The contribution of school health programs to disease prevention among children and youth has included immunizations, screenings, referrals, and in some instances, treatment for potentially health-threatening conditions. State and community policymakers, as well as children and youth advocates, have been prompted to consider a broader role for school health services, due to poor health status of children, high risk behaviors, inadequate health insurance, poor health care utilization, and barriers to public health care. Policy planners believe that comprehensive school health programs can respond to the health information and preventive care needs unsatisfied by society. Statistics are cited to reflect the poor health status and health-threatening behaviors of youth. The dearth of school health programs in the southern United States is attributed to inadequate funding, vocal opposition to school-based health services, and the autonomy of local school districts. States are urged to establish coherent and comprehensive state policy, support local determination of need, provide financial resources, monitor programs, evaluate programs, provide support services for school health personnel, and provide models of delivery. A table lists state regulations for health services in southern schools. Five models of state governments taking a leadership role in creating effective health services for school populations are briefly described.
Poor Health Status

Young people have long enjoyed good health, but that status is in danger: one out of five today's 31 million adolescents has at least one serious health problem. Poor and minority teenagers are especially at risk, and there appear to be few resources for addressing their health needs.

High Risk Behaviors

Unlike disease-related entities of a century ago, today's threats to young people's health are largely attributable to lifestyle. High risk behaviors such as smoking, drinking, unprotected intercourse, and substance abuse—often initiated during adolescence—jeopardize the health and welfare of our young people; the consequences of these behaviors can have a lasting impact.

Inadequate Health Insurance

A fair portion of our nation's youth face significant obstacles in receiving adequate and affordable health care. Nearly 20% (12 million) are without public or private health insurance. Among families that are poor or near-poor, have little education, and are minorities, the percentage of uninsured children is much greater. Even those with insurance find that coverage for primary, routine preventive care is severely lacking.

Schools as Health Providers

The challenge of addressing the health care needs of youth, argue many education and health policy planners, can be met by school health service programs. With its focus on health education, promotion, and screening, comprehensive school health programs can respond to the health information and preventive care needs unmet by society.
Youth at Risk

A national adolescent health survey of high schoolers by the Centers for Disease Control revealed that 30% of adolescents smoke regularly, 35% surveyed tried marijuana, and 8% tried cocaine. Within the past month, one third of all high school seniors engaged in heavy alcoholic drinking.

Reports of sexual activity among adolescents indicate that over 50% of young people are initiating sexual intercourse in their teenage years.

Teens, on the average, wait more than a year after initiating intercourse before they seek contraceptive providers, placing them at great risk for pregnancy or contracting sexually transmitted diseases.

Every year, 2.5 million teenagers become infected with sexually transmitted diseases. Over one million adolescents become pregnant each year - a majority of which are unintended and childbearing to adolescents has recently increased 10% among 15-17 year olds.

The mental health status of adolescents appears most troubling. An estimated 7.5 million (12%) of our nation’s children suffer from mental disorders severe enough to warrant treatment. National surveys of middle and high school students reveal an emotionally troubled adolescent population: 61% felt feelings of depression and hopelessness; 45% admitted trouble coping with stressful home and school situations; 56% reported having nothing to look forward to; 34% considered suicide; and 14% attempted suicide. Every year, approximately 5,000 young people take their lives, three times the rate of twenty years ago.

A century ago, communicable diseases were the common killers of young people. Today, nearly three-quarters of the deaths to adolescents are due to social causes, many of which could have been prevented.

The school’s ability to reach children and youth disenfranchised from the health care system and at highest risk for poor health and potentially health-threatening behaviors is unmatched. The advantages are clear.

School health service programs:
- are equitable. They offer an entry point into the health care system for all children;
- can provide a broad range of comprehensive, preventive services not reimbursed by a majority of health insurance policies;
- are confidential;
- are user friendly. The services are provided in a trusting and familiar environment;
- are convenient! Teens are more likely to walk in spontaneously.

A growing list of state and national organizations are recognizing the potential of school-based health services for enabling schools to contribute to healthy physical and emotional development, as well as intellectual development. The collaboration between schools and public health is gaining national attention through the efforts of the American School Health Association and the National Health/Education Consortium. Their leadership in the campaign to link public schools and health systems to achieve the synergistic goal of bringing young people into adulthood healthy, skilled, and productive gives tremendous political clout to a valuable program.

State government too has given much attention to school health services; the recommendation for comprehensive school health tops the list of nearly every state task force or strategic plan addressing the well-being of young people. Efforts to institutionalize these recommendations into policy have been the subject of legislative activity in many southern states. Education reform packages in Kentucky and Mississippi make specific recommendations for the inclusion of school health programs as a mechanism for achieving education goals.

