

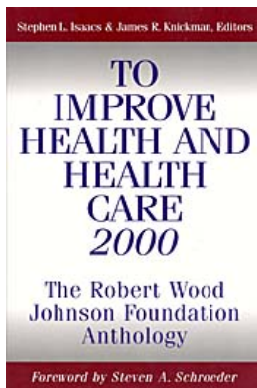
School-Based Health Clinics

BY PAUL BRODEUR



Robert Wood Johnson Foundation

Chapter One,
excerpted from the Robert
Wood Johnson Foundation
Anthology:
**To Improve Health
and Health Care,
2000**



Edited by
Stephen L. Isaacs and
James R. Knickman
Published 2000

Editor's Introduction

In this chapter, Paul Brodeur, a former staff writer for the *New Yorker* who specializes in environmental and health issues, tells the story of the Foundation's 25-year-plus involvement in school-based health clinics. These clinics bring a wide range of health care services to students in the place where they spend most of their days—the school building.

Schools are a logical place to provide care and referrals for young people because of their convenient location and because students feel more comfortable seeking health care advice—especially mental health counseling—from people there. Moreover, health education efforts can be directly targeted to meet the needs of students, and teachers who observe health problems in students can refer them to an in-house health professional. It is not surprising, therefore, that health clinics are now found in many schools throughout the country. According to a recent report, there are more than 1,100 school-based health clinics in the United States.

Despite their growing acceptance, school-based clinics can be controversial. The interest of some clinics in providing counseling about safe sex or distributing birth control methods sparked early resistance in some communities. Brodeur looks at the opposition in Dade County, Fla., and in San Fernando, Calif., and how, eventually, it was overcome. Ironically (and sadly), an evaluation of the School-Based Adolescent Health Care Program found that the clinics were successful in spreading awareness about health issues and risky behaviors, but this knowledge did not translate into less-risky behaviors nor did it affect sexual activity.

The Foundation's involvement in school-based clinics evolved from experimentation through establishment of clinics offering a broad range of services to the terrain of attaining long-term viability. In many ways, the challenges of finding long-term financing have turned out to be as difficult as the design challenges in the early years. School-based health clinics, like most community-based health programs, have needed to piece together funding from multiple sources. Moreover, the growth of managed care—and the growing number of state governments that have made arrangements with managed care plans to cover their Medicaid populations—has complicated financing as school-based clinics must now contend with a dizzying array of managed care plans to ensure that services provided by their clinics will be covered.

At an elementary school in Connecticut, an eight-year-old third-grader who has seen his father beat his mother and has a history of violent behavior tells a lie in class and is given detention. Soon afterward, he tries to hang himself when his parents, who are getting a divorce, seek to punish him for the infraction by refusing to let him play on a Little League baseball team. After being treated as an outpatient at a local hospital, he returns to school and starts seeing a social worker at the school health center. The social worker tries to help him recognize the kind of emotionally charged incidents—such as when he sees his brother hit his sister—that trigger violence and depression in him. The idea is that by so learning he will be able to cope with stressful situations and take charge of his life as he grows older.

In California, a suicidal 15-year-old tenth-grader tells a therapist at her school health center something she has never revealed to anyone: at the age of three she was raped by an uncle and two cousins who were living in her parents' home. At first she is deeply reluctant to disclose the names of her abusers, out of fear that she will get them in trouble and thus incur the wrath of her mother and father, both of whom have beaten her over the years. After talking with the therapist, however, she is persuaded, to her great relief, to identify her attackers. She then decides to join one of the health center's sexual-abuse therapy groups, where, in the company of girls who have experienced similar trauma, she comes to understand that what was done to her was wrong and not in any way her fault. As a result, she gains self-respect and self-esteem.

Intervention in psychological problems of such magnitude may come as a something of a shock to those who remember health care in school as amounting to little more than the school nurse excusing feverish kids from gym and advising them to see their family doctor. The fact is, however, that school-based health centers equipped to diagnose and deal with mental health problems, as well as with drug abuse, teenage pregnancy, sexually transmitted diseases and myriad ordinary physical afflictions are springing up across the nation. During the past 12 years, more than 1,100 health centers have been established in high schools and elementary schools in 45 states and the District of Columbia. Approximately one in 10 of them either have been supported or are being supported with the aid of grants from the Robert Wood Johnson Foundation, which has been a pioneering force behind the idea that health care can be delivered to children and adolescents most effectively where they most easily can be found—in the nation's schools.

