School-Based Health Centers:
The Attitudes and Perceptions of Austin Independent School District Principals and Area Superintendents

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CHAPTER ONE

Introduction

There is growing consensus in the United States that policy makers, educators and health professionals must make institutional changes if this nation's children are to be saved. Environments that once protected and nurtured young people have become fragmented and ineffective in addressing their needs. The absence of a national child and family policy has contributed to the steady decline of our children's well-being. Although most industrial nations have such policies, the United States does not.[1] Large numbers of children have become disengaged from society and may soon become a generation deeply scarred by the effects of poverty, lack of education and poor health. Statistics point toward a cataclysmic collision unless institutions start to coordinate their efforts.

Many child advocacy organizations are calling for the educational system to lead the way in child health and social service integration.[2] Traditionally, schools have been viewed as the means of escape from poverty; yet, recent data show that education alone can no longer address the complex problems facing

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[1]Southwest Education Development Laboratory, School-Linked Services:Avenues to Achieving Quality Education For All,(Austin: Luis Plascenia Quality Education for Minorities Project),7.

[2]Texas Education Agency Commissioner's Critical Analysis Series Number 2. Family and Community Support: Coordinated Education, Health and Human Services (Austin: Texas Education Agency),29.

today's youth.[3] Western democracies, particularly the United States, have traditionally relied on the family unit to be the initial provider of human services for children. In the past, when needed services stretched beyond a family's capabilities public, community and religious institutions stepped in to provide the necessary care.[4] Economic conditions of the last two decades have now limited those once steadfast institutions. The economy as well as the following projected national trends act as driving forces behind the call for educational reform:

- Technological advances are changing the knowledge and skills required in an information-based society and will require workers with higher order thinking skills.
- Minorities will become the majority in the more populous states by the year 2025 and nationally by 2080. Historically, such groups have attained the lowest levels of academic achievement.
- As babies of the 1988 "baby boomlet" enter school, enrollments in elementary programs are expected to rise dramatically over the next five to ten years. These children will be of greater racial and ethic diversity, more likely to live in poverty, and have more health and learning problems than any previous generation of students.

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[3]Center For the Future of Children, Foundation. The Future of Children, (Los Altos: The David and Lucile Packard Foundation, 1992),44.

[4]Ibid, 33.

- A projected teacher shortage may require new educational approaches.

- Together these factors are impacting basic assumptions about the experiences children bring to school, the content of curriculum, and the available instructional resources.5

Schools are now being called upon to act as the "critical linchpin" in improving the well-being of this nation's children.[6]

Research Purpose

This research project focuses on one service integration approach that is attempting to address children's problems, school-based health centers (SBHCs). The purpose of this research is three fold. First, the research will provide a descriptive outline of the SBHC approach. Second, the attitudes and perceptions of Austin Independent School District principals and area superintendents regarding SBHCs will be assessed through exploratory as well as descriptive research. Third, based on the findings recommendations for further policy analysis and development will be offered.

Conceptual Framework

The growing trend of SBHCs is evident by the mounting literature on the subject. The literary focus ranges from different models to those having similar characteristics. Studies identify and evaluate positive outcomes as well as

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[5]Southwest Education Development Laboratory, 3-5.

[6]Ibid, 2.

limitations and controversies. Much of the writing discusses the emerging reform efforts of education, health and social services. Although, the literature disseminates information from multiple perspectives, it has a central theme; to improve the well-being of children through accessible, acceptable and affordable health care. This set of factors provide the framework for SBHC study.

In addition to a general descriptive overview of the SBHC approach, a goal of this research is to assess the attitudes of local school officials. Principals are critical to the success of this health service delivery design. The literature suggests that early and sustained focus on school liaisons is essential if a health/educational partnership is to exist. This collaboration is the cornerstone to a successful program, and the principal is the foundation. For this reason, the researcher chose this group to survey.

A significant amount of exploratory research was necessary to gain an understanding of how much local administrators knew about this emerging concept. This exploratory element combined with the current literature form the basis for this research effort. The issues involved in the principal's adoption of school-based health services can be classified into five broad categories: knowledge of program characteristics, student and school "community" needs, barriers and obstacles, views regarding health and education collaboration, and philosophy regarding school function.

Austin Independent School District was selected for this study because it presently has school-linked and limited school-

based programs in operation. New innovative approaches are under study by local child health advocates at this time. Any insights that can be gained about the attitudes of school administrators regarding school-based health centers may be valuable in formulating local child health policy.

Chapter Summaries

Chapter Two reviews the current literature on school-based health centers. The material is based upon empirical data as well as expert opinion. The literature is categorized into sections: child health statistics, historical information relating to school health, barriers to health care, SBHC core attributes, content of services, limitations and controversies, and collaborative efforts/partnerships.

Chapter Three, the research/legal setting chapter, examines legislative mandates as they relate to SBHCs. Existing guidelines and program models are presented on national, state and local levels.

Chapter Four discusses the methodology, self-administered survey. A discussion of data collection is presented as well.

Chapter Five summarizes the results of the survey research and contrasts those results with the current literature and expert opinion. A quantitative approach is used for the survey results, while qualitative analysis is used for the given comments.

Chapter Six presents the conclusions drawn from the literature review and the survey research. The chapter concludes with recommendations for future action.

CHAPTER TWO

Literature Review

The purpose of this chapter is to examine the literature relevant to the topic of school-based health centers (SBHC). The chapter includes background statistics regarding the health status of United States and Texas children and the public health implications of such data. The historical background of school-based health centers will be reviewed. The barriers that adolescents encounter in mainstream health care delivery will be examined. SBHCs core set of health care attributes, content of services and positive outcome deliveries will be presented. Limitations and controversies of the centers will be identified. The collaborative efforts and interconnected partnerships needed to respond to the children health care crisis will be explored.

INTRODUCTION

Former Vice President Hubert Humphrey noted that the moral test of a government is how it treats those who are in the dawn of life, its children; those who are in the twilight of life, its aged; and those who are in the shadow of life, its sick, needy, and handicapped. He went on to say a government that can neither educate its children, care and sustain its elderly, nor provide hope and meet the needs of its sick, poor and disabled, is a

government without compassion.[7] It would appear our government has become that callous dominion of which Humphrey once spoke. As has been consistently pointed out by child and family advocates, children and adolescents are of low national priority.[8] This lack of coherent national policy has helped to put millions of children "at risk" of not reaching their full potential as productive healthy adults.

Much of the literature on child policy is divided into two age categories, young child and adolescence. The period of adolescence is marked as being a significant turning point in a child's live. This age offers opportunities to choose a path toward a productive and fulfilling life or one of a diminished future.' It is a period of great risk and opportunity. Although the biological changes that take place during adolescence have not changed over the years, the social and environmental context

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[7]Theodor J. Litman, Health Politics and Policy (Albany:Delmar Publishers Inc., 1991), xvii.
[8]M. Joycelyn Elders and Jennifer Hui, "Making a Difference in Adolescent Health," Journal of American Medical Association 269, 11 (March 1993): 1425; Carnegie Council on Adolescent Development, Turning Points Preparing American Youth for the 21st Century, (Washington:Carnegie Council on Adolescent Development, 1990),6; Carnegie Corporation of New York, Carnegie Quarterly; Turning Points Revisited.(New York: 1993),13.
[9]Carnegie Council on Adolescent Development, Turning Points Preparing American Youth for the 21st Century, (Washington: Carnegie Council on Adolescent Development, 1990), 6.

in which they occur have.[10] Changes in the economic structure, the family, the community, and the media[11] all contribute to a range of problems involving children and youth.[12]

Representative Pat Schroeder has stated "We haven't appeared to be a very caring society to our youth. We view them as a problem or a bother, and things are not going well as a result."[13] Children must be made to feel wanted. We must help them develop a healthy condition in the present and for the future. In our contemporary society, the fewer the opportunities children have for interaction with supportive adults, the more limited their abilities to cope[14] with the violence, disease and social ills of our country.

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[10]Susan Millstein and Allyn Mortimer, "Promoting the Healthy Development of Adolescents," Journal of American Medical. Association 269, 11 (March 1993): 1413.

[11]Ibid.

[12]M. Joycelyn Elders, "Schools and Health: A Natural Partnership," Journal of School Health 63, 7 (September 1993): 312.

[13]The School-Based Adolescent Health Care Program, The Answer Is At School: Bringing Health Care to Our Students, (Washington: The Robert Wood Foundation, 1993), 6.

[14]Millstein and Mortimer. 1413.

STATISTICS

Over the past thirty years, adolescents have been the only age group in the country whose health status has not improved.[15] Patterns of childhood mortality and morbidity reflect a shift from organic causes to one of social origin.[16]

United States

The leading health, social, and economic crises of today's youth are:

- United States infant mortality rate is higher than nineteen other industrialized nations.[17]
- Immunization rates for minority children are lower than fifty-five other countries.[18]
- Injury and violence account for three out of four deaths in children.[19]

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[15]The School-Based Adolescent Health Care Program, 6; and Council on Scientific Affairs, American Medical Association, "Providing Medical Services Through School-Based Health Programs," Journal of American Medical Association 261, 13 (April 1989): 1940; and U.S. Department of Health and Human Services. Public Health Services. School-Based Clinics That Work. (Washington: U.S. Department of Health and Human Services, Public Health Service 1994), 1.
[16]Arthur Elster. "Adolescent Health Promotion Overview." In American Medical Association State-of-the-Art Conference On Adolescent Health Promotion: Proceedings in Washington, D.C., May 1,1992, edited by Artur Elster, Susan Panzarine and Katrina Holt. 1-4. Arlington, VA: National Center for Education in Maternal and Child Health, 1993.
[17]Texas Education Agency, 7.
[18]Ibid.

- Homicide is the second leading cause of adolescent deaths.[20]

- Suicide is the third leading cause of adolescent deaths.[21]

- Infection with the human immunodeficiency virus (HIV) is now the sixth leading cause of death among fifteen to twenty-four year-olds.[22]

- One in ten fifteen to nineteen year-old females get pregnant each year.[23]

- Each year three million teens are infected with sexually transmitted diseases (STDs).[24]

- Thirty-six percent of high-school students report current use of tobacco; 36.9 percent report binge drinking; 13.9 percent report current marijuana use; and 2.1 percent report current use of cocaine.[25]

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[19]The School-Based Adolescent Health Care Program, 6; and National Center of Health Statistics. Health United States 1991, (Atlanta: U.S. Department of Health and Human Services, Public Health Services, Center for Disease Control and Prevention, 1992). DHHS publication PHS 92-1232, quoted in Joycelyn and Jennifer Hui, 1426.

[20]Ibid.

[21]Ibid.

[22]Ibid.

[23]Children's Defense Fund. An Opinion Maker's Guide to Children in Election Year 1992, (Washington: Children's Defense Fund, 1991), quoted in M. Joycelyn Elders and Jennifer Hui, 1426.

[24]The School-Based Adolescent Health Care Program, 6.

[25]1990 Youth Risk Behavior Surveillance System: Chronic Disease and Health Promotion Reprints from the MMWR. (Atlanta: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion; 1990), quoted by M. Joycelyn Elders and Jennifer Hui, 1426.

- For every one thousand children, approximately twenty-six between twelve and seventeen years, sixteen between six and eleven years, ten between three and five years, and six under two years of age have been victims of abuse or neglect.[26]

- Psychiatric disorders affect approximately 6 percent of adolescents.[27]

- More than one in four children lives in poverty or near poverty.[28]

- Poor children miss one-and-a-half times as many school days due to illness or injury as do those above poverty. And they average nearly one-and-a-half times as many hospital stays.[29]

- More than one million children under the age of eighteen are homeless.[30]

- Every day, 1.3 million latchkey children come home to no parental supervision.[31]

Texas

On the state level, Texas statistics are disturbing as well. This year it is estimated that for every 100 Texas adolescents:

- 81 will use alcohol
- 71 will try cigarettes
- 40 will use illicit drugs
- 36 will contract a sexually transmitted disease

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[26]Ibid.

[27]Ibid.

[28]The School-Based Adolescent Health Care Program, 6.

[29]Ibid.

[30]Texas Education Agency, 8.

[31]Ibid.

- 25 will live in poverty
- 22 will drop out of school
- 8 will become pregnant before graduation.[32]

Ernest Boyer, president of the Carnegie Foundation for the Advancement of Teaching, states:

> America is losing sight of its children. In decisions made every day we are placing them at the very bottom of the agenda, with grave consequences for the future of the nation. It's simply intolerable that millions of children in this country are physically and emotionally disadvantaged in ways that restrict their capacity to learn, especially when we know what a terrible price will be paid for such neglect.[33]

Other child advocates agree as well. Former Surgeon Generals Everett Koop and Joycelyn Elders believe it is easy to blame children for some of the problems in our communities, but many of their problems are symptomatic of larger problems in our society.[34] According to Joy Dryfoss, author of Full Service Schools, young people have specific needs that can best be met by

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[32]Texas Comprehensive School Health Initiative Awareness Committee. The Advocate, (Austin, TX., Texas Comprehensive School Health Initiative, 1993), 4; and Louise K. Iscoe, Texas Teens: The Status of Adolescents (Austin: Hogg Foundation for Mental Health), 22-89.

[33]Ibid, 9.

[34]Elders, 312.

practitioners who understand youth developments and treat problems as consequences of sex, drugs, violence and stress.[35]

HISTORICAL BACKGROUND

A growing trend in the delivery of adolescent health services is to "go where your patient is"[36] with school-based health centers (SBHC). But the notion of providing medical services in schools is not new. This concept dates to the origins of the public school system itself.

