciate access to caring adults on the school premises.

The concept of full service schools fits well with what we have learned from research about today's young people, who may lack parental support, go to endangered schools, live in troubled communities, and face many barriers to achievement. The idea embraces partial solutions to many of these problems, simultaneously addressing the need for individual support, comprehensive services, parent involvement, and community improvement, in the context of school restructuring. The concept incorporates the discourse on service integration, pushing toward the combination of health, mental health, and family services, along with recreation and culture in one site—the school—open from early in the morning until late at night, weekends, and summers.

Although a strong consensus has emerged across educational and social support domains in support of full service schools, critics raise

valid questions about the various models that we have reviewed. Perhaps the most powerful argument can be made that all of this will not make much difference in the lives of disadvantaged youth. By the time they are adolescents, this may be "too little, too late." For some very troubled young people, no matter what goes on behind the schoolhouse door, they still must return to dangerous households or the streets. No one would quarrel with the point that early intervention is essential, but this should not be used as a justification for ignoring the millions of teenagers who can still be assisted. At the same time, in communities with school-based services, attention is turning toward the development of more sites in elementary schools. The preferred arrangement is the "cluster," tracking youngsters from kindergarten (or even preschool) through high school with related support services at each school along the way.

Questions have also been raised about placing the locus of full service programs in schools in communities that are distrustful of the educational establishment. Some school systems are so resistant to change that community leaders have little confidence that the quality education part of the full service vision will ever materialize. Chaskin and Richman (1992) proposed an alternative model that places services in buildings run by community-based organizations in which families feel comfortable and are assured larger roles in decision making. The service integration theory still holds, but the locus of services is placed firmly in the neighborhood, directly operated under local control. The school board has no place in this model, obviating the difficult negotiations that can be stressful and time-consuming. Michigan's experience with its 19 teen health centers (11 school-based or school-linked and 8 in the community) suggested that community-based centers had greater flexibility, especially in regard to the provision of family planning; could more easily assure confidentiality; serve more dropouts; were free to set their own parental consent protocols; and avoided the (unfounded) suspicion that school funds were being used for nonacademic services (Miller, 1991). However, the school-based centers were found to have reduced the necessity for outreach; more readily involved school personnel; and served students on site. They were perceived to have more direct access to teens (increasing the likelihood of foundation support); took on the function of health promotion in the schools; and were able to garner in-kind resources from the school system, such as space, maintenance, utilities, and supplies.

Concern has been raised about the viability of full service schools as sites for dealing with young people who no longer attend school. Some of the existing school-based centers do serve out-of-school youth as well as siblings and parents of current students. Others do not. For two

major youth-serving organizations in New York City (El Puente and the Door), the transformation into full service schools started with the community organizations that added basic educational components to their rosters of services and obtained certification as part of the public school system (Cahill, 1994). This community youth center-school model offers an approach for working with school dropouts who are often youth agency clients. The disaffected youth are drawn back into the school system through the efforts of trusted youth service agency staff.

Much of the rhetoric in support of the full service schools concept has been presented in the language of *systems change*, calling for radical reform of the way educational, health, and welfare agencies provide services. Consensus has formed around the goals of one-stop, seamless service provision whether in a school- or community-based agency, along with empowerment of the target population. This review of current models shows that most of the programs have moved services from one place to another; for example, a medical unit from a hospital or health department relocates into a school through a contractual arrangement, or staff of a community mental health center is reassigned to a school, or a grant to a school creates a coordinator in a center. As the program expands, the center staff work with the school to draw in additional services, fostering more contracts between the schools and community agencies. But few of the schools systems or the agencies have changed their governance. The outside agency is not involved in school restructuring or school policy, nor is the school system involved in the governance of the provider agency. The result is not yet a new organizational entity, but the school is an improved institution and on the path to becoming a different kind of institution that is significantly more responsive to the needs of the community.

That few full service school models have been able to overcome the barriers to the formation of new kinds of governance should not be perceived as a deterrent to further service integration efforts. Past attempts at systems reform have shown that it is much more difficult to alter the way that entrenched administrators operate across agencies than to make incremental changes in the existing systems they run (Kusserow, 1991). The movement toward service integration as exemplified in full service schools has clearly had an effect on cutting red tape in some programs, but practitioners are still confronted with the conflicting eligibility criteria and restrictions that go along with categorical programs.

The concept of full service schools is an appealing and popular one. Implementation acts as a catalyst between educational initiatives and the drive for improved social supports. But enthusiasm could fade

rapidly if the support services programs are too weak to make a difference. Having an understaffed clinic or inadequate arrangements for after-hours backup crisis care may produce expectations that can never be met. Poorly trained practitioners may fail to connect with today's teenagers, whose lives are complex and troubled. Outside staffs may never communicate with school personnel, setting up expensive parallel systems of care that duplicate the services for some and never cover all the needs in a school. Even the best school-based program is politically vulnerable because of the high turnover in elected officials and school administrators. More than money is required to move toward wide replication. Technical assistance and training is essential to help schools and communities build strong programs, recruit well-qualified personnel, and establish strong accountability for these programs. The models are in the early stages of documentation and standard setting, ready for substantive evaluation and replication.

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