ROOTS OF SCHOOL-BASED HEALTH CLINICS

National awareness that school-age children in America were a medically underserved population came into focus during the mid-1960s when President Lyndon B. Johnson's War on Poverty identified serious

health problems in youngsters coming from poor families. The advent of Medicaid in 1965 highlighted the need for better health care for low-income children. In 1967, physician and pediatrician Philip J. Porter, head of pediatrics at Cambridge City Hospital in Massachusetts and director of Maternal and Child Health for the city's health department, assigned a nurse practitioner to work in an elementary school and deliver primary medical care to the children enrolled there. Four additional health clinics were opened in Cambridge schools in the years that followed.

During the early 1970s, school-based health centers staffed by nurse practitioners, part-time physicians and mental health professionals were established in Dallas and St. Paul. In 1972, the newly founded Robert Wood Johnson Foundation entered the field by funding several school health programs and by setting up a health center for children from impoverished families in Posen and Robbins—neighboring steel-mill towns near Chicago. Two years later, the Foundation supported a National School Health Conference in Galveston, Texas, which was attended by pediatricians and health professionals who were seeking to improve the quality and scope of medical care for school children.

In 1978, the Robert Wood Johnson Foundation underwrote an ambitious five-year School Health Services Program, which brought nurse practitioners into elementary schools attended by 150,000 children in Colorado, New York, North Dakota and Utah. The program, which was directed by Catherine DeAngelis, a physician and pediatrician with the Department of Pediatrics at the Johns Hopkins University School of Medicine in Baltimore, demonstrated that nurse practitioners backed by community-based primary care physicians could deliver adequate health care to children in elementary schools.

The project was not considered a success, however, because officials of most of the school districts in which the health centers operated concluded that the cost of maintaining them without Foundation funding would pose too great a financial burden.

As a result, officials of the Robert Wood Johnson Foundation came to the conclusion that if health centers serving the needs of the poor were to succeed, responsibility for their organization and financing would have to be shared by institutions within the community at large, such as community hospitals and health centers, state and city health departments, schools of public health, corporate foundations and school districts. So, in 1981, the Foundation launched its Community Care Funding Partners Program—

an initiative designed to encourage local corporations, foundations and other organizations to support community health centers that would serve the medically indigent.

Under the Community Care Funding Partners Program, the Robert Wood Johnson Foundation committed half a million dollars over an eight-year period to each of eight cities in which broad-based community support for health centers existed and in which local partners and, in some cases, national foundations could be brought together to sponsor the centers and help share in the cost of staffing and maintaining them. Between 1981 and 1989, under the auspices of the program, community health centers for families and children were established in Chicago, Dallas, Houston, Kansas City, New York and Philadelphia, as well as in Flint, Mich., and Wilmington, Del.

A striking aspect of the Community Care Funding Partners Program was the decision of officials in five of the eight cities to situate the community health centers in secondary schools. This decision reflected a growing concern across the nation about the deteriorating health status of American teenagers; according to a report issued by the Surgeon General in 1979, people between 15 and 24 years old were the only age group in the nation whose mortality rate rose between 1960 and 1979.¹

By the mid-1980s, it was estimated that six million adolescents in the United States had at least one serious health problem.² Five million adolescents had no health insurance, more than one in 10 had no regular source of health care, and approximately one in three had not been seen by a physician during the previous year.³ Increased drug and alcohol abuse on the part of teenagers was causing a steep rise in deaths and injuries from motor vehicle accidents. Increased sexual activity was creating a plethora of unplanned pregnancies among teenage girls. Statistics compiled by the Children's Defense Fund showed that the number of babies born to single adolescent mothers between 1950 and 1988 rose from just under 60,000 to well over 300,000.⁴ In addition, high-risk sexual behavior was resulting in a dramatic increase in the rate of sexually transmitted diseases among teenagers.

