
Health and Social Services in Public Schools: Historical Perspectives

David Tyack

Abstract

There is a long history in the United States of providing noneducational services to children in a school setting. Initially, as part of social reform efforts early in this century, health services were provided primarily by public health doctors and dentists who volunteered their services. Groups such as philanthropic women's clubs provided breakfasts or lunches, vacation schools, and playgrounds. In urban slums, settlement houses pioneered new forms of school-linked social work and vocational guidance. A primary goal of the earliest efforts to provide health and social services at schools was to help immigrant children cope with poverty and assimilate into the dominant culture. As health and social services became embedded in the schools, the services became more school-centered and less family-oriented, focusing on improving school attendance, for instance. The number of noneducational staff and the ratio of these staff to pupils has increased markedly in the past 40 years. Some communities, however—primarily the poorer ones—have often suffered cutbacks in such staff during budget crises. As in the past, the ultimate goal of today's renewed efforts to provide school-linked health and social services is to make students productive members of society. Current reform proposals build either on a "nation-at-risk" model, with the goal of improved academic performance and international competitiveness, or a "children-at-risk" model, with the goal of meeting the health and social needs of currently underserved children. The author contends that urban school reform should be based on the second model, incorporating lessons from the past.

“**T**he time has come for a new conception of the responsibilities of the school,” the reformer writes. The lives of youth in cities are desperate, parents “bring up their children in surroundings which make them in large numbers vicious and criminally dangerous,” and some agency must take charge of “the entire problem of child life and master it.” It is clear who should do so: “If the school does not assume this responsibility, how shall the work be done?”¹ An urban superintendent agrees: The school should “serve as a clearing-house for children’s activities so that all child welfare agencies may be working simultaneously and efficiently, thus creating a child world within the city wherein all children may have a wholesome environment all of the day and every day.”² A sociologist echoes this idea: All agencies dealing with “neglected or behavior-problem children” should “be closely

David Tyack, Ph.D., is the Vida Jacks professor of education and a professor of history at Stanford University.



coordinated” under the aegis of the school, including “medical inspection, school nursing, attendance control, vocational guidance and placement, psychological testing, visiting teachers and special schools and classes.”³

The reformer was the muckraker Robert Hunter, writing in 1904. The superintendent was William Wirt, of Gary, Indiana, speaking in 1923. The sociologist was Thomas D. Eliot, who, in 1928, urged a blending of education and other forms of child welfare.

The “forgotten half” in today’s reform movement has its precursor in Jacob Riis’s *How the Other Half Lives*.⁴ For a century reformers have called for school-based social services to prevent or remedy ill health, crime, child neglect, poverty, dropping out, addiction, hunger, pain, and unemployment.

During the years from 1890 to World War I, in the Progressive Era, activist writers like Jacob Riis, Robert Hunter, and John Spargo cast a bright light on the suffering of children—the wasting of the next generation—and cried out for action. Reformers pressed for school lunches, medical and dental inspections and clinics, classes for handicapped and sick children, vocational guidance and placement, school social workers to counsel wayward youth and to assist their parents, summer schools to provide recreation and learning for urban children in the long hot summers, and child welfare officers to deal with truant and delinquent youth. Some reformers created schools that were social centers, community-based institutions that provided counseling about welfare services, job training, English classes, recreation, crafts, sports, and civic instruction for all members of immigrant families in city ghettos. These ideas have been peri-

odically rediscovered, as in the war on poverty of the 1960s.⁵

Today, once again, reformers mount a concerted campaign to provide more and better-coordinated health and social services for children and their families. Current services are too skimpy and fragmented, they argue, and it is essential to create collaboration among different agencies that deal with health, delinquency, mental health, welfare, recreation, before- and after-school child care, nutrition, and various kinds of counseling.^{6,7}

What perspectives does the history of health and social services offer to policymakers today? Who proposed such services in the past and why? Who were the targets for these reforms? How did the “clients” react? How did public school employees respond to the new social services? To what degree did the new programs become embedded in the everyday operation of schools? Under what circumstances did the reforms succeed, and when and why were they abandoned or so transformed that they lost their original purposes? This essay suggests some answers to these questions and explores implications for reform in school-linked health and social services today.

Who Proposed Health and Social Services in the Progressive Era and Why?