Progressive Era

As early as 1840, it was suggested that "schools ought to have regular physicians, as much as our houses of industry, our almshouses, or our penitentiaries."[37] Horace Mann, the founder of common public schools, felt that schools were the great equalizer of the conditions of human beings[38] and was one of the first advocates of school health education.[39] In 1872, a New

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[35]Joy Dryfoss, Full Service Schools (San Francisco: Jossey-Bass Publishers), 160.

[36]Julia Lear, "School-Based Health Care," in Comprehensive Adolescent Health Care, ed. Stanford B. Friedman, Martin Fisher and S. Kenneth Schonberg (St. Louis: Quality Medical Publishing, 1992), 899.

[37]Michael Kort, "The Delivery of Primary Health Care in American Public Schools, 1890 - 1980," *Journal of School Health* 54, 11 (December 1984): 453.

[38]Dennis J. Palumbo, Public Policy in America ,(Orlando:Harcourt Brace Jovanovich, Publishers),274.

[39]Southwest Education Development Laboratory, 1.

York "sanitary superintendent" was employed to cope with the prevalence of smallpox among students." In 1902, New York City broadened the mission of school health services to establish the first school nurse service delivery system.[41] During these early years, the parameters of school health services were not fixed. World War I brought about educational reform and public health became an integral part of the nation's philosophy.[42] In 1918, the National Education Association (NEA) listed its seven main objectives of education; among these "seven cardinals of principles" was health.[43]

Post World War I

As power transferred from the federal authority of wartime government to private local interest medical ideology changed.[44] In the early 1920s and 1930s, two basic policies became clearly established. First, schools should focus on prevention as opposed to treatment; and second, boards of education should control and govern services provided in schools." Preventive

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[40]Kort, 453.

[41]Lear, 899.

[42]Kort, 454

[43]Kort citing C. H. Gross and C. C. Chander, A History of American Education through Readings (Boston: D.C. Heath, 1964), 343.

[44]Rosemary Stevens, In Sickness and in Wealth (U.S.: Basic Books, 1989), 103-131.

"Douglas Kirby, "Comprehensive School-Based Health Clinics: A Growing Movement to Improve Adolescent Health and Reduce Teen-age

services, including those in schools, were to supplement not substitute or compete with the private sector. School health was a reflection of the overall strict separation of preventive and curative services.[46] Health services were to be administered by physicians in private practice.

<u>Early 1970s to Present</u>

During the past two decades, however, concerns for the health and well-being of school children have caused public health officials," children advocates[q8] and communities to challenge Post War policies.[49] The contemporary school-based model has its roots in the earlier school health services introduced a century ago. In 1967, the first comprehensive clinics were physically placed in four elementary schools in Cambridge, Massachusetts.[50] In the mid-1970s, similar services were established in high schools in Dallas, Texas, St. Paul, Minnesota and Cambridge. By 1985, the number of centers had doubled,[51] until today, 1995, there are approximately 495 centers.[52]

Pregnancy," *Journal of* School *Health* 54, 11 (September 1986): 289.

[46]Kort, 454.

[47]U.S. Department of Health, 1-3.

[48]The School-Based Adolescent Health Care Program, 1-16.

[49]Kirby, 289

[50]U.S. Department of Health, 2.

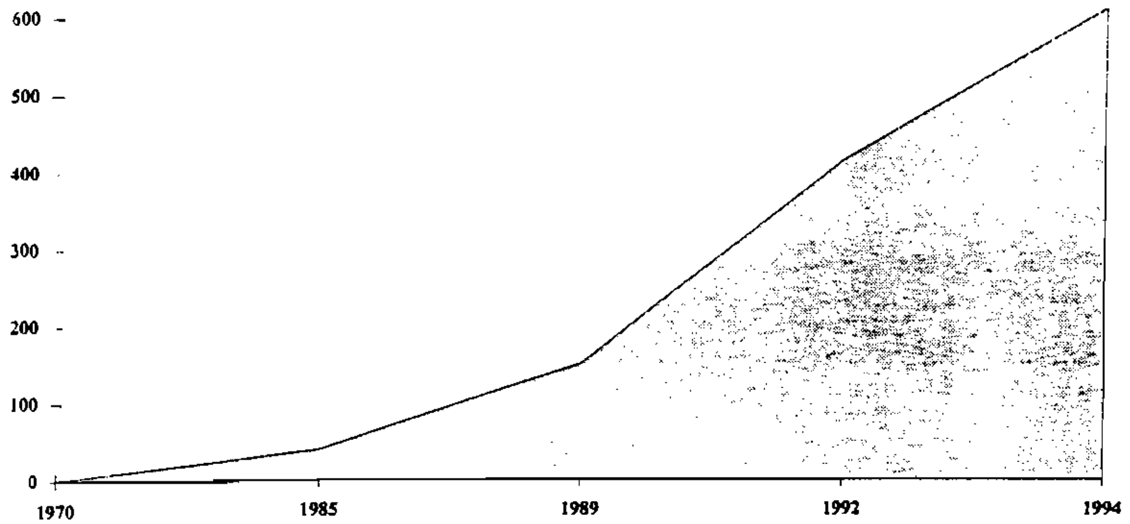
[51]The School-Based Adolescent Health Care Program, 9.

[52]U.S. Department of Health, 3.

Figure 2.1 illustrates the dramatic increase of SBHCs in the last two decades.[53]

Figure 2.1

School-Based Health Centers, 1970-94



[53]Making the Grade National Program Office. State Initiatives To Support School-Based Health Centers, (Washington:1994),3.

In twenty years, "the concept has evolved from scattered pilot efforts to substantial innovations occurring in almost every state in the nation."[54]

National Recognition

As of recent, school-based health centers have re-emerged as the most effective site for the delivery of services to children, adolescents and their families. In 1990, SBHCs were recognized by the U.S. Public Health Service as a vehicle to improve the health of the nation's children (Healthy People 2000). In its 1991 report, "Adolescent Health," the Congressional Office of Technology Assessment recommended their expansion. In 1992, the President's Advisory Commission on Social Security recommended the establishment of SBHCs in elementary schools with a federal budget as high as three billion dollars.[55] The 1992 Gallup Poll reported that seventy-seven percent 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.[56] The public, along with governmental offices, recognize the need to break down the barriers children encounter in mainstream health care delivery.

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[54]Lear, 900.

[55]U.S. Department of Health, 3

[56]Dryfoos, 84.

BARRIERS TO HEALTH CARE

There are many obstacles children and adoiescents face when seeking health care services. The lack of payment either independent of parents or by parents; lack of insurance that covers primary and/or preventive care; constraints imposed by changing family and work patterns; limited physical locations and office hours of medical facilities; too few providers in urban, rural and low-income areas; little coordination of community services; requirements of parental consent; perceived or actual lack of confidentiality; and feelings of alienation in traditional health care settings are all contributing factors.[57] Combined, these make children, particularly adolescents, an enormously difficult target population to reach. For many, the entry into the system is insurmountable. As a result, at the very time when society should be opening its door and helping to nourish and nurture its young people, it is locking them out. "Fewer opportunities for contact with supportive adults limit adolescents' abilities to weather the turbulence of growing up . . ."[58] School-based health centers can help navigate a sometimes rocky journey into adulthood.

SBHCs remove many of the problems children often confront in traditional health care delivery systems. They provide increased access to comprehensive health services, greater acceptability by the targeted group, and more affordable health care delivery.

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[57]Council on Scientific Affairs, 1940

[58]Millstein and Mortimer, 1413.

Although, there is no one best SBHC model, effective programs do have a common set of factors which work to break down barriers.

SBHC CORE ATTRIBUTES

There are many SBHCs designs. Although different in program, staffing patterns and funding sources,[59] they all have a core set of common attributes - accessibility, acceptability and affordability.[60]

Accessibility

The primary characteristic of accessible services is location. The school is where the young people are.[61] When health services are provided on school premises, a large segment of the student population can be reached.[62] It does not require the student to miss school or the parent to miss work to receive services.[63] One study has documented the importance of

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[59]Nancy Harold, "School-Based Clinics," Health and Social Work (Fall 1988): 303.
[60]Lear, 901.
[61]U.S. Department of Health, 18.
[62]Nancy Harold and Rena Harold, "School-Based Health Clinics: A Vehicle for Social Work Intervention," Social Work in Education 13, 2 (April 1991), 186; Terrance Keenan, "School-Based Adolescent Health Programs". Pediatric Nursing, 12,5 (September/October 1986):365; Phillip Nader, Susan Gilman, and David E. Bee, "Factors Influencing Access to Primary Health Care via School Health Services", Pediatrics, 65, 3 (March 1980):586.
[63]Clair Brandis, Susan Starbuck-Morales, Amy L.Wolfe and Virginia McCarter,"Characteristics Associated with Contraceptive use Among

providing services on school property (school-based) rather than nearby (school-linked). When the center was relocated across the street, it found the level of service activity declined thirty percent within the first year.[64] The school-based location requires no need for special transportation,[65] which is particularly important in rural communities where lack of transportation can render care inaccessible.[66] The financial barrier to care is removed by creating access for those without health insurance and/or ability to pay.[67] If there is no coverage, the care is either free or based on a sliding-fee schedule.[68]

Accessibility also provides for continuity. The continuity of care in the lives of contemporary youth alleviates many of the problems children and their families face.[69] Service continuity is ensured because the centers are designed to offer care over time rather than a particular episode. There is an emphasis on coordination and follow-up which in turn develops relationships between the provider and the child. In addition, this continuity

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Adolescent Females in School-Based Family Planning Programs." Family Planning Perspectives, 26, 4, (1994), 160.

[64]Dryfoos, 132.

[65]U.S. Department of Health, 18.

[66]The School-Based Adolescent Health Care Program, 4.

"Committee on Child Health Financing, American Academy of Pediatrics, "Financing Health Care for the Medically Indigent Child," Pediatrics 80, 6 (December 1987), 957.

[68]U.S. Department of Health, 18.

[69]Elizabeth McAnarney, "Discontinuity: A Dilemma for Adolescents," Pediatrics 80, 6 (December 1987), 1987.

makes for a link between clinic services and classroom health education.[70]

Acceptability

The second core attribute is acceptability. The students are familiar with the facility and staff which builds a sense of trust.[71] A 1992 survey conducted in three public high schools in Massachusetts found that a large proportion of students have health concerns they wish to keep private. One-fourth reported they would not seek care if they thought their parents, friends or teachers might find out." This study confirms the belief that confidentiality is of utmost priority to adolescents. In SBHCs, once parents have provided consent for their children to use the clinic, the students are assured of confidentiality in the provision of care. SBHCs are not only acceptable to the students, but to parents, teachers and traditional school nurses as well who come to accept and appreciate the center as a valuable resource.[73]

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[70]U.S. Department of Health, 18, and Kirby, 290.

[71]Harold and Harold, 186; U.S. Department of Health, 18; and Harold, 303.

[72]Tina L. Cheng, Judith Savageau, Ann Sattler and Thomas DeWitt, "Confidentiality in Health Care: A Survey of Knowledge, Perceptions, and Attitudes Among High School Students," Journal of American Medical Association 269, 11 (March 19931, 1405-1407.

[73]U.S. Department of Health, 6.

Affordability

Affordability is the third basic attribute. To date, most SBHCs have been established in low-income communities constrained by lack of money and no health insurance. Nevertheless, they have proven to be affordable. Because of the variation of models and sizes, annual costs range from $50,000 to $300,000 per year, with per-user costs ranging from $50 to $200.[74] In a cost comparison study of medical care provided in Middletown, Deiaware, a SBHC showed substantial savings when compared to a private physician's office. Potential out-of-pocket expenses for obtaining care in a private physician's office were eighty-nine percent more than through the SBHC.[75] In another cost evaluation study in Denver, Colorado, a full year of comprehensive heaith services can be provided for only $125 per student.[76]

CONTENT OF SERVICES

As mentioned earlier, SBHCs vary in regard to the scope and content of care offered. The needs of students differ in elementary, middle, and high school levels, and vary from community to community. According to the most recent survey from the Center for Population Options, 46 percent of the facilities are located in high schools, 16 percent in middle/junior,

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[74]Dryfoos, 89.

[75]Lucille Siegel and Todd Krieble, "Evaluation of School-Based, High School Health Services," *Journal of School Health* 57, 8 (October 1987) 323-325.

[76]The School-Based Adolescent Health Care Program, 30.

28 percent elementary, and 10 percent other (special centers or combination grade levels).[77] Most centers include preventive, medical and mental health services.[78] Most provide comprehensive care and thus address a full spectrum of services: physical examinations, immunizations, chronic and acute illness management, laboratory testing, counseling, health education, substance abuse treatment, reproductive health care and other services.[79] A comparison study evaluating the effectiveness of seven SBHCs to nonspecialized community clinics revealed SBHCs were detecting and treating a more comprehensive range of medical problems.[80] Due to the wide range of services, and the difficulty in evaluating multicomponent programs," only a few of the major evaluation studies will be presented here in detail.