Other problems were less obvious but highly disturbing. Relatively few of an estimated five million emotionally disturbed youngsters in the nation were receiving treatment. Nearly 20 percent of boys 12 to 17 years old were reported as having emotional or behavioral problems. One in three adolescents had considered suicide. One in seven had attempted it.⁵

THE SCHOOL-BASED ADOLESCENT HEALTH CARE PROGRAM

In 1986, spurred by the distressing state of teenage health and having had experience with secondary school health centers through the Community Care Funding Partners Program, the Robert Wood Johnson Foundation launched its School-Based Adolescent Health Care Program—a large-scale demonstration project that was designed to determine whether health centers in secondary schools could deliver comprehensive medical and mental health care to teenage students across the nation, and whether communities and local institutions could be persuaded to provide long-term support for school-based health centers. The program was directed by Philip Porter, who had become a senior program consultant to the Foundation. The codirector was Julia Graham Lear, also a senior program consultant as well as an assistant professor of child health and development at George Washington University's School of Medicine and Health Sciences in Washington, D.C.

In 1987, the Foundation awarded 19 six-year grants of up to \$600,000 to public and private institutions to set up adolescent health centers. As a result, health centers were established in 24 high schools in fourteen cities across the nation, including Baton Rouge; Denver; Detroit; Greensboro, N.C.; Jersey City; Los Angeles; Memphis; Miami; Minneapolis; New Orleans; New York; St. Paul; San Jose; and San Fernando.

Thanks to experience gained from previous programs, the Foundation had developed strict criteria governing how the new adolescent centers were to be set up, how they should function and how they were to be financed. Thus they were alike in many respects. Each center was:

- Operated by a local hospital, city health department or other qualified health provider, either directly or under contract.
- Staffed by one or more part-time physicians, a nurse practitioner, a full-time or part-time social worker, and a medical office assistant.
- Planned in consultation with broad-based community groups, whose membership might include parents, school administrators, school board members, faculty, churches, youth and family-service agencies, local health and welfare departments, and representatives of local business and industrial firms.
- Required to cooperate with the existing school nurses, teachers, coaches, counselors, and school principals and their staffs.
- Set up to function in coordination with a community advisory committee whose members were required to generate funds to help support the center during the initial six-year period of its development, and, more important, to maintain it after the Robert Wood Johnson Foundation's grant had expired.
- Financed from the outset by a coalition of public and private institutions—city and state health and welfare agencies, for example, as well as local corporations and foundations—that joined the

Robert Wood Johnson Foundation in underwriting the project for the first six years, and then worked with the community advisory committee to build a long-term funding base.

To further ensure the economic stability of the health centers, the Foundation required their administrators to submit financial management plans that included projected operating costs for the six-year start-up period and evidence that patient revenues and funds from public and private institutions would be available to make up expenses not covered by the Foundation grant. The administrators were also required to present plans for financing the centers after the Foundation grants ended.

To be eligible for a Robert Wood Johnson Foundation grant, an adolescent health care center had to be located in a city with a population of 100,000 or more and to be housed in one or more secondary schools with a combined enrollment of at least 1,000 students. Once established, the centers were required to provide a comprehensive range of services, including the following:

- treatment for common illnesses and minor injuries;
- referral and follow-up for serious illnesses and emergencies;
- on-site care and consultation, as well as referral and follow-up for pregnancy and chronic diseases;
- counseling and referral for drug and alcohol abuse, sexual abuse, anxiety, depression and thoughts about suicide;
- on-site care and referrals for sexually-transmitted diseases;
- counseling aimed at preventing high-risk behavior that leads to pregnancy, sexually-transmitted diseases, and drug and alcohol abuse;
- sports and employment physicals; and
- immunizations.

Parents and guardians were required to sign consent forms before their children could receive any of the services provided by the health centers. The consent forms listed the services available at the center, and parents and guardians were free to indicate any services they did not want their children to receive.

When the Robert Wood Johnson Foundation determined that the school-based centers established under its School-Based Adolescent Health Program should be planned in consultation with parents and parents groups, as well as with local civic, religious and business groups, it hoped to avoid objections that might be raised to some of the services that would be offered, such as those dealing with the prevention of

pregnancy and of sexually-transmitted diseases. From the beginning, however, many school-based health centers became the targets of protests mounted by religious and political groups.

Some objected that health care should be the prerogative of parents, not schools. Others said that counseling adolescents on the use of contraceptives to prevent pregnancy and sexually-transmitted diseases would encourage sexual activity and promiscuity. Still others feared that school-based health centers were little more than camouflage for abortion clinics.