Initially, the impetus for health and social services in education came mostly from outside the schools. Through vivid articles in popular magazines and books, muckrakers aroused public concern about children, especially the immigrant poor in city slums. Different groups of activists took the lead in different reforms, often beginning a service on a volunteer basis and then persuading school boards to adopt it as part of the school structure. Public health doctors; local, state, and national medical groups; and dentists interested in preventive medicine and dentistry, for example, were the pioneers in providing free inspections and clinics. Women’s clubs took the initiative in many reforms, including free or inexpensive school meals, transportation and special classes for sickly or handicapped children, playgrounds, and vacation schools. In many cities park and recreation programs collaborated with school districts in planning sites and

sharing facilities. Settlement-house workers developed model programs for social work and vocational counseling and placement—models that the public schools adopted. Foundations and the federal government publicized and sometimes financed the new health and social services.⁸

Schools were attractive targets for reformers seeking to improve the health and welfare of children, for schools provided sustained contact with children and a captive audience. Often, voluntary groups and school authorities collaborated for an extended period and cofunded activities. The voluntary groups usually saw their favored service as a cause rather than a job they intended to perform for pay. When the new reforms became incorporated as part of the school bureaucracy, with specialists paid by public funds, the character and clientele of the innovative program sometimes changed.

Health Programs

Confident that the rapidly developing science of medicine was generating the means to control epidemics and prevent or cure disease, physicians proposed in the 1890s and early twentieth century that schoolchildren be given medical inspections, vaccinations, and instruction in hygiene. In some cases they also created school clinics to treat indigent pupils, but in the 1920s the American Medical Association denounced free clinics as socialized medicine. “Medical inspection became one of the most highly touted panaceas of the Progressive Era,” William J. Reese observes. “It was variously endorsed as a way to eliminate ‘backward’ and ‘dull’ students,

to ensure all children equal educational opportunities, to promote the vitality of the ‘race,’ and to make parents more responsible citizens.”⁹ Whatever the hype about medical solutions, the health problems of the immigrants were real enough. Diseases and physical defects, many of them readily correctable, were rampant in poor and crowded urban ghettos.

Many of the key reformers in school medicine and health believed that immigrants were of “inferior stock” and ignorant about hygiene. The reformers had faith, however, that with proper medical attention and instruction, the human capital of immigrant children could be conserved. This would benefit both the individual and potential employers. “The children of today must be viewed as the raw material of the State,” observed psychologist Lewis Terman, and he calculated the monetary loss of each citizen who died as an argument for proper medical inspection and teaching of health.⁹ If parents objected to vaccination or prescription of medical care, that was just a sign of their ignorance.¹⁰⁻¹²

Schools were attractive targets for reformers seeking to improve the health and welfare of children, for schools provided sustained contact with children and a captive audience.

Like physicians concerned about public health, dentists looked on the schools as the logical site for inspections and instruction in hygiene. They found that poor children’s teeth did indeed need attention; in Rochester, New York, for example, almost half the pupils required dental work. Like doctors, dentists regarded their work as a cure-all, claiming that eliminating caries would bring good health, lessen school failure, and even prevent delinquency. Unlike physicians, however, dentists supported free clinics for schoolchildren. According to Steven L. Schlossman, JoAnne Brown, and Michael Sedlak, dentists supported free school dental clinics because they found children “troublesome patients; moreover, parents demanded lower fees for children’s care, and they often refused to pay the dentist’s bill for that care.”¹³

Other Social Services

Whereas physicians and dentists took the lead in introducing health services in the schools, nonprofessional voluntary groups were often responsible for the adoption of reforms in social services. Women's clubs, sometimes allied with elite groups like New York's Public Education Association and sometimes with socialist leaders, pioneered in establishing such reforms. These groups provided free or inexpensive breakfasts or lunches, vacation schools, and playgrounds and other recreational facilities for the out-of-school hours. Reformers working in settlement houses in urban slums pioneered new forms of school-linked social work and counseling.

Drawing on their experiences as mothers and (in many cases) former teachers, women reformers had firsthand knowledge of the needs of children and the time and social connections required to bring reforms to fruition. Proper nutrition for impoverished students was a common concern of "municipal housekeepers" who sought to expand their scope beyond the home. Scholarly studies confirmed the commonsense notion that a hungry child found it difficult to learn, and teachers agreed with the claims of the nutrition reformers that hungry scholars who were "restless, dull, and difficult to manage" became "studious, tractable, and bright" students when properly fed. Women's clubs provided free meals to poor children in dozens of cities but wanted school boards to offer them "in all public schools as part of their work and not as a charity."⁹