Family Planning Services

Although reproductive health care is the image many have regarding school-based health centers, it represents but a small portion of services. Not all centers offer family planning

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[77]Making the Grade National Program Office, 4.
[78]General Accounting Office. (1994). Health Care Reform School-Based Health Center Can Promote Access to Care. (GAO Report No. GAO/HEHS-94-166), Washington, General Accounting Office, 1.
[79]Ibid, 2.
[80]Felton Earls, Lee Robins, Arlene Stiffman, and Jack Powell, "Comprehensive Health Care for High-Risk Adolescents: An Evaluation Study," American Journal of Public Health 79, 8 (August 1989), 999-1005.
[81]Dryfoos, 123.

services, and of those that do, such services only account for about ten percent of student visits.[82]

However, for those SBHCs offering reproductive services, many clinics have reported a decline in their pregnancy rates. In thirteen years since the Jackson, Mississippi center was first introduced, the number of pregnancies declined from 88/1000 to 16/1000, representing a 450 percent decrease.[83] In two years Baltimore, Maryland reported a fifty percent reduction from 34/1000 to 17/1000.[84] A study of Zabin, et al. assessed the knowledge, attitudes and behavior regarding adolescent pregnancy and prevention before and after educational/clinical intervention. The findings reported significant improvement.[85] A similar study conducted by Galavotti and Lovick suggests that SBHCs may be having some success in encouraging and enabling sexually active adolescents to use contraception.[86]

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[82]School-Based Adolescent Health Care Program, 24.
[83]U.S. Department of Health, 12.
[84]Ibid.
[85]Laurie Zabin, Marilyn Hirsch, Edward Smith, Salie Street, and Janet Hardy, "Adolescent Pregnancy-Prevention Program," Journal of Adolescent Care 7 (1986), 77-87.
[86]Christine Galavotti and Sharon Lovick, "School-Based Clinic Use and Other Factors Affecting Contraceptive Behavior," Journal of Adolescent Health Care 10 (1989), 506-512.

School-based health centers have been criticized for promoting promiscuity. No evidence has been found that the presence of SBHCs increases the rate of sexual activity among students.[87]

Prenatal Services

Those SBHCs that have incorporated prenatal services have been successful in entering the pregnant girls into first trimester care.[88] A St. Paul study comparing pregnant SBHC students with a random sample of non-school clinic patients found the study group initiated care earlier and had fewer obstetrical complications and fewer low birth weight infants.[89] In a recent study regarding teenagers' perceptions of the barriers to prenatal care, findings suggest that specific changes are needed in the health care system to make it more accessible to pregnant teens. These changes include establishing links between prenatal clinics and school health systems, scheduling clinics at more convenient times, and enhancing Medicaid prenatal information.[90] Even after recognizing the complexity of teenage pregnancy

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[87]Dryfoos, 124-25.

[88]U.S. Department of Health, 12

[89]Marjorie Berg, Barbara Taylor, Laura Edwards and Erick Hakanson, "Prenatal Care for Pregnant Adolescents in a Public High School," The Journal of School Health (1979), 32-35.

"Peter Cartwright, Dorothy E. Caul, and Michael S. Swafford, "Teen-Ager Perceptions of Barriers to Prenatal Care." Southern Medical *Journal*(1993), 737.

problems, it would appear school-based health centers can be an effective means of prenatal care delivery.

School Performance

SBHCs have been promoted as an innovative approach in improving school performance. The interrelatedness of problems among disadvantaged youth and the growing economic gap between social classes have placed a heavy burden on education. With dropout rates reaching eighty percent in some inner-city schools, school systems are now more willing to allow outside organizations to operate programs within the school.[91] SBHCs have been promoted as an innovative approach in improving school performance. McCord's study examined the effect of SBHC registration/use on students' absence, suspension, withdrawal and graduation/promotion rates. Students who used the clinic were found significantly more likely to stay in school, to graduate and/or be promoted.[92]

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[91]Joy G. Dryfoos, "School-Based Health Clinics:Three Years of Experience," Family Planning Perspectives 20 (1988), 194.
[92]Marcella McCord, Jonathan Klein, Jane Foy and Kate Fothergill, "School-Based Clinic Use and School Performance," Journal of Adolescent Health 14 (1993), 51-98.

Additional Benefits

Additional positive benefits include: reduction in sexually transmitted diseases, decrease in substance abuse, early detection of mental and emotional problems, reduction of acts resulting in intentional or unintentional injury or death, and lower utilization rates of emergency rooms.[93]

SBHC LIMITATIONS

Despite the positive outcomes and support presented above, SBHCs do have limitations and opposition. Some clinical problems are: centers located in the school building can not serve non-students; many have limited days and hours; and some do not have adequate space allocation. Some centers do not have pharmacies while others can not perform laboratory testing. Turf issues between existing school nurses and outside agency personnel can be a problem.[94] Yet perhaps the most threatening limitation is the lack of long-term and stable funding. Despite SBHCs successes in obtaining a wide variety of financial resources, few are long-term and commitment on the federal government level is minimal.[95] The issue of funding will be discussed at greater length in the following chapter.

93U.S. Department of Health, 12; Judith W. Ross, "School-Based Health Clinics:An Opportunity for Social Workers to Address Youth Violence." Health and Social Work (1994), 82.

[94]U.S. Department of Health, 15.

[95]Keenan, 368.

CONTROVERSIES

In some communities, opposition has captured a lot of media attention. A typical newspaper headline, "Pill Goes to School" triggered an extended controversy over the opening of a center in Chicago, Illinois.[96] The most controversial challenges have come from conservative groups such as Phyllis Schlafly's Eagle Forum, Pat Robertson's Christian Broadcast Network, National Right to Life, Concerned Women of America, fundamentalist churches, the Roman Catholic Church, and Former Secretary of Education William Bennett.[97] Some outlined arguments include: clinics promote promiscuity; centers divert schools from educational mission; programs duplicate other easily available community services; unpredictable personal in-house liability exists; and centers present possible occurrence of "black genocide".[98] Researchers have noted that despite the politics and community controversies over such issues, most attempts to implement SBHCs have succeeded eventually.[99]

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[96]Dryfoos, Family Planning Perspectives, 193.
[97]Barbara Rienzo and James Button, "The Politics of School-Based Clinics: A Community-Level Analysis," Journal of School Health 63, 6 (August 1993), 268.
[98]Richard Weatherly and Jeanette Semke, "What chance for School-Based Health Clinics? Lessons from the Field," Social Work in Education 13, 3 (April 1991), 152-153.
[99]Dryfoos, 166.

COLLABORATIVE EFFORTS and PARTNERSHIPS

In an effort to respond to the needs of today's children, a significant consensus is emerging that "schools cannot do it alone".[100] Collaboration has become the buzzword for the 1990s. Studies involving school restructuring issues have highlighted the relationship between good health and educational achievement This intimate linkage between health and education has the potential to bring powerful institutions together.[101]

Task Forces

Turning Points , a publication of the Carnegie Council on Adolescent Development, challenges all sectors that care about youth to form creative partnerships and work to make childhood a time of purposeful exploration and preparation for constructive adult life. The Carnegie Task Force urges health educators and professionals to join with schools to ensure access to needed services, knowledge and skills that can prevent health damaging behaviors.[102]

Two historically diverse interest groups, the American Medical Association and the National Association of State Boards of Education, have formed a joint commission and issued an unprecedented statement. "Families, schools, neighborhoods, the health community, and public and private sectors will need to forge new partnerships to address the interconnected health and

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[100]Ibid, 6.
[101]Ibid, 149.
[102]Carnegie Council on Adolescent Development, 28.

education problems our young people are experiencing".[103] In their 1990 report, Code Blue : Uniting for Healthier Youth, the medical term "Code Blue" was used to signify the life-threatening emergency of contemporary health problems affecting youth. Their recommendations stem from the agreement that education and health are inextricably intertwined. Both groups maintain that any efforts to improve school performance that ignore health are ill conceived, as are any health improvement efforts that ignore education. The commission strongly supports the establishment of health centers in schools and the restructuring of public and private health insurance to ensure access to services.[104]

The Office of Technology Assessment, when charged by Congress in 1991 to review the health service of American adolescents and present options for congressional consideration, gave similar recommendations. The report was especially supportive of school-linked services, referencing the concept as the "most promising recent innovation to improve access to health."[105] In May, 1994, the United States General Accounting Office issued a report in support of school-hased health centers. They concluded that SBHCs do improve children's access to health care. SBHCs help to overcome financial and non financial

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[103]Dryfoss, 8.

[104]Ibid.

[105]Ibid, 9.

barriers that currently limit access, including the lack of health insurance, transportation difficulties, and insufficient attention to the particular needs of adolescents.[106]

Educational Reformists

Recently, a number of interesting educational reform movements have emerged which promote a mixture of educational and non educational services. Edward Zigler of Yale University, promotes an intervention called, "Schools of the Twenty-First Century". Under his model, schools would function as community centers, linking family support systems with child care systems. He contends that communities already "own" the school building, having invested one to two trillion dollars. He would open school doors from 7 a.m. to 6 p.m. everyday and provide full day care for ages three to twelve. The family centers would be run by early childhood educators and they would conduct home visits for parents of newborns.[107]

The School Development Program, which was started by James Comer, is a school-based management approach addressing the multiple needs of children. The program attempts to strengthen and redefine the relationships between principals, teachers, parents, and students. Representative management and governance is implemented through an elected School Advisory Council and a Parent Participation Program. Around the country, schools are

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[106]General Accounting Office, I

[107]Dryfoos, 9-10.

being "Comerized". According to its founder, the strength of the project is its focus on the entire school and its attention to institutional change rather than individual change.[108]

The School of the Future is another large school foundation effort to help schools evolve into primary neighborhood institutions. The Texas-based Hogg Foundation for Mental Health is supporting four major city efforts (Austin, Dallas, Houston and San Antonio) that combine several intervention approaches - Ziegler's Schools for the Twenty-First Century, the Comer Development Program, school-based clinics, programs for community renewal, and family preservation.[109]

Success for All is a demonstration program for elementary schools initiated by Robert Slavin of John Hopkins University. The program restructures the entire school to do "everything" necessary to insure that all students will be performing at grade level by the end of the third grade. Interventions might include a family support team, individual academic plans, on-site medical care, food distribution center and clothes bank.[110]

Organizational Roles

The specific roles of schools and community agencies are important in the development of school-based health centers. A task force from the National Health Policy Forum made the following observation that "leaders of innovative programs tend

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[108]Ibid, 69-70.

[109]Ibid, 73.

[110]Ibid, 70.

to conceptualize what they want to achieve, to pick their ways through mazes of public and private support, to build networks of people who share their vision, and to market their ideas to others."[111] Although a movement toward institutional collaboration is evident on the national level, significant changes will not materialize unless partnerships occur at local levels.

Lead Agency

No research studies have been identified that compare the effectiveness of SBHCs according to type of lead agency.[112] A review by a Washington health policy consultant group concluded that sponsorship by a community group rather than a school system had advantages; eligibility for public and private funding and third party reimbursements was more easily established; medical liability issues were handled by the outside agency; referrals were facilitated back to the sponsoring agency; and administrators and board members preferred to concentrate on academic rather than health related matters.[113] Terrance Keenan, a Robert Wood Foundation executive, states while schools should serve as the focus of health care, they should not impose the

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[111]Ibid, 164.

[112]Ibid, 145.

[113]Harriett Fox, Lore B. Wicks, and Debbra J. Lipson, "Improving Access to Comprehensive Health Care Through School-Based Program," (Washington:Fox Health Policy Consultant Inc. U.S. Department Health and Human Services, Maternal and Children Health Bureau),51.

responsibility for the organization, delivery, and financing of the centers. He prefers that traditional health service institutions such as health departments and hospitals assume the lead role.[114]

School Board

School boards generally determine overall policies, particularly in regard to the provision of birth control on school premises.[115] Contractual arrangements are usually signed by this governing body, and issues such as liability, confidentiality, and informed consent are addressed. A detailed examination of these issues will be provided in the following chapter.

School Leadership

In as much as the governing body of the school district must be involved from the beginning and view themselves as equals in the collaborative process, school-based health services cannot be implemented without the involvement of mid-level managers, the principals. They must serve as liaisons between the district and the outside community agencies.[116] This requirement may find the

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[114]Keenan, 365.

[115]Dryfoos, 150.

[116]Elders, 313.

principal assuming new leadership roles for which he/she was not trained.[117]

Principals

Dr. Joycelyn Elders, former U.S. Surgeon General and advocate for the school-based health center concept offers the following essential tasks for principals: They

- must be active participants in developing services at the school by sharing information about the children and community, must connect the planning group to parents and teachers, provide planners with a realistic understanding of day-to-day school operations, and maintain chief responsibility for the service center;

- must act as a school-based health center advocate with families, the community, other agencies, school staff, and their colleagues;

- must recognize and link key teachers and other school staff with staff from community health and social service agencies to provide optimal services for students; and

- must act as enablers and promote active involvement in the planning and monitoring of the school-based health service effort.[118]

The principal's pivotal role cannot be over stated and will be closely examined throughout this study.

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[117]Jeanne Jehl and Michael Kerst, "Getting Ready to Provide School-Linked Services:What Schools Must Do." The Future of Children (Los Altos; Center For The Future of Children, The David and Lucile Packard Foundation, 1992), 103.

[118]Elders, 314.

SUMMARY

As this literature indicates, the health of our nation's children is in "Code-Blue". Biomedical approaches have not been enough to address the unmet health care needs of our youth. The rise in our children's mortality and morbidity rate prognosticate a bleak picture for this country's future if something is not done quickly. Our schools and communities must try innovative approaches and revisit historical models that incorporate comprehensive programs.

The concept of school-based health centers includes a wide range of school designs. Because children's needs differ according to their physical, mental and psycho social characteristics and because health reform is ever changing, it is essential that schools and communities feel free to adopt varying styles. Although diversity characterizes the implementation of the SBHC concept, a core set of attributes emerge as common to most centers. They provide accessible, acceptable and affordable health care with a variety of services that address many health problems.

Despite the benefits associated with school-based health centers, expectations must be realistic. Proponents and opponents, alike, must be careful not to expect these programs alone to solve all complex problems confronting our country's children. Overall programmatic success cannot be judged by single issues. The failure to meet ambitious societal goals may overshadow the benefits of SBHCs. Major institutional change

must occur at national, state and local levels if the child and adolescent health care crisis is to be arrested.