Overt political opposition to the School-Based Adolescent Health Care Program occurred in Florida in 1987, when Governor Bob Martinez, a pro-life advocate, turned down a Robert Wood Johnson Foundation grant that had been awarded to the Dade County Health Department for a health center at Miami's Northwestern High School. It soon became apparent that the governor had taken a minority position. A survey of 619 parents conducted by the *Miami Herald* showed that two-thirds favored a health clinic that supplies contraceptives with parental approval to students in their neighborhood high schools. Moreover, community support for the proposed health center at Northwestern High was especially strong among the parents of students enrolled there, as well as among members of the Miami-Dade County School Board, who, in spite of bomb threats, voted in favor of it.

A health center was finally established at Northwestern High in 1988, after the Robert Wood Johnson Foundation awarded its grant to Dade County's Public Health Trust—an organization that sponsored Miami's Jackson Memorial Hospital and a number of community clinics. This had the effect of moving the project from state to local control. Today, the center at Northwestern High serves 2,500 of the 3,000 students who are enrolled there, and 15 additional school-based health centers have been established in Dade County schools.

In the 1980s, religious opposition to school-based health centers came for the most part from conservative Christian groups such as the Moral Majority and from the Catholic Church. Some of it originated in high places. In 1986, Archbishop (now Cardinal) Roger M. Mahoney, of the Los Angeles Diocese, issued a pastoral letter criticizing the decision of the Los Angeles Unified School District to establish health centers supported by Robert Wood Johnson Foundation grants at three high schools in the Los Angeles area. The Archbishop was particularly concerned about moral issues posed by the distribution of contraceptives to teenagers, and by referrals for abortion for pregnant teenage girls. In his letter, he declared that the Catholic Church viewed abortion as an unacceptable solution to pregnancy

and warned that "by making contraceptives readily available, the clinics' personnel will tacitly promote sexual relations outside of marriage." He went on to say that the clinics would "destroy the partnership between parents and school upon which responsible education is founded."⁶

In spite of such opposition, adolescent health centers were established in 1987 with the help of Robert Wood Johnson Foundation grants at the three high schools selected by the Los Angeles Unified School District. The three high schools had a combined enrollment of some seven thousand students. Within two years, 85 percent of the parents of students attending two of the schools and nearly 60 percent of the parents of students at the third had signed consent forms allowing their children to use the centers. Today, adolescent health centers are flourishing in more than two dozen high schools and elementary schools in the greater Los Angeles area.

By 1990, consent forms had been signed by more than 70 percent of the parents of some 34,000 students who were enrolled in 24 schools across the nation in which health centers had been established with grants from the Robert Wood Johnson Foundation. Largely as a result of parental support, none of them were forced to close because of controversy. Support for school health centers had by then been voiced by the U.S. Public Health Service, the American Medical Association, the American Academy of Pediatrics and the American School Health Association, as well as by the American Nurses Association and a number of other organizations that represented nurses and nurse practitioners. Further evidence that opposition to the centers was waning came in 1991, when President Bush's Advisory Commission on Social Security recommended that federally funded health centers be established in the nation's elementary schools. By the end of the following year, the number of school-based health centers in the United States had risen from fewer than 50 in 1986 to almost 300.

EVALUATION OF THE PROGRAM

In 1992, outside consultants to the Robert Wood Johnson Foundation evaluated the 24 school-based health centers supported by grants from the Foundation.⁷ To no one's surprise, the evaluation determined that the centers had increased the access of adolescents to health care. Indeed, more than half of the students who were enrolled in schools with health centers were receiving health care from them. Approximately one in four of their visits was to obtain treatment for acute illness and injury and about one in six to obtain mental health care.

According to the evaluation, most teenagers who sought psychosocial counseling were suffering from depression caused by basic adolescent concerns about relationships with peers and family members. However,

a significant amount of depression was found to be caused by serious emotional problems, such as those produced by family violence, excessive drinking by family members, drug use, and physical and sexual child abuse.

The evaluators found that requests for mental health care had risen sharply during the five years that the school-based health centers had been in operation. At first, students had been reluctant to avail themselves of the psychosocial services that were being offered, but as they came to realize that their problems would be held in strict confidence by health center staff members, they began to use the counseling services in greater numbers. Because of financial considerations, clinically trained social workers provided the bulk of this counseling. Only two of the 24 adolescent centers were found to have a staff psychologist; none had a psychiatrist. According to the evaluation report, the heavy reliance on social workers meant that some students with severe mental and emotional problems might not be receiving adequate treatment.