Philanthropic women also created what came to be called vacation schools for children who had no safe place to play and little adult supervision during sweltering summer days. The philanthropists usually negotiated with urban school boards for free use of empty schools and paid for the teachers from their own pockets. The advocates of vacation schools wanted them to be "pedagogic experiment stations" where progressive teaching methods held free rein. As they did in settlement-house programs, children took field trips to parks and to the countryside, studied nature, learned crafts, staged plays, and visited museums and other city attractions. This form of extended day care for children proved immensely popular with parents and pupils; demand far exceeded supply.^{5,9}

Reformers in settlement houses were prime advocates of two other forms of social services: visiting teachers (the forerunner of school social workers) and vocational guidance counselors. In the beginning, the visiting teachers, who were volunteers or were supported by charitable contributions, served as bridges between immigrant homes and the schools. They visited classrooms and families to determine why children were truant or having difficulty in school. Though they sometimes pursued individual psychological casework with children, they more often served as ombudspersons who sought to help immigrants adjust to a new land, to help educators interpret the mismatch between their pupils and the schools, and to find needed resources for families and

children. When social workers became professionals employed by school districts, their roles often changed. Like visiting teachers, vocational guidance counselors sought at first to link students with jobs and the school with the broader economy. This work, too, changed when schools incorporated it.¹⁴

Settlement houses were models, also, for reformers who tried to make schools into community-based social centers for all ages, serving not only children in all their many needs but also their families.^{9,12} A strikingly successful example of a community-centered school of this sort was Benjamin Franklin High School in East Harlem, a school founded and run by Principal Leonard Covello.¹⁵

Unlike Covello, who continually adapted school services according to the advice of community residents, elite reformers usually thought they knew what was best for immigrants; the elite seldom asked their clients' opinions about new social and health programs. Many of the reformers used a deficit model to characterize the people they sought to help: Immigrants did not know about proper health care, dental care, or nutrition; they did not possess acceptable civic values; and they did not know how to raise children. The reformers had a utopian faith, however, that their services could fix people: Clean mouths could produce clean minds; proper playgrounds could eliminate juvenile delinquency; adenoidectomies could prevent academic failure; and vocational counselors could mesh youth with jobs through a smooth process of social engineering.¹⁶

The elite reformers' clients were often on better terms with reality than the reformers. They found some programs helpful though they were not cure-alls. Parents were eager to place their children in the supervised vacation schools or to use school facilities for evening adult classes in sewing or English. Families struggling to make ends meet probably welcomed free or subsidized breakfasts and lunches in the schools. Some women who sponsored these meals recognized that the children had different food preferences (in one community school, for example, thick soups for Italians, thin for Irish). Visiting teachers were often able to counsel parents and children and help them adjust to a strange new country.⁹

But many immigrant parents fought the more intrusive activities of those who would "improve" them and their children. This was especially true of their reaction to medical interventions. In New York in 1906, Jewish parents rioted outside a school when a rumor spread that school officials were "slitting the throats" of their children; without parents' permission, doctors were excising students' enlarged adenoids. "During the same year," Reese reported, "1,500 angry Italian mothers in Brooklyn fought police, pelted the local school with stones and other objects, and prevented any medical treatments." A mother complained to a teacher when she received a note from a medical inspector saying that her son smelled bad: "Teacher, Johnny ain't no rose. Learn him; don't smell him."⁹

Did These Services Become Embedded in Schools? To What Degree Did Incorporation Change Them?

School officials, like immigrant parents, differed in their responses to the new social services. Conservatives wanted to stress academic subjects; these officials viewed the new services as a diversion from their central tasks. Economy-minded school boards, struggling to provide enough seats in conventional classrooms for waves of incoming students, worried about who would pay for nonacademic services. Progressive educators argued, however, that compulsory attendance and child labor laws were bringing in new types of students and making it imperative to broaden the scope of the school beyond academic instruction. It was necessary, progressives claimed, to find an appropriate place for exceptional pupils, to train youths for work and help them find jobs, to attend to health and emotional needs, and to help the young adjust to a complex society. Only thus could secondary education meet the needs of its diverse clientele while inculcating the norms of democracy. The National Education Association's *Cardinal Principles of Secondary Education* symbolized the progressive consensus in 1918; it included health, worthy home membership, vocation, worthy use of leisure, and ethical character as five of its seven guiding principles.¹⁷