The school-based health center approach has great potential to turn the health status of this population around and give it new direction. The physical and mental well-being of our nation's children must be improved and society's negative impact softened. This literature review has explored the relevant research on school-based health centers and forms the conceptual framework for this project.

The next chapter will describe the setting in which this research occurred. Included will be an examination of the legal mandates and principles by which most school-based health centers develop and operate. Funding sources will be identified at national, state and local levels. A report on Austin Independent School District health projects currently in operation will be provided.

CHAPTER THREE

Research And Legal Setting

This chapter will examine specific legislation that deals with child health care poiicy. Historical legal mandates at national, state and local levels will be reviewed. A discussion of school-based health center funding will be intermingled in this chapter because it is directly tied to most legislative action. A brief description of some suggested and/or required legal guidelines offered by the Texas Department of Health will be presented. The Austin Independent School District's policies and programs regarding school health services will be examined.

POLICY FORMATION

Historically, policies for improving the lives of young children have come primarily from federal rather than state government.[119] The federal government has generally set the tone on most reform issues untii recently, when the responsibility for many social programs shifted from the federal government to states arid, in turn, from states to municipalities.[120] It is in that historical order that child health legislation as it relates to school health delivery will be reviewed.

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[119]Louise Iscoe K. Action for Texas Children:Trends and Influences in Child and Family Policy. (Austin:Institute of Human Development and Family Studies The University of Texas at Austin),4.

[120]Ibid, 26.

Early National Policy

For more than one hundred years agencies have been bringing medical and social services into schools.[121] Legislative programs and policies dating back to the Progressive Era sought to improve the health of children through the American public school system.[122] With the powerful combination of compulsory school attendance and child labor laws, immigrant children were pushed into the traditional school setting for the first time.[123] As social reformers grew distressed by the poor health and living conditions of immigrant children, they sought to broaden the educational concentration of the basic "three R's." The Progressives were committed to eliminating a range of social ills from poor housing and unsafe working conditions to juvenile delinquency and child labor.[124] The earliest school-based efforts focused on communicable disease prevention, as public health departments linked with boards of education to provide vaccinations to school children. In 1904, otolaryngological inspections were mandated for the first time,[125] setting a precedent for future school health screening programs.

At the turn of the century, educational theory shifted from subject matter emphasis to one of childhood development, and for the first time, powerful organizations crossed paths. The

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[121]Dryfoos, 19.

[122]Kort, 454.

[123]Dryfoos, 20.

[124]Kort, 454.

[125]Ibid, 453.

American Medical Association and the National Education Association formed a joint commission report linking poverty with educational need and called for the expansion of public health programs in schools.[126] Early childhood advocates such as Florence Kelley were influential in persuading President Theodore Roosevelt to organize the first White House conference dealing with child and family issues. Recommendations from that "Conference On The Care Of Dependent Children" gave strong impetus to the movement for mothers' pensions and ultimately resulted in the program Aid to Families With Dependent Children. It was six years before legislation was passed creating the Children's Bureau (CB). The CB specifically called for research on child welfare, infant mortality, child employment and neglect but stopped short of authorization to provide services.[127]

World War I

The Progressive Era's early childhood innovation and social reform was stopped abruptly by World War I. The conservative sweep of the nation all but eliminated governmental development in children's services. Many school-based health and social services were seen as avenues for socialism and campaigns against public health interventions were launched. Child advocates legislative crusade was severely restricted.[128]

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[126]Dryfoos, 24

[127]Ibid, 25.

[128]Ibid, 26.

In 1921, the first federally funded health care program was passed by the United States Congress, the Maternal and Infancy Care Act (PL67-97, Sheppard-Towner). It provided states matching funds establishing prenatal and child health service centers, to be operated by nurses, mid-wives and trained lay women. The program sought to make preventive care a universal public service and is cited as being the most important federal child health initiative in our nation's history.[129] Not surprising, the succinct legislation met with powerful opposition from the American Medical Association (AMA). By 1929, the profession had mounted such a highly effective campaign against socialized medicine, the program was eliminated.[130] It marked the end of female expertise in the field of health care and shifted the provision of preventive health services from the public to the private sector.[131]

The Depression

The Depression years necessitated a swing back toward federal government intervention in child health policy. The 1935 Social Security Act (PL74-271) created a federal bureau to fund Maternal and Child Health (MCH) services. MCH provided state funding for child welfare and handicapped programs. Public health clinics were provided for low-income families, but not

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[129]George J. Annas and Sylvia A. Law, American Health Law (Boston: Little, Brown and Company), 938.
[130]Dryfoos, 26.
[131]Annas, 938.

until later would MCH become the major funding source for school-based centers.[132] Although, New Deal Reform provided for maternal and child health programs outside the school-setting, within the walls of education, the acceptable form of school health intervention was strictly health education and promotion. Such presentations were not threatening to the private medical sector[133] and, as a result, clearly defined lines separating education and service delivery were drawn.

Regulations governing school health became institutionalized.[134] Schools became images of American medicine at-large, upholding strict separation between preventive and curative services. Educators and public health professionals began the debate over the control of school health services. Even though health department personnel claimed they were the most appropriate providers of school health, state laws did not uphold their contention.[135] School boards of education emerged as the governing authority of school health policy[136] and enacted statues which only permitted for health appraisal, emergency care and counseling.

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[132]John J. Schlitt, Kamala D. Rickett, Lisa L. Montgomery, and Julia Graham Lear, A *Making* the Grade Report: State *Initiatives* To Support School-Based Health Centers. (Washington, D.C., Making the Grade National Program Office), 4.

[133]Dryfoos, 27.

[134]Ibid, 454.

[135]Kort, 455, and Dryfoos, 29.

[136]Kort, 454.

Post Depression

In 1948, the National School Health Bill was designed to give federal grants-in-aid to school health. The American Academy of Pediatrics feared the bill would provide funds for medical treatment of those financially able to take care of themselves and insisted "that any treatment proposed in any bill should remain within the jurisdiction of private physicians."[137] The bill was defeated.

Medical treatment for children outside of private practice continued to be de-emphasized until the 1960s, when Kennedy and Johnson administrations reintroduced social commitments through public health. Many federal health service grants became availabie, and a variety of new programs were implemented. In 1961, a Child Health and Human Development Institute was added to the National Institutes of Health. Two of the most important pieces of federal health policy were enacted as 1965 amendments to the Social Security Act (PL89-97), Medicare (Title XVIII) and Medicaid (Title XVIII).[138] These amendments addressed complex issues such as social security, unemployment insurance and public assistance. Although child medical services attracted but a small amount of attention initially, the act did formulate a new child health approach called Children and Youth Projects. These grants provided funds for screening, diagnosis, preventive services, treatment and correction of defects. This concept

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[137]Ibid, 455.

[138]Annas, 29.

later translated into the vast i967 Medicaid initiative called EPSTD (Early Periodic Screening Diagnosis and Treatment),[139] a program which continues to provide health care for economically disadvantaged children.

War on Poverty

The 1960s "War on Poverty" established many specially funded health centers which included a broad spectrum of child services (e.g., Head Start, mental health). Although each had an impact on child policy, the dispersment of service responsibility across the "giant bureaucracy" inadvertently caused a problem for all child health policy. With no identifiable central point for child health issues, they became lost in the bureaucratic maze.[140] In 1966, Title I of the Elementary and Secondary Education Act (ESEA, also known as Chapter 1) provided specific funding for the expansion of school health for large disadvantaged populations.

1970 To 1990

In 1974, Title I's intent was restated to provide priority to its educational purpose,[141] although the act still remains a significant source of funding for school health services. The 1970 Family Planning Services and Research Act (H.R.19318)(also known as Title X) funded programs related to family planning and

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[139]Dryfoos, 35.

[140]Ibid.

[141]Kort, 456.

teen-age pregnancy.[142] Presently, SBHCs can obtain Title X grants if they have approval from the local school board; however, most are not funded from this source and refer students to outside family planning clinics.[143] In 1975, Congress enacted the landmark Education for All Handicapped Children Act (PL94-142) requiring special services for disabled children, which included medically necessary services.[144]

The "New Federalism" of the Reagan years produced a substantial degree of health policy change and resulted in extensive cuts and reorganization.[145] The Omnibus Budget Reconciliation Act of 1981 (PL97-35) consolidated health programs targeted to mothers and children to form the MCH Block Grant (also known as Title V).[146] Title V is not an entitlement program; rather, states have broad discretion to make grants directly to providers of health and health-related services. Title V programs have been widely recognized for their quality and comprehensivness.[147] In addition to prenatal care, Title V's most recent priorities have focused on the development of preventive and primary care systems including school-based health centers.

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[142]Dryfoos, 257.
[143]U.S. Department of Health and Human Services, 11.
[144]Texas Education Agency, 24.
[145]Theodor J. Litman, Health Politics and Policy (Albany:Delmar Publishers, Inc),108.
[146]Dryfoos, 250.
[147]Litman, 932.

Present

The prospects for an expanded federal role in the development of SBHCs appears positive for the 90s. Even though President Clinton's national health reform plan did not pass (SBHC expansion was recommended),[148] the first federal programs targeted specifically to SBHCs were announced in May, 1994. The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act (PL103-112) provides $3.25 million to fund school-based primary care services for homeless and at-risk youth at fifteen to twenty new sites. MCHB is providing a additional $1 million to these same sites for health education. The Bureau is also funding a separate $1.5 million grant program to states and universities for SBHC staff development.[149]

Additional federal legislative mandates and programs with linkages to SBHCs are the Drug-Free Schools and Community Act, Juvenile Justice and Delinquency Prevention Act, Job Training Partnership Act, Department of Agriculture's Supplemental Food Program for Women, Infants and Children (WIC), Community and Migrant Health Service, Indian Health Service, Substance Abuse and Mental Health Services, and Division of Adolescent and School Health (within the Centers for Disease Control and Prevention).[150]

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[148]Ibid, 192.

[149]General Accounting Office Report, 3.

[150]Dryfoos, 192.

Texas

Texas has followed the national pattern of public concern for children and youth. In every legislative session, bills are passed that impact children. Those efforts over the last two decades will be highlighted here.

In 1971, the Office of Early Childhood Development was created by executive order with its primary function to provide leadership in assessing the needs of children. It stated "the well-being of children - and thus the future of Texas - is a responsibility shared by all of us."[151] In 1974, the Interagency Task Force on Youth Care and Rehabilitation recommended that programs serving children focus on prevention, early intervention and be community based. The 1987 Select Committee on Tax Equity pointed to major flaws in health and human services. Among them was the state's low national ranking in serving populations in need, particularly the increasing numbers of children living in poverty and single parent families (especially among racial and ethic minorities). A United Way report the following year reiterated the emerging profile of Texas children. The number living in poverty was estimated to increase, pointing to statewide crisis due to poverty, child abuse, teenage pregnancy, substance abuse, and school drop out rates.[152]

In 1991, aware that Texas was behind most states in the indicators regarding maternal and child health, the Texas MCH

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[151]Iscoe, 3.

[152]Ibid, 4-11.

Coalition recommended a new "seamless system" of services that would fill in the gaps of health coverage for every pregnant woman and every child.[153] The Texas Comptroller conducted a comprehensive review of state government which resulted in the passage of two major pieces of legislation: House Bill 7 and House Bill 2009. Both restructuring bills have affected child policy.[154]

Governor Richards responded to the state's health crisis by creating a Health Policy Task Force. Among the proposals was the general recommendation to increase utilization of school-based health care services, to develop a state-level interagency group to provide technical assistance to SBHCs, and to explore Medicaid funding.[155] In 1992, a statewide children vaccination program "Shots Across Texas" received funding in the 73rd Texas legislature with its goal to improve the immunization rate of Texas children.

In 1993, Senate Bill 55 created the Texas Commission on Children and Youth. Its major objectives are as follows:

- to develop a comprehensive proposal to improve and coordinate public programs for children;

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[153]Texas Research League, "School-Linked Services." TRL Analysis 15, 4 (Austin 1994), 27.

[154]Iscoe, 12-13.

[155]Texas Health Policy Task Force. Report of the Texas Health Policy Task Force:Texas Health Care New Directions, (Austin) 1994, 105-106.

- to achieve the goals of the commission in education, health care, juvenile justice, and family services;

- to organize community-based commissions throughout the state to promote cooperation among government, voluntary organizations and other private interests in meeting the needs of children;

- to encourage the involvement of parents and volunteers; and

- to develop local solutions to the problems.[156]

Austin

With social program responsibilities having shifted from federal, to state, to city and county government, the importance of local level legislation and budgeting cannot be overestimated. The Children's Defense Fund, one the best known national advocacy groups for children, gives this account of the importance of local policy:

> Cities and towns are where policies affected children and families are implemented. The everyday lives of children are affected by nearly every service cities provide. By tracking city legislation and budget proposals, meeting with elected officials, and pushing for new and improved rograms, advocates affected significantly what their community offers children and youth.[157]

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[156]Iscoe, 16.

[157]Ibid, 26.

Faced with the evidence that more and more Austin area children were not getting basic preventive medical care,[158] the community undertook several local efforts to improve the health status of its children. The Austin Independent School District (AISD) and the Austin Health and Human Services/Travis County Health Department developed a community partnership to address childrens' health issues through school programs. SBHCs experts emphasis that careful attention should be paid to establishing mutually beneficial inter organizational relations at the local level.[159] In 1992, an Austin city ordinance (No.940912-D) was passed that provided funding for two school-based health and social service programs in AISD. In November, 1994, that ordinance was amended (No.941103-F) to include additional funding of school-linked services.[160] These programs are governed by a binding legal document called "Interlocal Cooperation Agreement" which specifies the duties and responsibilities of both parties[161] (to be discussed in the following section).