The report, issued in 1993, found that school-based health centers had had little effect on high-risk behavior, such as drug use and unprotected sexual activity, or on teenage pregnancy rates. Indeed, the report estimated that one in four female students at the schools under study would become pregnant by their senior year, and that about half of the pregnant girls would bear children. As a result, the authors of the report suggested that earlier and more intensive intervention to reduce unprotected sexual activity among adolescents might be appropriate.

The authors also noted that dental facilities were lacking at most of the centers. In addition, they found that many centers either had not tried or had not been able to recover significant portions of their operating expenditures from third-party insurers such as Medicaid. In fact, Medicaid was found to be contributing less than 5 percent of the operating costs of the school-based health centers. For this reason, the evaluators warned that long-range financing for the centers could become a critical issue, especially in light of health care reforms that were being proposed and adopted across the nation.

The evaluation found that the School-Based Adolescent Health Program, despite its shortcomings, demonstrated that health care focusing on both physical and emotional needs could be provided in school-based settings to thousands of adolescents, especially those living in low-income communities who had previously gone without adequate medical and mental health attention. Nowhere was this stated more dramatically than in the frontispiece of the evaluation report, which quoted testimony given to the

U.S. Senate Committee on Labor and Human Resources in July of 1992 by Laura Secord, a nurse practitioner who had gone to work at a health center established with Robert Wood Johnson Foundation funding at Ensley High School in Birmingham, Ala. Secord described her first patient and her first weeks at Ensley High:

She was a 17-year-old with a severe kidney infection. She was also six months pregnant and had been starving herself to keep her pregnancy a secret. She was severely depressed. Her pregnancy was a result of sexual abuse by an older family friend. By the end of the first month, I had treated kids with a wide range of problems, including strep throat, fractured femur, diabetes, high blood pressure, severe depression, dental disease, anemia, epilepsy and gonorrhea.

THE MAKING THE GRADE PROGRAM

Through the early 1990s, school-based health centers had been supported largely by private foundations, local health departments, and Maternal and Child Health block grants provided by the U.S. Department of Health and Human Services. Only a few states—Arkansas, Connecticut, Delaware, Maryland, Michigan, New York and Oregon—had initiated state funding for school health centers. By 1992, it was apparent that if health centers were to become established in the nation's schools, their long-term financial stability must be secured through state and community involvement. As a result, in July of that year, the trustees of the Robert Wood Johnson Foundation authorized \$25.2 million for a new program called Making the Grade: State and Local Partnerships to Establish School-Based Health Centers.

The goal of Making the Grade was to increase the availability of comprehensive health care for school-age children by reorganizing state and local funding policies. Under the program, the state partners were asked to reduce funding barriers for school-based health centers—for example, by making it easier for the centers to receive reimbursement from state-controlled Medicaid funds. Community partners were asked to mount a collaborative effort in which school districts, parents' groups, community groups and a health provider—a local hospital, perhaps, or a municipal health department—would commit themselves to establishing health centers at two or more high schools, middle schools or elementary schools in at least two communities.

This program was launched in the spring of 1993, and it has been directed since then by Julia Graham Lear, who works out of a national program office located within the George Washington University Medical Center's School of Public Health and Health Services. (Lear is now an associate research

professor in the school's Department of Health Services Management and Policy.) During the first phase of the program, which was completed in early 1994, the Foundation awarded \$100,000 grants to 12 states to develop new policies for financing school health centers and for planning the establishment of at least two new school health centers in each of two communities. In the second phase, in 1995 and 1996, the Foundation awarded implementation grants of up to \$2.3 million each to nine of these states to develop policies that would guarantee long-term financing for the centers and to help support them during their first four years of operation. The states were Colorado, Connecticut, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island and Vermont.

In 1993, most of the states participating in the program were planning to pay for new school-based health centers by augmenting state grant commitments with money from President Clinton's ill-fated Health Security Act, which included \$300 million for health care in schools. However, the collapse of federal health care reform the following year, together with mounting opposition to government-sponsored programs in general, persuaded many states to abandon this strategy and to search for alternative funding. As a result, with the exception of Louisiana, the states with Making the Grade grants shelved plans to increase their grants to school health centers and shifted their attention to contractual arrangements that would integrate the centers into Medicaid managed care.