Schools gradually incorporated some of the new health programs initiated by physicians and dentists. By 1910, 312 cities provided medical inspection, and in the next decade the practice became common in most cities containing large numbers of immigrants. Draftees in World War I flunked their medical examinations in such large numbers that all states soon mandated physical education. Medical examinations performed by physicians or nurses employed by school boards became common in most districts. Health education classes appeared in teacher education programs and were taught in most progressive high schools. Hundreds of cities created "open air" classes for tubercular, anemic, and sickly children.^{10,13,18}

A survey in 1940 found that, in almost all cities with a population over 30,000, there was some form of public-health service—usually the availability of school nurses and medical inspection. In 70% of the cities reporting, the school district ran the service; in 20%, the department of health; and in 10%, the two agencies collaborated. In most cases a physician was responsible for administering the program. Despite the Great Depression, medical budgets and staff increased during the decade from 1930 to 1940. In cities with a population over 100,000, one nurse served 2,600 pupils.¹⁸ More and more dentists and dental hygienists became school employees, and school dental clinics experienced a steady growth even through the hard times.¹³

Other social services appear to have had a more checkered fate, although valid statistics on trends are hard to discover. In an effort to stem delinquency and promote mental hygiene, foundations subsidized school social workers during the 1920s. Despite the publicity given to these efforts, school districts did not invest much in mental health personnel. In financially strapped districts in times of retrenchment, these ancillary staff members were often the first to walk the plank. In 1937, in cities with over 100,000 people, the ratio of mental health professionals and students was 2.82 psychologists, 17.54 psychiatrists, and 27.55 social workers per 100,000 students.¹⁷

School systems . . . assimilated reforms and made them standard operating procedures.

After World War II, school social workers and mental health personnel were phased back in. This was especially true in prosperous districts in the 1950s and as part of campaigns inaugurated in the 1960s to decrease the number of dropouts. The free-lunch policy had to overcome many arguments before becoming a regular part of the public school program and budget. Conservatives objected that free meals produced a paternalistic state and weakened the family. Not until the efforts of the New Deal and a federal law of 1946 did subsidized lunches become a familiar fixture in most school districts. Summer schools were commonplace in urban systems by the 1920s; even small cities sponsored the summer sessions. The number of summer school programs decreased during the 1930s, however. (In 1930, 71% of cities of more than 100,000 sponsored summer schools, but the number dropped to 39% in 1936.) For the most part, though, the new health and social services remained at the periphery of the regular school program, even when no ideological objection prevented their presence.^{12,17}

Why did some reforms find a niche in the system and persist? One reason is that they enjoyed external support from influential constituencies (such as doctors and elite women's groups). These new programs met the genuine needs of children, many of whom did have poor teeth, empty stomachs, or abusive parents. Such reforms

did not challenge the central core of classroom instruction or require teachers to behave differently. Indeed, the new programs may have facilitated the running of schools, which were complex organizations in which the clients were heterogeneous, involuntary, and unselected. The new programs created new specialists with an understandable interest in keeping their jobs.

Goal Displacement

School systems, then as now, were adept at responding to lay criticism by incorporating innovations and then transforming them into smoothly running parts of the pedagogical machinery. In other words, they assimilated reforms and made them standard operating procedures. In the process of institutionalizing the new services, from 1920 to 1960, educators often bent the programs to their own uses. The programs may have been functioning, but they may not have been serving the original intents. Nevertheless, the schools were addressing the needs of children in a broader fashion than they had before adopting the programs.

The original "visiting teachers," for example, were privately funded ombudspersons, not school employees. They often were trained in social work and saw themselves as advocates for children and families. Hence, to a degree, they were critics of the educational system that alienated their clients. Like the women who worked as factory inspectors to enforce child labor laws, the visiting teachers took a broad view of their part in improving general social conditions and maintaining "simple and natural contacts" with immigrant families.¹⁹ Like settlement-house workers, they hoped to connect the methods of the schools "to the home conditions of vast numbers of the city's [impoverished] population."¹⁹ An analysis of the work of school social workers in 1916 disclosed that half their tasks "involved helping the child's family use resources in the community."¹⁹

But as school social workers became employees of school districts and specialists with distinct professional training and organizations, two kinds of pressures emerged to change their outlook and functions. One was pressure for school social workers to work as part of the attendance machinery in securing compliance with compulsory education laws. Attendance laws and school standards are the allies of the school social worker, said one

experienced visiting teacher, “limiting the kinds of demands that may be made upon her—freeing her . . . to concentrate on helping children accept them as impersonal and inevitable as the change of seasons and to put their energy into growth rather than dissipate it in fighting or evasion.”¹⁹ If the law made the social worker a hooky cop, so be it.