It is the general consensus among expert policy makers that local conditions are important in determining the form and structure of any local effort. Community agencies and/or individuals seeking to establish SBHCs should not look for the

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[158]Austin American Statesman (Austin). November 3, 1994
[159]Dryfoos, 185.
[160]City Council of the City of Austin, Ordinance No. 941103-F (November 3, 19941
[161]Austin Independent School District and the City of Austin,"Interlocal Cooperation Agreement".

"one best model", but rather should carefully assess the local context.[162] It appears AISD has adopted this approach. The district consists of several different projects:

- school-based health and social services in two low-income elementary schools;
- a school-linked preventive care team rotating in ten low-income elementary schools;
- a mobile health unit in five low-income elementary schools;
- immunization teams in any school as needed;
- WIC - City of Austin Women, Infants, and Children's nutritional program in three high schools with child care; and
- City of Austin Dental Program targeting Chapter 1 elementary schools.[163]

LEGAL GUIDELINES

Although the degree of state involvement varies, most state governments have in place, or are undertaking, the development of service standards, staffing guidelines, long-term financing strategies, and quality assurance guidelines.

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[162] Southwest Education Development Laboratory, 6; and Texas Research League, 66.

[163] Jan Ozias, AISD Health Services Coordinator, interagency memo, "Current School-Based Health Service Project with City". November 1, 1994.

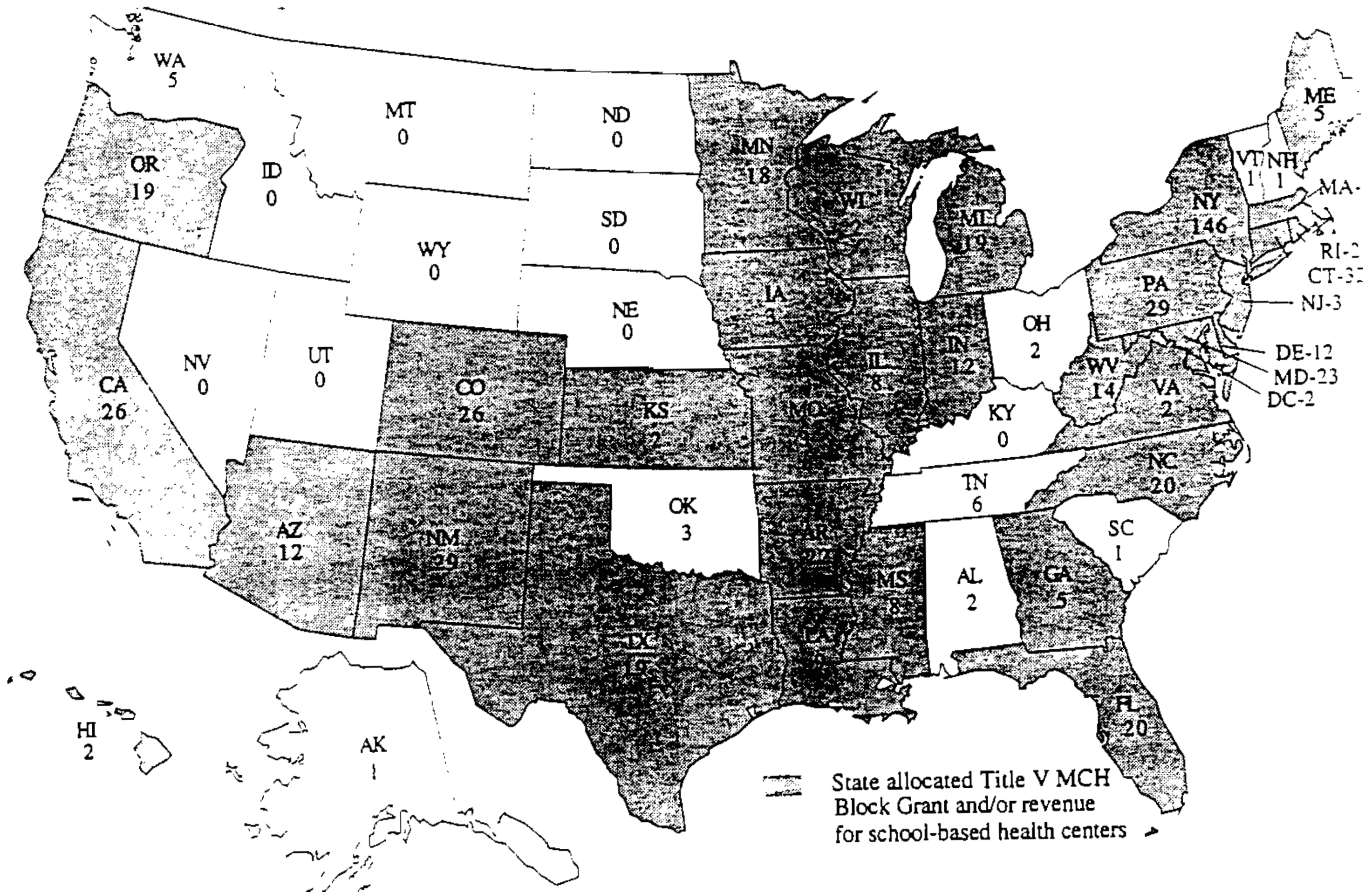
Locations

Some have developed state level offices to provide technical assistance to state funded centers. The following map shows those states which currently receive MCH funding and the number of programs in each state.[164] (see Figure 3.1) In 1994, thirty-two states reported Title V funding for school-based health centers. Even some of those states reporting no MCH funded centers have programs funded through other sources (e.g., Kentucky).

[164]Making the Grade, 3.

Figure 3.1

School-Based Health Centers, October 1994



Financing

State deployment of MCH block grant dollars, Medicaid, local public funds, private foundations and patient revenues represent many of the revenue sources for school-based health center programs. Table 3.1 which follows estimates the number of MCH programs in the state of Texas along with the funding break down as reported by the Texas State Department of Health.[165]

[165] Ibid, 14.

Table 3.1

School-Based Health Centers By State, 1994

SCHOOL-BASED HEALTH CENTERS BY STATE, 1994

STATES	SCHOOL-BASED HEALTH CENTERS. OCT. 1994					FINANCING, FY 1994				
	HIGH SCHOOL	MIDDLE/ JUNIOR	ELEM.	OTHER (1)	TOTAL	STATE MONEY	TITLE V	MEDICAID	SITE SPECIFIC (2)	PLANNING ACTIVITIES
Oklahoma	0	1	1	1	3	$0	LOCAL	√	√	$0
Oregon *	19	0	0	0	19	$664,000	$10,000	√	√	$100,000
Pennsylvania	6	6	17	0	29	$50,000	$600,000	√	√	$10,000
Puerto Rico						DID NOT RESPOND				
Rhode Island *	1	1	0	0	2	$69,000	$60,000			$100,000
South Carolina	1	0	0	0	1	$0	LOCAL	√	√	$0
South Dakota	0	0	0	0	0	$0	$0			$0
Tennessee *	3	0	2	1	6	$0	LOCAL	√	√	$124,000
Texas (3)	5	4	10	0	19	$0	$2,000,000	√	√	$0
Utah	0	0	0	0	0	$0	$0		√	$50,000
Vermont *	0	0	0	1	1	$0	$0	√	√	$100,000
Virginia	1	0	1	0	2	$300,000	$0	√	√	$300,000
Washington	5	0	0	0	5	$0	$0		√	
West Virginia	6	5	3	0	14	$250,000	√	√	√	$300,000
Wisconsin	2	0	0	0	2	$38,000	$320,000	√	√	$0
Wyoming	0	0	0	0	0	$0	$0			$0
SUBTOTAL	49	17	34	3	103	$1,371,000	$2,990,000	10	12	$1,084,000
TOTAL	281	97	171	58	607	$22,314,242	$12,006,909	29	37	$3,623,014

KEY

√ Sites receive funds from these sources. but the amounts are unknown.

* Making the Grade grantees, each of which has been awarded $100,000 far planning

1. The OTHER category includes K-12, K-7/8, 7-12, and Head Start/Teen Parent Schools.
2. "Site specific" may include support from local public funds, private foundations. patient revenues, the United Way, and community heal
3. Doer not include 41 school-linked sites.

** The figurer included in this chart arc estimates of the number of school-based health centers and their financing as reported by state agency representatives. The Making the Grade National Program Office urges cautious interpretation of this information due lo the imprecise definition of school-based health centers across states and communities and some states' inability la track independent community-based programs.

State Guidelines for Operation

Policy development was initially the domain of SBHC sponsors and funders (e.g., health care organizations and foundations). As states' financial involvement has grown, the attention to policy and program issues has increased as well. Many states have used grant initiatives as an opportunity to establish goals, service and staffing standards, and define prototypes for replication. Table 3.2 categorizes the states according to their range of program guidelines.[166]

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[166]Making the Grade, 5.

Table 3.2

State Guidelines for School-Based Health Centers

Required/Suggested Guidelines[2]		In Development[3]	No Guidelines[4]	
Colorado	Michigan	Arkansas	Alabama	Nevada
Connecticut	Nebraska	Iowa	Alaska	New Hampshire
Delaware	New Jersey	Maryland	Arizona	North Dakota
Florida	New Mexico	Missouri	California	Oklahoma
Georgia	New York	Rhode Island	Idaho	South Carolina
Hawaii	Nonh Carolina	Tennessee	Kansas	South Dakota
Illinois	Ohio	Utah	Kentucky	Washington
Indiana	Oregon	Vermont	Minnesota	Wisconsin
Louisiana	Pennsylvania	West Virginia	Mississippi	Wyoming
Maine	Texas		Montana	
Massachusetts	Virginia			

1 With many states developing new school-based health center initiatives and other stales assessing and re-assessing their preferred models, all state guidelines might be considered "works in progress."

2 States in this category have either issued guidelines which must be complied with as a condition of stare funding or have developed guidelines that are recommended to communities bur are not a requirement for funding.

3 Some states that have funded school-based health centers using general guidelines are now clarifying their service standards and staffing requirements. These stares are moving towards an explicit comprehensive model. A number of states are elaborating several models for health services in school, ranging from limited services to comprehensive health centers. States thar have recently funded school-based health centers arc developing their initial standards by drawing upon the experience of older programs.

4 States that have not developed guidelines for school-based health centers either do not suppon centers or have a total commitment to local control.

TDH Guidelines

The Texas Department of Health (TDH) established a state level office, the School Health Program, in 1992. The office has required/suggested guidelines for all state funded programs. The standards are judged to be well-defined, comprehensive and well-utilized by communities in the development of school-based health center models. The guideline summaries are presented in Table 3.3.[167]

[167]Ibid, 6.

Table 3.3

State Guidelines for School-Based Health Centers,1994

TEXAS	Establish collaboration of families, schools and community; Assure medical home for student; Provide access for specialized medical care: Promote health and use of health systems.	Eligible providers may be civic or charitable organization, community health centers, public health agencies, hospital districts, school districts, medical schools, or private providers; Full support of school district must be evident.	At a site on or near school grounds.	Core services, which must be made available, include: maintenance of health record and health plan, screenings, exams, immunizations, diagnosis and treatment of simple illness and minor injuries, education and counseling, and mental health.	May be scheduled full or part-time: physician/ medical director or an appropriately trained licensed nurse practitioner under physician direction, mental health counselor; social worker, registered nurse, and clerk. The existing school health personnel and the SBHC staff work as a team.
TEXAS	Advisory council of parents, youth, churches, youth and family services, physicians, nurses, and other health care providers, business, school nurses, school administrators, and faculty to: set policy, identify services, oversee budget. evaluate program; assist in generating community resources.	General consent form that identifies all of the services available; Parent must be offered opportunity to identify specific services that they do not consent to being provided.	Must provide written agreement for provision of after hours and summer care; Must provide protocol for communicating with child's medical/ health provider; Must describe mechanisms for exchange of medical, social and financial eligibility information.	Must participate in statewide data collection, Must provide protocol for physician involvement in record review and consultation. State health department conducts technical assistance and quality assurance site visits	

Source: *School Health Programs Request for Proposals, 1994.*

Additional Requirements

States can require different guidelines and provide varying degrees of assistance depending on their population. TDH requires additional components and technical assistance worthy of discussion here.

Administrative

The office provides funds and technical advice but does not administer individual program sites. Each site is required to establish a governing board that is representative of the community.[168] Schools unable to allot physical space within the school building can establish health center sites adjacent to school property. Standards for off-site referral and community linkages ensure continuum of care beyond the programs' scope of services and operational hours. TDH requires that a mid-level practitioner with physician oversight lead the core staff in addition to mental health professionals being on staff. Standardized data collection is required.[169]

Eligibility

All students at all sites are eligible to receive services; however, each student must have a signed consent from his/her parent or guardian.[170]

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[168]Texas Research League, 100-102.
[169]Making the Grade, 2-11.
[170]Texas Research League, 102.

Funding

TDH funded programs are expected to seek additional funds from the following:

- sources that were pre-existent at the schools (e.g., the funds of agencies currently serving the schools);
- appropriate public programs (e.g., Medicaid EPSDT);
- private third party insurers;
- local financial support (e.g., actual dollars, services, or in-kind contributions); and
- a sliding-fee scale for families not Medicaid eligible and whose incomes are above 100 percent of the federal poverty level.[171]

TDH also details the specific requirement that SBHCs become Medicaid providers to ensure maximum recovery of federal and state dollars.[172] Literature suggests the pursuit of Medicaid reimbursement will become increasingly complicated by the recent growth in Medicaid management care programs. Such managed care programs require intensive contractual negotiations and may put additional strain and frustration on already overextended SBHC administrations. State governments are in the early stage of determining the appropriate relationship and, for the most part, are being developed at the local level.[173]

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[171]Ibid.