A major flaw in this strategy, however, was that Medicaid did not reimburse many of the mental health, health education, and preventive services that were being provided by school-based health centers. For example, group therapy and consultation with teachers and parents regarding health matters were not covered by Medicaid. As a result, officials of Medicaid managed-care plans were reluctant to negotiate contracts with school health centers. Although some centers began to contract with Medicaid managed care plans, Medicaid revenues in many cases covered only a small fraction of the school-based health center's operating costs.

This problem notwithstanding, most states have tried to encourage and facilitate negotiations between school-based health centers and Medicaid managed care plans. As might be expected, state strategies for allowing the health centers to tap into Medicaid managed care dollars have varied widely. Some states confer preferential status on school-based centers by a so-called "carve-out" process that provides special treatment for children and adolescents or for certain services, such as those dealing with family planning, substance abuse and mental health. Other states—among them Connecticut, Delaware, Maryland, Massachusetts, Michigan and New York—require managed care plans serving Medicaid beneficiaries to

enter into contracts with school-based health centers. Still others, such as Colorado, have tried to encourage school-based health centers and Medicaid managed care plans to enter into voluntary partnerships.

What has resulted is a hodgepodge of different relationships and a maze of varying contractual arrangements. For example, in Connecticut—a state that is considered to have one of the best school health programs in the nation—the sponsors of fourteen school-based health center programs and officials of eleven Medicaid managed care health plans have had to negotiate 125 separate contracts. A major reason for this is that all of the state's managed care plans contract separately for dental services, and most of them subcontract for mental health services. In New York City, where 150,000 children rely on 99 school-based health centers for primary health care and no fewer than 25 Medicaid managed care plans are in operation, the task has been even more daunting. Small wonder that no one knows just how many of the nation's 1,200 or so school-based health centers have made agreements with Medicaid managed care plans! What is known is that some school-based health centers that were billing Medicaid under fee-for-service arrangements have reported a decline in revenue since the Medicaid managed care plans were introduced.

One way the financial plight of school health centers could change for the better is if states decide to finance them with part of the money they will receive under the 1998 agreement that settled their litigation against the tobacco industry. Another funding source could be the State Children's Health Insurance Program, which was passed by Congress in 1997. Under this program, Congress has authorized \$48 billion over 10 years for states to buy health insurance for an estimated three million uninsured children who come from low-income families. As many of these uninsured children are enrolled in school-based health centers, it is hoped that the Children's Health Insurance Program will reimburse the centers for the services they are providing. Depending upon decisions yet to be made, school-based health centers may also be eligible to receive some of the \$4 billion that Congress has set aside under the program for what are described as "related purposes," which could include safety-net providers such as school-based health centers.

Unfortunately, many congressional and state legislators appear to be laboring under the assumption that an adequate provider system already exists for the delivery of medical attention to uninsured and underprivileged children. This assumption is, of course, questionable for many communities. Indeed, the

fact that an adequate provider network does not exist for millions of poor children is precisely the problem that the Robert Wood Johnson Foundation has been trying to remedy for more than 20 years.

THE SCHOOL-BASED HEALTH CENTER IN BRIDGEPORT, CONN.

Today, the Robert Wood Johnson Foundation is contributing to the support and development of forty-four school-based health centers serving poor children in low-income areas across the nation. One is at the Read Elementary and Middle School in Bridgeport, Conn. Once a thriving steel-fabricating and textile center, Bridgeport has fallen on hard times in recent years and is struggling to rebound from bankruptcy. Despite the city's economic woes, the Bridgeport Health Department has been a strong supporter of health care programs in the city's schools since the mid-1980s. The department currently operates nine of the city's 10 school-based health centers, including the one at Read, which it opened in November of 1996 using funds awarded to the state of Connecticut under the Making the Grade Program.

About half of the kindergarten-through-eighth-grade children who attend Read are African American. More than a third are Hispanic and come from homes in which English is not the primary language. Three out of four qualify for free or reduced-price meals because they come from low-income families. Many of them have parents who are unemployed or who receive vocational training.

Sixty-four percent of the children at Read are enrolled in the health center, which is staffed by a full-time nurse practitioner, a social worker, an outreach worker and a medical assistant. These full-time staff members are assisted by a physician from a local pediatrics group, who visits the school once a week, and by a dentist and dental hygienist, who pay weekly visits to provide dental treatment.