Intended for the poor, school services may in fact have gone disproportionately to the well-to-do to the degree that they became institutionalized from 1920 to 1960.

But another pressure was the desire to upgrade the professional standing of the occupation by disassociating it from down-trodden or delinquent clients. The trend was to base school social work on a mental health model borrowed from psychology and medicine. Increasingly, school social workers stressed treating the “maladjustment” of individual children (locating the trouble in the child more than in social conditions) and collaborating with mental hygiene clinics which began to appear in large cities. In the 1930s a leader in the field attacked the “stigma” associated with delinquency prevention and advised visiting teachers to work “in good, average, or superior school districts in many cities before attempting work in less privileged ones, in order to avoid any stigma and make it possible to work with children coming from all types of homes.”^{14,19}

Similar goal displacement occurred in vocational guidance and in vacation schools. Here, too, services became generalized to the whole student population rather than being focused primarily on the poor. Guidance counselors often departed from their original purpose of matching working-class youth with jobs. Instead, the counselors greased the machinery of the school by advising students about courses and appropriate tracks and by assisting in school discipline and management. Reese pointed out that, as vacation schools became incorporated as publicly funded summer schools, they became standardized as “a place for students to repeat failed work or to do advanced work.” In the process, “what had once been an experimental, evolving, non-formal alternative to the schools was now part of the system.”^{9,20}

Who Received Services and Who Did Not?

Health and social services were originally designed as compensatory treatment for urban immigrants: Middle-class parents were supposed to be able to provide what was needed for their children. Intended for the poor, school services may in fact have gone disproportionately to the well-to-do to the degree that they became institutionalized from 1920 to 1960. One reason is that services cost money. In an educational system based primarily on taxes on local property, as the system was at that time, the result was often more services to the rich and less to the poor.

Whole sectors of the American public had no school services. The worst off were southern rural blacks. African-Americans in the Dine Hollow School in the deep South had no desks or books, not to mention such luxuries as health care. By contrast, rich suburban high schools like the one in Shaker Heights, Ohio, often had large libraries, elaborate lunchrooms, doctors and nurses, and counselors with time to attend to the bruises of upper-middle-class adolescence. New Deal reformers focused their own health and social service efforts directly on poor children rather than putting money into general support for the schools. They did not trust the educational establishment to spend funds on those who needed help the most.²¹

In hard times, like the 1930s, educational leaders have often targeted social services for retrenchment or elimination, in part because they were on the periphery of the system. Meanwhile, the basic academic subjects were the last to feel the knife. Here again, rich communities were often able to preserve services when needy communities were not. Prosperous Evanston, Illinois, kept its health and social services intact during the Great Depression while Chicago cut its social services to the bone.¹² In the present fiscal crisis in Los Angeles, where one in five children is poor and one in three lacks medical insurance, layoff notices went in April 1991 to 276 of the district’s 526 nurses and to hundreds of other health workers; relatively few teachers of regular academic subjects received pink slips.²² The vulnerability of school-linked health and social services in hard times and the frequently unequal distribution of these services across wealthy and poor districts and across so-

cioeconomic lines are issues to which I will return at the end of this essay.

What Are the Developments Since World War II?

Michael W. Sedlak and Robert L. Church noted that during the 1950s educators attempted “to develop and apply social service universally to virtually all students,” believing that “even conscientious parents and well-organized families could not guarantee that the delicate task of child rearing would be carried out effectively.”¹² Professionals provided health and social services in prosperous suburbs as well as in inner cities, confident that their training and official positions certified their expertise.

During the 1960s, as during the Progressive Era, reformers targeted “particularly disadvantaged populations,” especially the poor and minorities in cities, as the recipients of services. Reformers were also concerned with assisting whole families, not only children.¹² A time of vigorous social movements for African-Americans, Hispanics, women, and the handicapped, among others, the decade of the 1960s was also a period when edu-

During the 1960s, as during the Progressive Era, reformers targeted “particularly disadvantaged populations,” . . .

cation was a vanguard institution in the war on poverty. The federal government passed the Head Start legislation and the Elementary and Secondary Education Act of 1965 (whose Title I focused on the poor) and developed programs to improve nutrition, job training and placement, and health.¹²

As money flowed to schools from these federal and state programs, educators expanded services for the poor. This balanced—somewhat—the uneven distribution of social and health services between the haves and the have-nots, a situation that resulted from the highly uneven tax base of states and individual school districts. But, at the same time, many of the federal sponsors of such programs as well

as the poor and minorities themselves questioned the top-down model of the professional caregiver and the passive client.²¹