[172]Ibid, 103.

[173]Making the Grade Program, 18.

SITE SELECTION

Program sites throughout the state are funded by TDH through a competitive grant process. According to Nancy Sisler, School Health Consultant, Texas Department of Health, projects are selected using pre-established evaluation criteria (e.g., high number of impoverished/underserved students, inadequate number of Medicaid providers, availability of other community resources). As of October 1994, TDH funds nineteen programs.[174] Currently, there are no Austin area TDH funded programs.

Austin Independent School District

AISD's school health services can be grouped into three categories:

(1) traditional school. nurse services with a staff of approximately forty-five full/part time nurses, two clerical,coordinator of health services, and medical advisor all employed by AISD;

(2) AISD and Austin Health Department project of *school*-based health and social services at two elementary schools. Services provided include: well-child checkups including treatment referrals, immunizations for students and siblings, family service and case management upon school referral, and abuse-prevention classroom education. Staff includes two registered nurses and two community workers employed by City of Austin;

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[174]Nancy Sisler, Texas Department of Health, School Health Consultant interview by author, Office meeting, Austin, Texas, March 3,1995.

3a) AISD and the Austin Health Department project of *school*-linked preventive care started in January 1995 and rotates through twenty elementary schools. Services provided include well-child check-ups including treatment referrals, immunizations, and parent education about resources (to include identification of regular source of medical care). Staff consists of three teams each including a program manager, administrative community worker, and registered nurse. An administrative manager and community worker oversees the program. Each team goes into one school for one month; and

(3b) AISD, City Health Department and Brackenridge Foundation/Children's Hospital mobile health unit project will start in August 1995 and be stationed outside five (estimated) elementary schools one day per week. Services to be provided include well-child checkups, limited treatment conditions requiring medical intervention and assist families in securing health care providers. Staff will include a nurse practitioner and paraprofessionals.[175]

Eligibility

Certain eligibility requirements were required of those schools interested in the school health projects. Participating students required signed consent forms as well.

Schools

All thirty-one Chapter 1 elementary schools were considered for site selection using the following criteria:

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[175]Jan Ozias, AISD Health Services Coordinator, interview by author, Office meeting, Austin, Texas, February 17 and 24 1995; and Patsy Benavediz, City of Austin Health Department Community Outreach Program Coordinator, interview by author, Office meeting, Austin, Texas, March 10,1995.

- chronic absentee rate,
- immunization deficiencies,
- unnecessary outpatient visits to Children's Hospital Emergency Room in 1993 as evidenced by zip-code database,
- percentage of students on free/reduced lunch program,
- geographical barriers to community health facilities,
- campus administrator's demonstrated support for and capacity to successfully facilitate student health care, and
- active parent participation in school events.[176]

Students

All students are eligible to receive services provided a Health and Social Services Center Consent for Services is on file (see Appendix A). This form also contains a Consent to Share Necessary Information requirement at the bottom of page.

Liability

The literature strongly recommends that all SBHC partnerships be legalized through a binding contract or memorandum of agreement. This creates a formal structure and clarifies roles and responsibilities for all parties.[177]

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[176]Patsy Benavediz, City of Austin Health Department Community Outreach Program Coordinator interview, office meeting, and City of Austin Health Department Memo, March 10,1995
[177]Dryfoos, 150.

Local Partnership Agreement

The Interlocal Cooperation Agreement between Austin Independent School District and the City of Austin is the binding document by which duties and responsibilities are assigned.(see Appendix B) *Of special note is City Responsibility 4D which prohibits gynecological medical procedures as well as any other family planning services.

Standard Protocols

SBHC programs have a set of medical and social service guidelines consisting of specific protocols for the treatment of different presenting problems and issues. Chart documentation is required upon each encounter. Arrangement for back-up services which may or may not include emergency care and referrals is clearly identified. Provisions for outreach and follow-up are specified. Quality assurance site visits insure proper protocols are followed.[178]

Major Texas Statues

There are several major Texas Statutes which govern school health services. The Texas Health and Safety Code (Section 81.007) provides the most comprehensive liability protection. It states:

> A private individual performing duties in compliance with orders or instructions of the [Texas] department [of Health]

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[178]Nancy Sisler, interview and telephone conversation, March 17,1995.

> or a health authority issued under this chapter [8] is not liable for the death of or injury to a person or for the damage to property, except in the case of willful misconduct or gross negligence.[179]

The exception for "gross negligence" is common to most statues and is defined as acting with conscious indifference to the rights of others.[180]

The Texas Education Code (Sections 21.912 & 21.935) provides protection to employees and professional volunteers (physicians, RNs, LVNs, physician assistants and other licensed or certified health care professionals) when such duties are conducted under the auspices of a school district. It states:

> A professional employee will not be personally liable for any act involving the exercise of discretion which is incident to or performed within the scope of duty, except when he has used excessive force in the discipline of a student or negligence resulting in bodily harm to a student.[181]

Volunteers are also protected from liability for ordinary negligence in much the same way as school employees. Though it is not mandatory for RNs or LVNs to purchase additional professional liability insurance, it is advised.[182]

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[179]Texas Department of Health, The Liability Risk Associated With Immunizing Children, (Austin),4.

[180]Ibid, 26

[181]Ibid, 29.

[182]Nancy Sisler, interview, telephone conversation, March 17,1995.

Additional Statues

The Texas Tort Claims Act protects districts from all liability for negligence unless it involves the use or operation of a motor vehicle.[183] The Communicable Disease Prevention and Control Act and the Charitable Immunity and Liability Act provide additional immunity.[184]

It would appear that school districts, their volunteers and employees are well-insulted from liability law suits so long as they are acting within the scope of their duties and are not grossly negligent. Texas has an established policy of protecting schools and their volunteers. As a result, judgments against school districts and school personnel are nearly impossible to obtain.[185]

CONCLUSION

Public schools have been involved in the delivery of health and human services since the turn of the century. Many of the Progressive Era's school-based social reforms were reintroduced during the Great Society. These reforms characterized the belief that federal government should serve as the direct provider of care. The 1980s introduced a shift from federal and state implementation to one of city and county control. With this new approach, local municipalities and agencies have joined forces

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[183]Texas Department Health, 28.

[184]Ibid, 6.

[185]Ibid, 29.

with school systems. A number of program guidelines, state statues, and local contractual agreements provide liability protection to school health service providers.

The legal framework and literature review both point to the possibility of continued development of SBHCs. This research project's purpose is to review this service intergrated approach and to measure local attitudes and perceptions. The methodology used to examine these issues is presented in the next chapter.

CHAPTER FOUR

Methodology

This applied research project is a descriptive and exploratory study, utilizing survey research as the method for data collection. The purpose of this chapter is to describe the methodology used in addressing the research question. The strengths and weaknesses of the survey research and justification for using this method is examined. A discussion of the study population is included. The questionnaire development, survey design and methods of analysis are presented.

SURVEY RESEARCH

As a measurement and collection of relevant data, survey research is perhaps the most frequently used mode of observation in the social sciences.[186] Surveys are used in studies that have individuals as the units of analysis and is probably the best method available in collecting original data. Survey research is an excellent method for measuring attitudes and perceptions of a given population.[187]

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[186] Earl Babbie, The Practice of Social Research, (California: Wadsworth Publishing Company, 1992),147.
[187] Ibid, 163.

STRENGTHS AND WEAKNESSES OF SURVEY RESEARCH

Strengths

Surveys are particularly useful in describing a large population's characteristics. Through the use of a sample population survey, the researcher can make predictions about a larger population. A survey is the best vehicle for describing a large population (e.g., Austin Independent School District Principals and Area Superintendents).[188] Surveys are flexible giving the researcher an opportunity to ask many questions on a given topic, as well as allowing the researcher choices of analysis. Another survey research strength is the standardization by which questionnaires are designed. Each respondent is asked the same questions lending itself to an accurate and reliable measurement of a population. Finally, surveys make a large sample size feasible, which is important in descriptive and exploratory research.[189]

Weaknesses

While standardization is regarded as a strength it also represents a weakness in survey research and does not always lend itself to the finding of commonalties among individuals. Surveys often appear superficial and may not address the context of social life. Flexibility can also be a weakness of survey research because the researcher is fixed into a rigid design, not

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[188]Ibid, 262.

[189]Ibid, 278.

allowing new variables to be included if needed. Finally, survey research is weak on validity. The artificiality of the instrument forces respondents to indicate in a standard format and may not be a valid measure of individuals opinions.[190]

While taking into consideration both the strengths and weaknesses of survey research, this project used a self-administered questionnaire to gather responses from principals and area superintendents on their attitudes and perceptions of school-based health centers.

<u>Self-Administered Questionnaire</u>

Mail surveys are the typical form of self-administered survey. It is an instrument completed by the respondent, not an interviewer. Generally the mailed distribution contains the following: a cover letter explaining the project, the questionnaire and a self-addressed stamped return envelope. A short follow-up reminder is suggested.[191]

POPULATION AND SAMPLING ISSUES

The sampling frame consisted of a list of AISD principals and area superintendents. Surveys were mailed to 103 principals (eleven high school, fifteen middle/junior high, seventy elementary and seven special centers) and seven area superintendents. No attempt was made to sample a particular type

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[190]Ibid, 163.

[191]Ibid, 263-64.

of administrator; thus, the data represents a range of principals and area superintendents. (Appendix 3 includes a copy of the cover letter used to explain the project and the survey instrument. A self-addressed, stamped envelope was also included with the questionnaire.) The surveyor contacted AISD Research and Evaluation Department to determine the mailing options available in the district: (1) home addresses, (2) school addresses, or (3) official inter district distribution only after a proposal review ninety days prior to mail out. Because of time constraints, the third option was ruled out. Upon discussion, the department director expressed concern that AISD administrators were over surveyed and schools were over burdened with mail. He went on to state that response rates were sometimes poor for this group. The surveyor choose the home mail out using the 1994 AISD Directory, hoping that home addresses would result in at least fifty responses. A follow-up post card was sent two weeks later to encourage response.

QUESTIONNAIRE DEVELOPMENT AND SURVEY DESIGN

The self-administered survey was designed to reveal the attitudes and perceptions of Austin Independent School District principals and area superintendents regarding school-based health centers. The questions were developed from a descriptive study of the literature and exploratory interviews with local school health experts. This triangular approach included extensive literature research and personal interviews which allowed the

researcher to address a broad range of historical, attituainal and behavioral issues.[192]

Questionnaire Development

Questions were developed from the literature and interviews. Early in the survey's development, conversations (office and telephone) were held with the ASID Health Services Coordinator, City of Austin Health Department Community Outreach Program Coordinator, and Texas Department of Health, School Health Consultant. The surveyor sought to gain a clearer understanding of the district's knowledge of the subject. The questions focus on five key concepts as illustrated in Table 4.1.

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[192]Robert K. Yin, Case Study Research.(California:Sage Publications Ltd., 1994),92.

Table 4.1

Key Concepts and Question Items

Key Concepts	Questionnaire Item
Collaboration of Health and Educational Institutions	1,3,23,24
Student and School "Community" Needs	2,4,5,6,14
SBHC Characteristics	7-12,13
Administrators' Philosophy and Support of SBHC Approach	15-21
Barriers and Obstacles	22
Demographics	25-30

A copy of the survey is contained in Appendix C.

Survey Design

The survey contained thirty questions and was designed to capture both qualitative and quantitative information through the use of closed-ended, forced choice, and open-ended questions. Eighteen questions were answered on a five point Lickert scale (2 = always true, 1 = sometimes true, 0 = neutral, -1 = seldom true, and -2 = never true). Nine questions were answered from a provided list of attributes. Three open-ended questions allowed respondents to answer in a less structured narrative form. The demographic questions were placed at the end of the survey. According to Babbie, at first glance potential respondents should

not be discouraged by being asked to reply to the most sensitive questions early on.

Before the survey was sent out to AISD administrators, a pre-test was given to the AISD Health Services Coordinator and three outside principals. Each reported that the instructions were clear, although some suggestions were made regarding terminology. Those modifications were made.

ANALYSIS OF SURVEY DATA

The responses were summarized using an overall mean rating, percentages per category, and essay form. Tables were developed to illustrate the results of the survey. These findings and interpretations are presented in Chapter Five.

CHAPTER FIVE

Research Results

The purpose of this chapter is to present the results of the research. The response rate, survey results and analysis of the responses are discussed using both a quantitative and qualitative approach. The administrators' attitudes and perceptions toward school-based health centers is the focus.

SURVEY RESULTS

The surveys were mailed to 103 Austin Independent School District Principals and seven Area Superintendents, and 26 (25.2%) were returned. Because of the response, the generalizability of the results is low. However, of those responding, the responses and comments suggest high interest in the topic. The results are grouped into five categories which assess administrators attitudes and perceptions. Summary discussion and comments to the open-ended questions are included within each category. The demographic data are presented separately.

Demographic data

Demographic characteristics of the respondents are presented in Table 5.1. The distribution is given according to the grade level of the principal's school, gender, age, racial/ethic group, level of educational attainment, and years as school

administrator. There were significantly more female (73 %) than males respondents.