As at most school-based health centers, the nurse practitioner and the back-up physician at Read provide diagnosis and on-site treatment for acute illnesses, such as sore throats, earaches, headaches and stomach upsets. They also deliver reproductive health care, including pregnancy testing, Pap smears, diagnosis and treatment for sexually transmitted diseases, and education and referral for birth control, if necessary.

A master's level social worker at Read provides individual, group and family counseling for psychosocial problems. She and the nurse practitioner also give classroom presentations on topics such as reproductive health, conflict resolution and substance abuse. In addition, the social worker leads special counseling

groups that deal with gender issues, life skills, asthma (about 50 children at Read suffer from this disease), anger management and self-esteem.

Health center staff teach first-graders about stranger danger and how to distinguish good touch from bad touch; third- and fourth-graders are taught how to resolve conflicts and control their behavior; seventh-graders discuss dating, marriage, sex, drugs and violence; and eighth-graders learn about the consequences of early sexual activity and the importance of abstinence. At the request of teachers, the social worker holds special sessions on depression and sadness. Nearly half of the diagnoses are for emotional problems, including depression, anxiety, behavioral disorders, parent-child problems and family problems.

On a midweek afternoon in October of 1998, a visitor to the Read School Health Society—the name the children at Read have picked for the center—is invited to attend an impromptu meeting of its staff members. That morning, in addition to dealing with the usual colds and sore throats, the nurse practitioner has examined a wheezing 14-year-old boy who suffers from asthma but is not taking his asthma medicine. The social worker, who has seen the boy because he has been sleeping in class and often behaves in disruptive fashion, points out that he has a history of truancy, is smoking marijuana and is using LSD. According to the outreach worker, the boy's mother works evenings and exercises little control over him. The social worker reminds her colleagues that when the boy was suspended for disorderly behavior, he showed up at school, claiming he didn't have any other place to go. The staff members agree that they should discuss with school authorities whether this boy's problems can be dealt with at Read or whether he should be transferred to a special education school with a modified curriculum that can better meet his needs.

That same morning, the social worker at the health center counseled a 14-year-old girl who feels that some of her teachers have been nagging her unfairly. The social worker knows that the girl's father is dead, that she has great difficulty in dealing with an alcoholic mother, and that she has run away from home on several occasions. The outreach worker, who recently visited the home, found the girl's mother to be inappropriately dressed, apparently drinking and unreceptive to dealing with her daughter's problems. According to the nurse practitioner, the girl has acknowledged having sex with a boyfriend. In counseling sessions, the social worker has found that the girl wants desperately to talk about her feelings and problems. As a result, she referred the girl to an outside support group that works with adolescents who must deal with alcohol and substance abuse by family members. Meanwhile, she is trying to provide

the girl with some of the approval and acceptance that are obviously lacking in her home, and is acting as an advocate for the girl to help resolve her problems with her teachers.

THE SCHOOL-BASED HEALTH CENTER IN SAN FERNANDO, CALIF.

One of the first school-based health centers to be financed by the Robert Wood Johnson Foundation was at San Fernando High School, about 25 miles north of Los Angeles. More than 90 percent of the students at the school come from Latino families, including old and new immigrants from Mexico and refugees from war-torn countries in Central America such as El Salvador, Guatemala and Nicaragua. About 40 percent of the residents of the area have incomes below the federal poverty line. During the 1980s, the region had one of the worst teenage birth, teen prenatal care and teen homicide records in all of California.

In 1987, San Fernando High School was one of three schools in the Los Angeles Unified School District to be selected as the site for a health center funded by the Robert Wood Johnson Foundation's School-Based Adolescent Health Program. At the time, the need for a health center at San Fernando High seemed great. More than one in three of the 2,500 students who were then enrolled at the school had not seen a physician in three years. More than half had not seen a physician in two years or more, and many had never seen a physician at all. In addition, two out of three sexually active female students at the school said they never used birth control, and one in eight said they used them only rarely.

Even before it opened, Archbishop Mahoney voiced opposition to the establishment of a health center at San Fernando High in his pastoral letter of November, 1986. Protest marches, candlelight vigils and petition drives were subsequently organized by anti-abortion and anti-birth control groups, as well as by a priest from a Catholic church near the school. Much of the opposition appeared to originate outside the local community. During one protest meeting, a plane flew over the school towing a sign that read "RWJ Go Home." This prompted the principal of San Fernando High to observe that the parents of his students didn't have enough money to hire airplanes.