Like their predecessors in the New Deal,²¹ federal poverty warriors of the 1960s often lacked faith in the ability of public educators to understand or assist the poor. Sometimes these reformers bypassed the schools entirely and funneled money for services through community-action agencies of various kinds. When program planners included schools, they often required the participation of client families on advisory boards and as employed aides and other workers. Sedlak and Church observed that reformers sought to “demystify expertise and to undermine professional hegemony . . . by placing racial minorities and the poor in positions of autonomy and authority in the administration of federally-funded programs.”¹² Not surprisingly, this produced, in schools and other public agencies, conflict with existing authorities, who were accustomed to running health and social services without consulting their clients.

Another source of conflict was the habit federal and state governments had of mandating new services without allocating sufficient new funds to pay for them. A prominent example was the legislation requiring expensive new programs in special education. “As a result,” Sedlak and Church noted in 1982, “many educational administrators have begun to withdraw as a constituency vocally committed to preserving non-academic social services.”¹²

During the late 1970s and 1980s, talk about education policy began to shift from concern about poverty and equality—and related health and social services—to worries about academic standards and international economic competitiveness. This back-to-basics ideology triggered legislation in almost every state. The new laws were designed to stiffen graduation requirements, improve the performance of teachers, and test students’ academic achievement. Nonetheless, as demonstrated by the increasing proportion of school staff who were not teachers (see figure 1), schools were increasingly becoming multipurpose agencies—even when the antipoverty fervor of the 1960s diminished.

Today, discussions of education seem to be debates about restoring an imagined golden age of academic rigor. Lost in these

Figure 1. Ratio of Pupils to Noninstructional Public School Staff (pupils per staff person)

	1950	1960	1970	1986
Teacher aides	—	—	795	120
Guidance counselors	—	2,026	936	586
Psychological personnel	—	16,589	7,396	2,921
Transportation staff	308	311	260	—
Food service staff	365	217	169	—
Health care staff	2,668	2,185	1,717	—
Recreation personnel	4,382	1,180	457	—

Source: Adapted from National Center for Education Statistics, Table 61: Staff employed in public and secondary elementary school systems, by functional area, 1949-50 to fall 1986, *Digest of Education Statistics*, 1988.

debates and ignored even in discussions of school-linked services is an important fact: In the years from World War II to 1991, school administrators, willy-nilly, have become managers of schools that deliver complex social and health services as well as academic instruction. The dimensions of the change are striking. In 1950 teachers constituted 70% of all school employees. In 1986 only 52% of school employees were teachers. In that same period the ratio of pupils to support staff (that is, noninstructional employees) fell from 83 to 30; the absolute number of support staff rose from 303,280 to 1,348,813, not counting the nonteachers who were members of the instructional staff.^{23,24}

Who are these nonteachers, and what do they do? It is not easy to answer these questions because of shifts in statistical categories year by year—hence the incomplete columns in figure 1. During the last 40 years, there has been a fairly steady growth in the number of support staff in almost every category, from bus drivers and secretaries to principals. Of course, these are national statistics that do not reflect reductions that may have occurred in particular states or localities.

Busing, feeding, counseling, making medical inspections, nursing, supervising play—these became an increasing part of everyday work in school systems from 1950 to 1986. Health and social services were not a new idea advanced by lay reformers, as in the Progressive Era; they were established programs provided by a diverse set of public agencies, including the schools.

Some reformers in the 1990s are asking how to coordinate these services and make them effective where they are most needed.

How Do Current Reform Proposals Relate to History?

Schools have become major agencies of broad social welfare, not just academic institutions. Some see these noninstructional services not as a virtue, but as a diversion from the main task of schools; others would like to see still more school-linked health and social services. To see policy choices today in broad perspective, it may be useful to sketch in broad brush two current conceptions of reform.

The first sketch might be called a vision of a *nation* at risk. According to this view, schools should be lean and mean. Education should radically improve the academic performance of the next generation so that the nation can be viable in international competition. Reacting to reports of lackluster scholastic performance, reformers who share this vision argue that schools should shuck off what they regard as extraneous functions, trim “bureaucracy,” and concentrate on strict instruction in the “basics.” School administrators are already overburdened and ineffective, these critics say; professionals in education are struggling to reconcile federal and state programs with conflicting mandates, are beset by regulations and legal rulings that tie their hands, and are failing to educate

ghetto children. Adding to their burdens by asking them to collaborate with other agencies in providing services would simply make them even less effective in their main task.^{25,26} Some people of this persuasion point to parochial schools as models of lean and effective institutions that attend to academic business while, generally, not performing or coordinating a host of other services.