Table 5.1
Characteristics of Survey Respondents

(n=26)

Characteristic	Elementary School	Middle/ Junior	High School	Special Center	Area Supt.
Gender					
Female	13	3	1	1	1
Male	3	2	1		*1*
Age Range	40-60	44-59	46-47	52	53-61
Racial/ethnic group					
American Indian					
Asian/Pacific American					
Black/African American	2	1			
Mexican American/ Chicano	4	2			1
Other Hispanic/ Latin American					
Puerto Rican					
White	10	2	2	1	1
Other					

Level of Educational Attainment					
Masters	12	3	1	1	1
Doctorate	4	2			1
Post Doctoral			1		
Years as School Administrator					
<5 years					
5 to 10 years	8	1	1	1	
11 to 20 years	6	3			
21 to 30 years	1		1		2
>30 years	*1*				

Collaboration of Health and Education

This section indicates administrators' attitudes toward health and education collaboration as presented in Table 5.2 The means were above 1 which indicates respondents overwhelmingly agree in the need for collaborative partnerships. They agree education and health are intertwined, and SBHCs have the ability to bring education and health and human services together.

Table 5.2
Collaboration of Health and Education

Overall Mean Ratings (n=26)

Education and health intertwined	1.44
SBHC are effective collaboration between education health human services	1.6

The open-ended questions ask for suggestions in creating partnerships. With the first question, ten respondents agreed services should be "brought to where the children are" through SBHCs on or near campuses. Five suggested the school building serve as "community depots" which would act as satellite service providers contributing to the well being of the entire community not just the insured and paying. Four respondents narrowed their comments to address the student individually by suggesting: use a case management approach in the school; increase emphasis on the whole child; and medical history services should be updated and included in each individual educational plan. Only one respondent disagreed with the idea of health and education collaboration.

The second question asked for suggestions in bridging the gap between education, health and human services. Seven respondents suggested more open honest dialogue between community service agencies and schools. Six proposed that medical personnel which might include nurse practitioners, social workers and more mobile health units be placed on campus for the entire day. One suggested health services be included in the mission statement of the school district and backed with necessary funding. One respondent remarked that a joint community task force should be the minimal approach, and mandated state legislation would be the maximum. It was suggested that turf issues be settled between school personnel and services agencies. One response suggested showing "naysayers" the positive results of service integration.

Student and School "Community" Needs

Administrators' perceptions regarding student and school "community" health needs are presented in Tables 5.3 and 5.4. As shown in Table 5.3, they agree school "communities" need a more comprehensive health delivery system for children (with a mean over 1), while the mean rating of individual student health needs was not as high.

Table 5.3
Student and School "Community" Needs

	Overall Mean Ratings (n=26)
In my "community" children need a more comprehensive health delivery system	1.19
Complex needs of student make intellectual and health development difficult	.83
My students health status worsening	.54

Table 5.4 indicates the range of services needed by students. Mental health counseling and social services were viewed as the most important with over 80% of the respondents agreeing. Acute, chronic and preventive medical services were rated high with over 75% responses. The need for dental services was significant (73%). The prescribing and dispensing of medications as well as the need for laboratory testing were listed as key components (61%). Those services dealing with

human sexuality were not viewed as important. However, this rating is possibly due to the high response of elementary grade principals and is not viewed as relevant to their age group of students.

Table 5.4
Services most needed by students

Survey Items	Percent That Agree (n=26)
Mental Health and Social Services	
Social services	84.6%
Group and/or family counseling	80.8%
Student crisis intervention	69.2%
Mental health assessment	65.4%
Student counseling	65.4%
Medical Services	
Preventive medical services	76.9%
Care of acute illnesses/injuries	76.9%
Management of promotion	73.1%

Service	Percent
Dental Services	
Medicines and Laboratory Tests	
Basic laboratory tests	65.4%
Prescription of certain medicines	61.5%
Dispensing of certain medicines	57.7%
Human Sexuality	
Pregnancy prevention	42.3%
Pregnancy testing	30.8%
Prenatal care	30.8%
Testing/treatment sexually transmitted diseases	30.8%
Other	
Special needs of multiply-disabled	11.5%

The open-ended question in this section allowed for additional comments. Those specific services not included in the list above were: counseling for students of divorced parents, counseling for problems directly related to poverty, teenage drinking and drug abuse.

SBHC Characteristics

Administrators overwhelmingly agreed that SBHCs have the effective characteristics to improve the health status and well-being of children. All means were well above 1 and close to the maximum rating of 2 (range of 1.88 to 1.54).

Table 5.5
SBHC Characteristics

Characteristics	Overall Mean Ratings (n=26)
Health care becomes more accessible to students	1.65
Helpful for children of poor families	1.85
Improves delivery for Medicaid eligible children	1.73
Helpful for children with no health insurance	1.88

Provides "medical home" establishing continuity of care	1.54
Improves educational performance by addressing unmet health needs	1.81

Factors Important in Deciding to Host SBHC

Table 5.6 indicates those factors administrators consider to be important in deciding to host a school-based health center. Those issues directly affecting the child were considered most important. Nutrition and health issues (e.g. number of students on federal school lunch program, high rate of medical problems, and inadequate physician coverage) were most often cited. Those issues related to family dysfunction (e.g. high incidence of child abuse/neglect and school truancy/dropout) were the second most cited. Although, support from parents and school administration was listed as important, it did not appear to be the deciding factor regarding SBHC adoption. Interestingly, respondents did not consider juvenile crime to be much of a factor. Perhaps crime is viewed as more of a community issue only indirectly affecting individual children. Other factors respondents included in the list were inappropriate emergency

room visits, inadequate clinic coverage in school "community", and chemical dependency within school.

Table 5.6
Factors important in deciding to host

Survey Items	percent of total(n=26)
Factors Directly Affecting Children	
Nutrition and Health	
Students on Federal School Lunch Program	91.7%
High rate health related problems	91.7%
Inadequate physician coverage in community	75.0%
Family Dysfunction	
High rate absenteeism truancy and dropout	83.3%
High incidence of child abuse/neglect	79.2%

Evidence of Support	
Evidence of school district support	70.8%
Evidence of parental and community - based support	62.5%
Community at Large	
High incidence juvenile crime in community	54.2%
Other	12.5%

Philosophy and Support

The mean ratings given in Table 5.7 indicate that administrators strongly agree that principal, teacher/staff, and parental support is crucial to the adoption of the SBHC approach. A mean rating of .04 reflects their neutrality regarding the idea that traditional school nurses are underutilized. They do not believe that a school's function should be limited to academic instruction, nor do they believe that the procurement of children's health services lies solely with the family.

Table 5.7
Administrator's Philosophy and Support

Perceptions	Overall Mean Ratings (n=26)
Principal's support and involvement critical to adoption of SBHC	1.65
Parental support crucial to establishment of SBHC	1.5
Teachers and staff connective links between student and center	1.42
School nurses are underutilized resources	.04
Schools function should be limited to academic instruction	-.88

Responsibility for procurement of health and human services lies solely with family	-.69
Schools have role in coordinating service delivery efforts	.54

Barriers and Obstacles

In Table 5.8, the results of those factors considered to be SBHC barriers and obstacles are presented. The responses were weighted; three times the number one responses, two times the number two responses and one times the number three responses. The numbers were totaled to reflect a ranking. The administrators overwhelmingly agree that human sexuality issues are the greatest obstacles for SBHCs. Reproductive health ranked first, and AIDS prevention ranked second. At first glance, these results may seem contradictory to the previous question regarding student reproductive health care needs. However, the earlier question related to individual student needs as perceived by administrators at the local level. These factors represent obstacles affecting the SBHC approach at-large. The third ranked factor was parental consent which can be related to a variety of controversial isssues.

Table 5.8
Barriers and Obstacles

(1st being the most controversial)

Issues	ranked 1st	ranked 2nd	ranked 3rd	weighted scores
Reproductive heaith issues	12	3	0	42
AIDS prevention	3	7	0	23
Parental consent	1	5	4	17
"In house" liability questions				15
Lack of adequate space	1			12
Unstable funding sources	2	2	1	11
Other	2	0	0	6
Student confidentiality	0			
Family privacy	0			
Turf issues between school personnel and service aqencies		1		

The next chapter summarizes the research and compares the survey results to the literature. Recommendations are offered as well.

CHAPTER SIX

Summary and Conclusions

The purpose of this applied research project was three fold. First, a study of the current literature provided a descriptive outline of the emerging school-based health center concept. In addition, exploratory discussions with local school health experts furnished insight into the local level of knowledge and understanding of the intergrated approach. Second, the attitudes and perceptions of Austin Independent School District Principals and Area Superintendents regarding school-based health centers were assessed. Third, the results of the survey were compared to the literature research. This chapter will summarize those findings and provide recommendations.

Collaboration of Health and Education

Traditional settings which once strictly separated education and health have been challenged by the alarming statistics regarding the health status of children. Child policy experts and reformists are calling for the cooperation among institutions and the integration of services. AISD administrators appear to understand the necessity for collaborative efforts and agree that children's issues must be addressed through an integrated approach.

Student and School "Community" Needs

The needs of AISD students as perceived by principals and area superintendents are comparable to those presented in the literature. Mental health and social service needs were those most cited. Medical and dental services were often mentioned. The needs of local students appear to be consistent with those on the national level.

School-Based Health Center Characteristics

The literature considered certain attributes to be essential in the delivery of effective school health services: accessibility, acceptability and affordability. Administrators agreed that SBHCs have the potential to effectively address these issues and ultimately improve the health status of children.

Administrators' Philosophy and Support of SBHC Approach

Child health policy makers contend local administrative philosophy sets the tone for the development and implementation of the SBHC approach. AISD principals and area superintendents agreed. They extended that support system to include teachers/staff and parents.

Barriers and Obstacles

Research suggests that most SBHC controversy centers around certain issues. Human sexuality topics, including birth control and AIDS prevention, cause the most conflict. Local

administrators overwhelmingly agreed. The literature points to the problem of stable and long term funding as well.

Conclusions and Recommendations

The school-based health center approach is not the cure-all for children's health. SBHCs can not address all of the complex and inter related problems affecting our nation's youth. However, they do offer an exciting and promising model by which critical issues can be addressed. Alarming national, state and local statistics point toward a sense of urgency. It is within this context, in addition to the survey responses of AISD administrators, that the following recommendations are made:

- Conduct a through student needs assessment of each school. Not all school populations and "communities" have the same problems.

- Establish a strong school coalition prior to start-up. The coalition should include principals, parents, local school community leaders, existing school nurses, teachers, counselors and school support staff.

- Develop a clearly defined mission and set of goals which would include; scope of services, program protocol, staff responsibilities and liability issues.

- Develop and implement an effective evaluation tool Emphasis should be on outcomes not outputs.

It is hoped that some of these findings and recommendations will prove worthwhile in local efforts to improve the health status and the well-being of Austin Area students.

Si es necesario, usredpuede obtener esra forma en español en la oficina de la escuela.

HEALTH AND SOCIAL SERVICES CENTER.
CONSENT FOR SERVICES

1994-1995 SCHOOL YEAR **1995-1996** SCHOOL YEAR **1996-1997** SCHOOL YEAR

Dear Parent or Guardian:

The City of Austin Health and Human Services Department can provide free health, counseling and social services in addition to those of Austin Independent School Disuict at our school. The new services are listed below. To use these services you MUST fill out and sign this form for each of your children at school. First, choose ONE of the following three options:

CONSENT TO RECEIVE SERVICES

1. _____ NO, I do not want my child to receive any of the services.
2. YES, I want my child to be able to receive any of the services, if needed.
3. YES, I want my child to be able to have some services.

If you checked option #3 and want just some services for your child, please indicate those below:

SERVICES AVAILABLE ARE:		I DO want:
a.	Well child check-ups and Early Periodic Screening, Diagnosis. and Treatment (EPSDT) physicals.	a. _____
b.	Assist families in finding medical resources.	b. _____
c.	Immunization shots (vaccinations) - need consent form for each shot.	c. _____
d.	TB skin tests and blood tests to detect problems such as anemia and high blood pressure.	d. _____
e.	Counseling about individual health and safety. puberty, personal responsibilities and decision-making.	e. _____
f.	Assess your child for health problems (i.e. earache, sore throat, skin rash) and refer when necessary	f. _____
g.	Counseling about problems at school and home.	g. _____
h.	Group activities to build skills in communication and making decisions.	h. _____
i.	Home visits with family.	i. _____

_______________ Parent/Guardian Signature _______________ Print Parent/Guardian Name _______________ Dale

_______________ Print Child's Name _______________ Birth Date _______________ Grade _______________ Child's Teacher

****

CONSENT TO SHARE NECESSARY INFORMATION

I give permission for sharing of information about my child, only if needed, among the staff of the Austin Independent School District, the City of Austin Health Services Team, and School-Linked Services in my child's school.

I give permission to the staff to make referrals, if needed, to other service agencies. I know that information about services for my child may be included in statistical reports, like those to evaluate the program and identify community needs. Such reports will not identify my child or family by name.

I know my consent for any of the above action is voluntary and can be withdrawn at any time by notifying school personnel.

_______________ Parent/Guardian Signature _______________ Dare

5/94

INTERLOCAL COOPERATION AGREEMENT BETWEEN TIN I IDEPENL EN I SCHOOL DISTRICT AND THE CITY)F AUSTIN TO PROVIDE HEALTH AND SOCIAL S] TO CHILDREN

The parties to this Interlocal Cooperation Agreement ("Agreement") are the Austin Independent School District ("AISD") and the City of Austin ("City").

WHEREAS, AISD and the City provide services to children within their respective areas of authority and jurisdiction; and

WHEREAS, the City provides primary health care services and social services to children who attend AISD schools and are educated by AISD; and

WHEREAS, in order to make available additional health care to children the City has requested AISD to provide space so that children may be provided certain health care and social services in close proximity to where they are being educated; and

WHEREAS, AISD has available certain space which may be used by the City for provision of health care and social services without interference with the provision of education to children; and

WHEREAS, AISD and the City desire to cooperate to make available health services and social services to children:

NOW, THEREFORE, the parties to this Interlocal Cooperation Agreement agree as follows:

1. Provision of Space. AISD shall provide to the City certain space in the elementary school(s) as determined by local campus principals and City agreement. The location of the space may be changed and additional space may be added from time to time by revisions agreed to by the representatives of the local campus. The space shall be hereinafter described as the "Provided Space."