Criticism of the health center, which opened in November of 1987, soon dissipated, thanks to strong support from parents, students, faculty and the Northeast Valley Health Corporation, which operates the center in cooperation with the University of California at Los Angeles Medical Center. Today, 60 percent of the 4,500 students currently enrolled at San Fernando High make regular use of the center, which handles about 10,000 patient visits during the school year. Roughly 5,000 of these visits are for the treatment of illness and injury or for physical examinations, immunizations, health education, pregnancy

tests and family-planning counseling. These services are handled by a full-time nurse practitioner and two assistant nurses, with the help of a physician from the UCLA Department of Pediatrics, who visits the center twice a week. (The health center's services do not include abortion counseling and referral.)

The other 5,000 visits are occasioned by mental health problems, such as depression, anxiety, grief, suicidal tendencies and emotional trauma caused by violence, abusive families, substance abuse, sexual abuse and child abuse. Students with such problems are treated by a 10-member staff that includes a clinical psychologist, three licensed therapists and six UCLA graduate students who are training to be psychotherapists.

The clinical psychologist at San Fernando High is José Cárdenas, who has worked at the health center since it opened. A graduate of San Fernando High himself, he is familiar with the neighborhood and its predominantly Hispanic school population, and the students trust him. Cárdenas says that depression is the most common diagnosis he makes at San Fernando High. He points out that a large percentage of students at the school come from families that have recently emigrated from Mexico or Central America. These students are often made fun of and discriminated against by students whose families have been in the United States longer, and they need counseling to help them adjust to new surroundings, new customs and a new language. Bilingual therapists at the center provide such counseling in a group that meets once a week. Other therapy groups have been formed to help students who feel isolated because they are African-American or gay.

Additional therapy groups at San Fernando High help students deal with sexual abuse, psychological abuse, suicide, grief and domestic violence. Over the years, patients have ranged from a 16-year-old girl who was suffering from severe depression and suicidal thoughts because she had been raped by her mother's boyfriend at the age of 12 and subjected to repeated beatings by her mother and her grandmother to a boy of 17 who, suffering from shock after learning of his cousin's murder on the evening television news, was about to join a gang to avenge his cousin's death. Therapists at the health center helped the girl to feel her anguish without thinking of suicide, and to regain her self-esteem and well-being by asserting herself when she felt in danger. Grief therapy in the form of individual and group counseling helped the boy to realize that he was not alone in his loss and sadness and to seek support by forming new friendships. The school performance of both students improved markedly following therapy, and both went on to graduate from San Fernando High.

Cárdenas believes that early intervention in such cases is crucial. He points out that if children and adolescents who have been traumatized by sexual abuse and domestic violence are not diagnosed and treated at an early age, they are going to lead troubled lives and have an adverse impact on society later on. He is a strong advocate of group therapy, because he feels that it is important for children to be able to empathize with their peers and show compassion. "Kids have to learn to talk about their problems with other kids," he says. "What better place is there for them to do that than in school?"

Notes

¹ Surgeon General. *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, Department of Health, Education and Welfare, Publication No. 79-55071 (Washington, D.C.: Government Printing Office, 1979), pp. 43-52.

² E. L. Marks and C. H. Marzke. *Healthy Caring: A Process Evaluation of the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program* (Princeton, N.J.: MathTech, Inc., 1993), p. 1.

³ J. G. Lear, H. B. Gleicher, A. S. Germaine and P. J. Porter. "Reorganizing Health Care for Adolescents: The Experience of the School-Based Health Care Program." *Journal of Adolescent Health* 12, Sept. 1991, 450-458.

⁴ Cited in J. G. Lear, *The Answer Is at School: Bringing Health Care to Students*. Washington D.C.: The School-Based Health Care Program, 1993.

⁵ Marks and Marzke, 1993, p. 1.

⁶ Archbishop Roger Mahoney, "A Pastoral Letter." *The Tidings*, Nov. 7, 1986.

⁷ The consultant team consisted of experts from Mathematica Policy Research, Inc. and MathTech, Inc. The project director was William A. Morrill. See the final evaluation report: E. L. Kisker, R. S. Brown and J. Hill, *Healthy Caring: Outcomes of the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program*, MPR Reference Number 7787-440 (Princeton, N.J.: Mathematica Policy Research, Inc., 1994).