This vision of a nation at risk has spawned a myriad of proposals for reform. The proposals incorporate ideas from curriculum change to new testing requirements to giving parents a choice of schools by giving them vouchers. This latter strategy would replace the present system of public governance of schools by a regulated market.²⁶

The second vision focuses instead on children at risk. According to this view, the key problem in American schooling is that it vastly underserves the poor, especially immigrants and people of color. Child advocates who hold this view would not take away the safety net of health and social services already provided to poor children and their families; instead, they would greatly expand it by coordinating and intensifying existing services that are presently meager and fragmented. Public schools, they contend, should collaborate with other agencies to bring these social and health services to the downtrodden.⁷

In theory, there need be no conflict between seeking higher academic standards and providing school-based services. In practice, however, the two approaches may well collide, especially if parents can use vouchers to send their children to either public or private schools. Indeed, some reformers may argue that, without the support of multiple noneducational services, the primary goal—academic improvement for a significant percentage of students—is unachievable.

Public schools are *required to admit all students* and to educate those with special needs—those with handicaps, for example, or those wanting vocational training. Public schools also provide other safety-net services. Parochial and private schools, by contrast, *can select and reject students*, and this helps to explain their good record of educating pupils in academic subjects. Also, they are usually not required to offer special education, vocational classes, or other services.²⁶

If a voucher plan of free choice were adopted, it is possible that some private or public schools would offer health and social services as an attraction for needy families. Thus far this has been rare in magnet schools, which have disproportionately enrolled students from middle-class families who wanted more stress on academic achievement. The likeliest result of a full voucher plan in big cities, would be that the well-informed, middle-class, and prosperous parents of students with few special needs would send their children to schools, private or public, where the majority of pupils came from similar backgrounds.²⁶

In big cities the result could be an even greater concentration of at-risk children than now exists; the public schools could become, to an even greater extent, a holding bin for the leftover students. From one point of view this could be useful: Services could be intensified in such schools. But from other points of view, this could mean trouble. Poor children could become even more segregated from age-mates who could help them learn more effectively in terms of academics and social behavior. Another problem might be, for middle-class parents, the loss of an already slim sense of commitment to schooling as a common good. These parents could devise their own solutions to educating their offspring, and education might be

In theory, there need be no conflict between seeking higher academic standards and providing school-based services. In practice, however, the two approaches may well collide, . . .

viewed, increasingly, as a consumer good rather than a public good. Some advocates suggest that a carefully designed voucher plan could mitigate these problems. A voucher plan that put a bonus on the heads of children with special needs could, for example, enhance racial and socioeconomic integration, but in the present political climate implementation of such a plan seems unlikely.

Conclusions

Urban school reform should be based on the second model: that which avoids segregating children with special problems but sharply increases the number of and access to health and social services available to them in community-based programs and schools. Already we have a model of this in Head Start. Until recent appropriation increases, however, this excellent program reached only about a quarter of eligible children. This fact suggests that American commitment to public education as a process to redistribute opportunity is fragile.

If Americans were to take seriously the goal of providing school-linked social services in ample degree to those who need them most, what are some of the concerns that emerge from the history we have examined?

1. Purposes and procedures of service delivery, together with plans to make providers accountable, need to be carefully designed to prevent goal displacement of the sort that happened in the past. Services are meant to help children; greasing the pedagogical machinery or enhancing the status of health and welfare specialists is secondary at best. In this work a major task will be to anticipate and deal with the potentially conflicting norms, interests, and practices of service providers in different bureaucracies.

2. It is important to consult and involve the clients, to discover what they want and need. The rational plans of outsiders often fail, for parents in the past

have found ways to sabotage services they found intrusive. Lack of coordination of services may seem irrational to the planner, but it may benefit those clients who have learned to play one part of the system off against another. Some forms of linkage between services could prove more of a problem than a benefit to clients—as in the case of the Wisconsin plan that linked welfare benefits to school attendance.²⁷

3. School leaders are understandably wary of new mandates with inadequate funding. They have seen foundation, federal, or state grants that prime the pump and then diminish or disappear. Whatever the source of funding, new programs must be so incorporated into regular budgets and become so central to the operation of community and school that they will not be regarded as peripheral, the first targets during periods of retrenchment. Stable funding will require building powerful supportive constituencies: parents; educators; welfare and health professionals; business, professional, and labor groups; and local, state, and federal officials.