2. Charges and Expenses. AISD has available existing space and the expenses incurred by AISD in providing the Provided Space will be minimal. In consideration of the benefits to AISD students by the City pursuant to this agreement and of the resulting benefit to the educational process in AISD, AISD shall make no charge for the Provided Space. The City shall be responsible for its activities in the Provided Space, including the provision of equipment and furnishings necessary to carry out the health services and social services.

3. AISD Duties. AISD shall have the following duties under this Agreement:

   A. Make the Provided Space available and accessible.

   B. Provide customary services such as electricity, water, heat, air conditioning, light, staff restrooms and janitorial services to the Provided Space.

   C. Designate the dates and times when the Provided Space will be available for use by the City.

4. City Responsibilities. The City will be responsible for the following:

   A. Inspect the Provided Space and determine, at the City's sole discretion, whether it is suitable for providing health services.

B. Provide services, as agreed to by the local campus principal and City, with City staff who may include a community health nurse. a social worker, a licensed mental health counselor, a clerical support person, ouaeach worker (to include volunteers) and other appropriate health care providers (to be defined as a dentist and a nurse practitioner or physician's assistant)

C. Provide preventive and primary health care and social services appropriate for children including:

(a) developmental assessment
(b) immunization
(c) well child assessment
(d) treatment for illness under City medical protocol
(e) referral for specialized care and non-protocol illness
(f) supplemental health related instruction and program
(g) home visitation as necessary

D. No health services or social services under this Agreement other than the types set out in this Agreement will be performed by the City. Specifically, no gynecological medical procedures, or birth control services, including referrals for abortion or provision of birth control devices, will be performed on site, and all referrals will be made after no cation and consent of parents or guardians, except as otherwise required under federal or state law.

E. Provide health services and social services only after informed parental consent

F. Provide services only for students and the students' siblings from the attendance area of the school where the Provided Space is made available. An exception is those services necessary for other household members that may directly affect the student

G. Be responsible for all employees, volunteers or agents of the City and others, excluding AISD employees, providing health related services in the Provided Space.

H. Be responsible for all medical waste and sanitation prior to and after provision of health services.

5. **Independent Entity and Acknowledgment of Responsibilities.**

A. Independent Entity. The parties expressly acknowledge and agree that City and AISD are independent entities and each assumes all the rights, obligations, and liabilities applicable to it as an independent entity. No employee of the City shall be considered an employee, agent, or representative of AISD. No employee of AISD shall be considered an employee, agent, or representative of the City.

B. City Responsibilities. City acknowledges that as between City and AISD, to the extent City has liability under applicable law, City is solely responsible for any claims or losses from personal injury, death, or property damages that are caused by the acts of omissions of the City or its employees, agents or representatives. regardless of whether the claims or losses arise as a result of claims by parties to this Agreement or external parties. City shall not assume any liability whatsoever for any claims or losses from personal injury, death, or property damage that are caused by the acts or omissions of AISD, its employees, agents, or representatives, and

does not waive the provision of the Texas Ton Claims Act by entering into this agreement with AISD.

C. AISD Responsibilities. AISD acknowledges that as between City and AISD, to the extent AISD has liability under applicable law, AISD is solely responsible for any claims or losses from personal injury, death, or property damages that are caused by the acts of omissions of AISD or its employees, agents, or representatives, regardless of whether the claims or losses arise as a result of claims by parties to this Agreement or external parties. AISD shall not assume any liability whatsoever for any claims or losses from personal injury, death, or property damage that are caused by the acts of omissions of the City, its employees, agents, or representatives.

6. Termination. This Agreement or the use of any Provided Space shall be terminated by either party, without cause, upon thirty (30) days written notice to the other party, at the address listed below.

7. Responsibility for Health Services. The parties agree that no AISD employee or AISD volunteer shall provide health or social services outside their own job description. All health services contemplated by this Agreement shall be provided by the City and the City shall be fully responsible and liable for the provision of all such services. The City shall have the responsibility of securing informed parental or guardian's consent. Because the City is fully responsible for the provision of health and social services, the City agrees that in the event AISD is named in any claim or litigation regarding the provision of health and social services by the City, the City Law Department will provide legal counsel to defend AISD, its Trustees, officers, employees and volunteers in cooperation with AISD legal counsel. The parties agree that they shall cooperate with each other in the coordination of health care services through assessment, referral and case conferencing.

8. Access to Records. After parental or guardian informed consent, AISD shall provide to City employees access to student records, including information regarding parent or guardian's address and telephone numbers.

9. Disclaimer of Warranties. AISD makes no warranty to the City or to any person or the parent or guardian of the person to whom health or social services are provided as to fitness of purpose for intended use of the Provided Space, habitability of the Provided Space or suitability for intended use of the Provided Space. AISD specifically disclaims any and all warranties of any type, express or implied, regarding the Provided Space.

10. Term of Agreement. This agreement shall be in full force and effect as of the _______ day of ________________, 19 ___, and shall continue thereafter for an indefinite term, bur either party hereto shall have the right to terminate the same on any anniversary date hereof or at the end of any fiscal year, upon giving notice in writing to the other party not fewer than thirty (30) days prior to the date of termination, or the same may be terminated at any time by mutual consent.

11. Application of Law. This Agreement shall be governed by the laws of the State of Texas and venue for any litigation concerning this agreement shall be in the City of Austin, Travis County, Texas. If a final judgment of a court of competent jurisdiction invalidates any part of this Agreement, then the remaining part shall be enforced to the extent possible consistent with the intent of the parties as evidenced by this Agreement.

12. Survival. Conditions and covenants of this Agreement which by their terms are performable after the termination, expiration or end of this Agreement shall survive such

termination, expiration or end and remain fully performable.

13. **As[illegible].** Neither party shall assign, sublet or aansfer its interest in this Agreement without the prior written consent of the other.

14. **Address for Notice and Representatives of the Parties.** The address for notice for the parties and the representatives of the parries are as follows:

City of Austin
Health & Human Services Department
2100 E. St. Elmo, Bldg. E
Austin, Texas 78744-1886

Austin Independent School District
1111 West 6th Street
Austin, Texas 78703

Representative

Representative

The names of the representatives and the addresses of the parries may be changed by written notice from one party to the other.

15. Legal Obligations. Nothing herein shall alter the duty of the parties to comply with applicable requirements of law.

16. **Nondiscrimination.** City and AISD shall provide all services and activities required by this Agreement in compliance with the Americans with Disabilities Act of 1990. City and AISD shall not discriminate against any person based on race, religion, color, sex, national origin, age, or disability.

17. Formal Process. Any change to the provision of this Agreement or any attachments to it shall be made in writing and signed by both parties after approval by the City Council and the Board of Trustees.

18. **Entire Agreement. All** oral and written agreements between the parties to this Agreement relating to the subject matter of this Agreement that were made prior to the execution of this Agreement have been reduced to writing and are contained in this Agreement Any agreement, covenant or understanding that is not included in this document has been superseded by this Agreement

CITY OF AUSTIN

By: ______________________

AUSTIN INDEPENDENT SCHOOL DISTRICT

By: ______________________

January 16,1995

Dear Austin ISD Principal/Area Superintendent;

I am a graduate student at Southwest Texas State University, pursuing a Masters of Public Administration. Because of my interest in education and health, I have chosen the topic of School-Based Health Centers for an applied research project. I am conducting a survey of AISD Principals and Area Superintendents for the purpose of determining local administrative perceptions toward this collaborative movement.

This research project is not connected with your school district but rather is an independent graduate student's project. I would appreciate your cooperation in answering this survey. Every response and comment is important. Your reply will be anonymous.

Please return the questionnaire using the stamped envelope at your earliest convenience but no later than March 10. Thank you.

Sincerely,

Deborah Durham
17842 Park Valley Drive
Round Rock, TX 78681
521 244-2302

If you would like to receive summary of the survey results, please provide your mailing address below and return this letter with the survey.

____

____

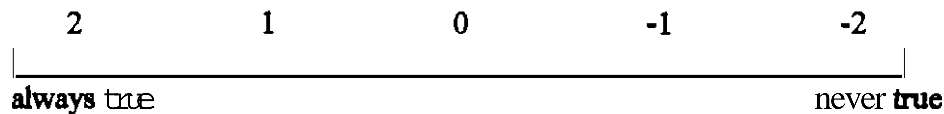
____

SURVEY OF PRINCIPALS and AREA SUPERINTENDENTS

For the purpose of this survey only, the definition of a "school-based health center" : space set aside on a school campus where services delivered by one or more heath and human service agencies are co-located and coordinated with school personnel.

Thank you for taking time out of your busy schedule to answer this survey.

Please circle your response using this scale.



Collaborative Effort

1. Education and health are inextricably intertwined.
   2 1 0 -1 -2
2. The complex needs of today's student make it increasingly difficult to promote intellectual achievement and healthy development.
   2 1 0 -1 -2
3. School-based health centers can be an effective collaboration between education, health and human services.
   2 1 0 -1 -2

School and Community Needs

4. As a whole, I see the health status of my students worsening.
   2 1 0 -1 -2
5. In my school "community", I see the need for a more comprehensive and effective health care delivery system for children.
   2 1 0 -1 -2
6. What factors are important in deciding whether or not to host medical and social work services on a school campus?
   - number (%) of students on Federal School Lunch Program
   - strong evidence of parental and community-based support
   - strong evidence of school district support
   - ____ school "community" has inadequate physician coverage
   - ____ school has high rate of health-related problems (e.g. teen-age pregnancy, substance abuse, mental disorders)
   - ____ high rates of school absenteeism, truancy, and dropout
   - echool "community" has high incidence of juvenile crime
   - school has high incidence of child abuse/neglect
   - other (please be specific)

   ____

   ____

SBHC's Characteristics

7. School-based health centers make health care more accessible and convenient for students.
   2 1 0 -1 -2
8. School-based health centers are helpful for children living in poor families.
   2 1 0 -1 -2
9. School-based health centers can improve service delivery for Medicaid-eligible children.
   2 1 0 -1 -2
10. School-based health centers are especially helpful for children with no heatth insurance.
   2 1 0 -1 -2
11. School-based health centers can provide students with a "medical home" establishing continuity of care.
   2 1 0 -1 -2
12. School-based health centers can improve student's educational performance by addressing unmet health care needs.
   2 1 0 -1 -2
13. Please indicate those services which are needed by your school population:
   ____ preventive medical services (e.g. anual checkups)
   care for acute illnesses/injuries (e.g. ear infections)
   management of chronic medical problems
   ____ prescription of certain medicines
   ____ dispensing of certain medicines
   ____ basic laboratory tests (e.g. strep throat cultures)
   mental health assessment/referral/coordination of outside services
   student counseling
   ____ group and/or family counseling
   student crisis intervention
   ____ health education/promotion
   social services (e.g. enrollment in)
   dental services
   pregnancy testing
   ____ pregnancy prevention
   ____ prenatal care
   testing/treatment for sexually transmitted diseases
   ____ other (please be specific)
   ____
   ____
14. What do you consider to be the most serious unmet medical and/or psychosocial care needs of your students?
   ____
   ____
   ____
   ____

Philosophy and Support

15. The function of schools should be limited to academic instruction.
    2 1 0 -1 -2
16. Responsibility for the procurement of health and human services lies solely with the family.
    2 1 0 -1 -2
17. Schools have a role to play in coordinated service delivery efforts.
    2 1 0 -1 -2
18. Principals' support and involvement is critical if the school-based health center concept is to be adopted.
    2 1 0 -1 -2
19. Parental support is crucial to the establishment of school-based health centers.
    2 1 0 -1 -2
20. Teachers and school staff can be connective links between the students and the center.
    2 1 0 -1 -2
21. Presently, school nurses are underutilized resources in the delivery of health care.
    2 1 0 -1 -2

Barriers and Obstacles

22. Please rank what are considerd to be the most controversial issues surrounding school-based health centers:
    (# 1 being the most controversial)
    ____ AIDS prevention
    ____ family privacy
    ____ "in house" liability questions
    ____ lack of adequate space
    ____ unstable funding sources
    ____ parental consent
    ____ reproductive health issues
    ____ student confidentiality
    ____ turf issues between school personnel and service agencies
    ____ other (please be specific)

    ____
    ____
    ____

Comments/Suggestions

23. Describe what you believe an ideal partnership might be between health care providers and educators?

    ____
    ____
    ____
    ____
    ____

24. What do you think could be done to bridge the gap between educational, health and human service institutions as each works to improve the wen-being of children.

____
____
____
____
____
____

Demographic Data (optional)

25. What is your gender?
____ female
____ male

26. What is your age?
____

27. Are you?
____ American Indian
____ Asian/Pacific American
____ Black or African American
____ Mexican American or Chicano
____ Other Hispanic or Latin American
____ Puerto Rican
____ White
____ Other

28. What is your level of educational attainment7
____ Masters ____ Doctorate Post Doctoral

29. How many years have you been a school administrator?
____ < 5 years
____ 5 to 10 years
____ 11 to 20 years
____ 21 to 30 years
____ > 30 years

30. You are a principal at what grade level?
____ elementary school
____ middle/junior high school
high school
____ special center

If you would consent to a personal interview regarding your attitudes and perceptions of school-based health centers, please provide your name, address and phone number below.

____
____
____

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