School Health in the South

Despite the recognition of school health services as an essential part of the prevention paradigm, the concept still is not universally embraced. In fact, the status of school health programs around the South seems as fragile as the health of those they are designed to serve. Many schools are plagued by inadequate health personnel and insufficient funds to adequately cover the myriad health needs of the school-aged population. Reports from school nurse consultants reveal that most schools across the region are not covered by the minimum standard of care — one school nurse per 750 students—adopted by professional health organizations. School health personnel are frequently shared among several schools and may be
## State Regulations for School Health Services

<table>
<thead>
<tr>
<th>State</th>
<th>Regulations</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>150-200 school nurses across the State. Nurse student ratios range 1:750-1:1250 funded through local. Chapter One Special Education funds.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Each district shall have a health services program under the direction of a licensed or registered nurse in attendance of 1:1000. No school nurses statewide.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Delaware</td>
<td>State law mandates one school nurse per 500 students (which may be approximately 1:800). A school district is entitled to at least one school nurse every 1000 students less than 10 teachers. Nurses are funded through state appropriations.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Florida</td>
<td>State law mandates school health programs to be coordinated through local education agencies. $150 million of state revenue is awarded for basic school health projects. An additional $100 million was appropriated in 1992 for expanded school health services.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Georgia</td>
<td>No legal basis.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Essential health services and screenings are required to be provided, but not exclusively by a licensed or registered nurse. 100% of all counties have school nurses.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>No legal basis.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Maryland</td>
<td>Regulations require basic standards, but are neither promulgated nor funded. Rate varies 1:800-1:1500. State task force on school health officer recommendations no action at this time.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Legislate authorized State Department of Health to implement school nurse program but provided no funds or positions. Resources unavailable to put nurses where they're needed. Health agency has used creative mixture of Title II, Title VI, and Title X. A $25 million grant to fund school nurses, however, such resources are currently unavailable.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Missouri</td>
<td>No legal basis. 75% of all counties don't employ nurses because of limited budgets. Bill pending to tax smokeless tobacco for school health programs.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>North Carolina</td>
<td>State Law Authorizes but does not mandate school health program. Nurse student ratios range from 1:600-1:2000. State provides funds, but only a few mandated. State task force on elementary school health recommended nurse student ratios of 1:30. No action as of this date.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Legal basis but no mandate.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Tennessee</td>
<td>No legal basis for programs. Ratios range from 1:2,000 to 1:7,500. 268 nurses statewide.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Texas</td>
<td>Essential school health services (screening, health counseling, emergency care, communicable disease control) are required to be provided but not exclusively by a registered nurse. The State Department of Education recommends one school nurse (registered nurse) per 1,000 students. Two-thirds of the 1,266 districts, however, have less than 1,000 students in average daily membership.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>Virginia</td>
<td>No legal basis.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
<tr>
<td>West Virginia</td>
<td>State Law mandates 1:1,500 nurse student ratios and requires certification by state education agency. Nurses must be licensed or registered. School nurses are funded through state appropriations and at the same salary as teachers.</td>
<td>fluoride through local. Chapter One Special Education funds.</td>
</tr>
</tbody>
</table>
Toward More Effective State Policy

Considering the poor health of a growing number of children and youth, the fragile status of school health services, and the barriers to program implementation, states clearly must play a role in facilitating the development of school health programs at the local level. Leadership from state health, education, and mental health agencies is essential to assisting communities in identifying both needs and resources, educating local leaders about those needs, and cultivating broad-based support for on-site school health programs. To this end, states should:

Establish Coherent and Comprehensive State Policy

A comprehensive school health policy should be delineated at the state level which sets minimal standards of practice for all school districts and allows for and supports a wide range of school health programs that meet individual community needs. Such authorization should ensure that basic health services, such as screenings, health assessments, and counseling activities are provided in every school. Policy and program guidelines should be furnished to each local education agency with protocols for program operation and standards of procedure, including HIV and communicable disease policies, medication administration, and emergency transportation.

Support Local Determination of Need

State education and health agencies should assist communities in assessing student health needs and developing programs to meet those needs. Health risk data, gathered through surveys and a review of local public health statistics, can be helpful in designing school health programs, as well as in enlisting the support of community members and policymakers. Such data is also useful in targeting high prevalence areas where, given limited resources, school health programs should be a priority.

Once school health needs are determined and program objectives have been established, states should assist local agencies in negotiating state policies and regulations which might interfere with implementation.

Provide Financial Resources

A greater long-term commitment of resources, through a collaboration of state and local dollars, is necessary to finance school health programs and to provide health personnel salaries commensurate with other health professionals performing similar tasks in like settings. Several legislatures in the region have allotted state appropriations to support the development of school health services (see state models).

Monitor Programs

To ensure that state standards are being met in each school district, states should provide a mechanism for oversight and quality assurance. In many states, a school health nurse consultant coordinates local programs and related activities. assures local compliance, oversees peer review of school health providers, assists with program evaluation, and provides technical assistance for new programs.

Evaluate Programs

States should prescribe measurable outcomes for school health programs and provide technical assistance for incorporating evaluation components to
provide an internal support system among school health professionals.

**Provide Models of Delivery**

States should provide schools with a menu of successful program models which can be adapted to community needs and resources. Certainly, not every school in each state can become the focal point for comprehensive physical health and mental health care services for all young people; many lack the financial resources and staff to accomplish such a task. The following three models, basic health, expanded health, and comprehensive health, are examples of program frameworks that can be adapted to schools based on financial and staffing resources.