4. The danger in hype, in overpromising results, is the possibility of disillusionment and the blaming of the victim. Health and social services have never been a panacea, and they are not now. They were and are one sensible response to a desperate situation.

Once again, education reform and social pathologies have become prime-time, first-page news. If Americans do not help and heal the children at risk, the nation's social fabric will be in quite as much danger as its standing in the world economy.

1. Hunter, R. *Poverty*. New York: Harper & Row, 1905, p. 209.
2. Wirt, W. Ways and means for a closer union between the school and the non-school activities. In *Addresses and proceedings of the sixty-first annual meeting of the National Education Association*. Washington, DC: NEA, 1923, p. 446.
3. Eliot, T. Should courts do case work? *The Survey* (September 15, 1928) 60:601-603.
4. William T. Grant Foundation Commission on Work, Family, and Citizenship. *The forgotten half: Non-college youth in America*. Washington, DC: William T. Grant Foundation, 1988; Riis, J. *How the other half lives*. New York: Scribner, 1902.
5. Sedlak, M., and Schlossman, S. The public school and social services: Reassessing the Progressive legacy. *Educational Theory* (Fall 1985) 35:371-83.
6. Kirst, M., and McLaughlin, M. Rethinking policy for children: Implications for educational administration. In *Educational leadership and changing contexts of families, communities and schools*. B. Mitchell and L. Cunningham, eds. Chicago: University of Chicago Press, 1990.
7. Dryfoos, J. School-based social and health services for at-risk students. *Urban Education* (April 1991) 26:118-37.

8. Cohen, S. *Progressives and urban school reform: The Public Education Association of New York City, 1895-1954*. New York: Teachers College, 1964.
9. Reese, W. *Power and the promise of school reform: Grass-roots movements during the Progressive Era*. Boston: Routledge & Kegan Paul, 1986, pp. 218, 225.
10. Terman, L. *The hygiene of the school child*. Boston: Houghton Mifflin, 1929, chap. 1.
11. American Academy of Medicine. *Conversation of school children*. Easton, PA: AAM, 1912.
12. Sedlak, M., and Church, R. *A history of social services delivered to youth, 1880-1977*. Final report to the National Institute of Education (Contract No. 400-79-0017). Washington, DC: NIE, 1982.
13. Schlossman, S., Brown, J., and Sedlak, M. *The public school in American dentistry*. Santa Monica, CA: Rand Corp., 1986, p. vi.
14. Levine, M., and Levine, A. *A social history of the helping services*. New York: Appleton-Century-Crofts, 1970.
15. Covello, L. *The heart is the teacher*. New York: McGraw-Hill, 1958.
16. Spring, J. *Education and the rise of the corporate state*. Boston: Beacon Press, 1972.
17. Tyack, D. The high school as a social service agency: Historical perspectives on current policy issues. *Education and Policy Analysis* (September-October 1979) 1:45-57.
18. Rogers, J. *Health services in city schools*. Washington, DC: U.S. Government Printing Office, 1942.
19. Costain, L. A historical review of school social work. *Social Casework* (October 1969) 50:439-53.
20. Bloomfield, M. *Readings in vocational guidance*. Boston: Ginn, 1915.
21. Tyack, D., Lowe, R., and Hansot, E. *Public schools in hard times: The Great Depression and recent years*. Cambridge, MA: Harvard University Press, 1984.
22. Judge weighs fate of school employees. *Los Angeles Times*, April 18, 1991, at B1.
23. National Center for Education Statistics. Table 61: Staff employed in public and secondary elementary school systems, by functional area, 1949-50 to fall 1986. *Digest of Education Statistics*, (1988) 24:77
24. Meyer, J., Scott, R., Strang, D., and Creighton, A. *Bureaucratization without centralization: Changes in the organizational system of American public education, 1940-1980* (Project Report No. 85-A11). Stanford, CA: Stanford University, Institute for Finance and Governance, 1985, Appendix: Table 1.
25. Chubb, J., and Moe, T. *Politics, markets, and America's schools*. Washington, DC: Brookings Institute, 1990.
26. Clune, W., and Witte, J. *Choice and control in American education: The theory of choice and control in education*. New York: Falmer, 1990.
27. Wisconsin makes truancy costly by tying welfare to attendance. *New York Times*, December 11, 1989, at A1; Wisconsin's learnfare: A bust. *New York Times*, January 29, 1990, at A23; On welfare and truants. *New York Times*, March 21, 1990, at B5.