**Schools as Health Screeners: Basic Health**

Basic health services, the most common services model used in the region, perhaps the country, is the foundation of all school health programs. Services are preventive in nature (screenings, assessments, counseling), typically delivered by a part-time health provider or school personnel trained to administer screenings. Emphasis is placed on the detection of health problems and referral to community health services for treatment.

**Schools as Community Brokers: Expanded Health**

By building on a rudimentary school health services foundation, schools can extend the range of basic health screenings to include more accessible, comprehensive care for medically underserved students. This model typically employs a full-time health provider for one school or school district, or brings existing public health and mental health providers into the schools on a part-time basis. With health personnel on the school site for greater periods of time, more attention can be given to preventive education (in the classroom and in the clinic), managing students' health care, and linking families to community health services not provided on-site.

**School as Principal Health Setting: Comprehensive Health**

The school-based health center meets the broadest range of health needs. Services are comprehensive and self-contained, testing, diagnosis, counseling and treatment are all part of the on-site services. Health personnel typically include a team of nurse practitioners, registered nurses, social worker, nutritionist, and supervising physician. Over 90 clinics have been established across the region, many in urban areas with high concentrations of low income, high-risk families. Reports from clinic administrators reveal that utilization of these school-based centers is extremely high. Frequently requested services include sports physicals, acute medical care, mental health counseling, and pregnancy testing. Physical appearance is of great concern to school-aged youth; health personnel provide weight loss and nutrition information, dermatological advice, and dental referrals (in some schools, dental screenings are available).
There are obvious advantages and disadvantages to each model. Basic and expanded health care systems rely on follow-through and compliance with health care referrals and assume that the services are available and affordable to the family. In many instances, health personnel are not on the premises full-time and the range of services provided is limited due to the high nurse-student ratio. Additionally, school-based services are not generally available year-round, although a few do keep their doors open in the summer.

While the comprehensive school-based model is ideal, it is the most expensive of the three (the average operating budget is $150,000 annually) and is prone to controversy. The interest in school-based clinics and their possible impact on adolescent pregnancies has prompted opposition from parents concerned about family planning and abortion counseling on school property. For this reason, most clinics in the region do not dispense contraceptives and ALL school-based health programs require parental consent prior to student treatment. The controversial nature of comprehensive school health programs has prevented many states from supporting those schools that provide such services with state funds, or endorsing the expansion of successful models in other communities. Consequently, private foundations and health organizations have been the mainstay of financial and human resources support.

State Policy Models

The following are excellent models of state governments taking a leadership role in creating effective health services for their school populations.

**WEST VIRGINIA:**
**Mandating School Health Services**

Each county school board is required by law to provide one school nurse for every 1500 students. State regulations further require that school nurses be registered professional nurses certified through the state Department of Instruction. Funding for school nurses is appropriated through the state, with salaries commensurate with those of other professional education staff.

Contact: Lenore Zedosky, West Virginia Student Support Services 314/348-8830

**FLORIDA:**
**Creative Funding for School Health Services**

Florida's proposal for expanded school health programs included a price tag that nearly prohibited its implementation. By repealing a sales tax exemption on physical fitness club memberships, the state was able to forecast an additional $3 million to fund school health initiatives, with an anticipated $9.6 million for 1991-92 projects. School districts are provided a menu of school health models that can be adopted, including health service teams and comprehensive health centers.

Contact: Josephine Newton, Florida Department of Education 904/488-8974

**ARKANSAS:**
**Giving a Voice to School Health**

The State Health Officer Dr. Joycelyn Elders is a champion of school health services, not just in Arkansas, but across the country. Using her position of leadership, she has given the issue enormous visibility, and in little over four years, has brought public health services into 21 of 75 counties and 48 schools across Arkansas. Public health officials should play a pivotal role in health promotion, decision-making, disease prevention, and treatment through school-based health education and services programs, argues Elders. At the invitation of local school boards, public health nurses now come into the schools on a regular basis providing screenings, counseling, and immunizations. Schools provide the space and the health department provides the rest.

Contact: Missy Fowler, Division of Child and Adolescent Health 501/661-2241
Conclusion

The changing health status of our nation's young people demands a rethinking of the way in which health services are delivered to them. Schools appear best poised to provide the multitude of physical and mental health needs to those most likely to be disconnected from traditional health providers. With its broad focus on education, counseling, and services, school health programs not only cater to those needs, but augment the community's capacity to address substance abuse, child abuse, AIDS and other sexually transmitted diseases, adolescent pregnancy, and suicide prevention as well. Many schools in the South are only beginning to provide a base of preventive health services. Others are expanding the school walls even farther to address difficult health issues like pregnancy, drug and alcohol abuse, and mental stress. The aforementioned examples of leadership in this report indicate that change is occurring, and can occur. But necessary to that change is a partnership of vision, leadership, funding, and determination to expand traditional boundaries and forge collaborations to meet the goal of a healthier youth.

Footnotes

21. Center for Population Options, School-based Clinics Enter the '90s: Update, Evaluation and Future Challenges, Author: Washington, D.C.
Southern Center on Adolescent Pregnancy Prevention

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$5.00