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Family Planning Perspectives, Vol. 20, No. 4. (Jul. - Aug., 1988), pp. 193-196+198-200.

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School-Based Health Clinics: Three Years of Experience

By Joy G. Dryfoos

Summary

In the last three years, comprehensive school-based clinics have proliferated throughout the United States: There are currently 138 clinics in 30 states and the District of Columbia, and at least 65 more are in the planning stage. Clinic programs differ widely in their organizational structure, operating costs, range of services and funding sources. Although some clinics are funded by private foundations, increasingly, programs are being initiated by local public health departments supported by state funds.

Only 10–25 percent of all clinic visits are for family planning services. While all of the clinics provide counseling on family planning, most of the state-funded clinics either prohibit the use of funds for contraceptive supplies and abortion referral or allow grantees to decide what to do about the issue of pregnancy prevention. To date, no study has found that rates of sexual activity increase among students who participate in clinic programs. There is some evidence indicating that participation in school-based clinics may have a positive impact on contraceptive practice.

Introduction

Three years ago in this publication, I reported that comprehensive school-based health clinics might hold promise as an approach to preventing teenage pregnancy.¹ At that time, there were 14 programs operating 32 school clinics in nine states. Since then, efforts to develop school-based clinics have been initiated in almost every major city in the United States as

Joy G. Dryfoos is an independent researcher. The research on which this article is based was funded by the Carnegie Corporation. The views expressed herein are those of the author, however, and do not represent the opinions of the Carnegie Corporation. The author wishes to acknowledge the assistance of many colleagues who reviewed drafts of this article and contributed their ideas.

“... The movement to make comprehensive health, social and family services accessible to school populations is very strong . . . [and] is propelled by new, large-scale youth-at-risk initiatives sponsored by states and foundations.”

well as in many rural areas; by the latest count, 138 such clinics are now in operation.* While the debate over comprehensive health clinics continues, interest in school-based programs has been spurred by a growing recognition of the link between low basic skills and school dropout, poverty and early childbearing.

A body of literature on school-based health programs has begun to emerge.² The National Research Council of the National Academy of Sciences has singled out comprehensive health clinics in schools with large, high-risk populations as a most promising approach to pregnancy prevention.³ The Office of Technology Assessment has recommended the development of comprehensive school-based clinics in order to reduce high-risk pregnancies among teenagers.⁴ In addition, a number of prominent national organizations, including the National Parent-Teacher Association, the American Academy of Pediatrics, the National Education Association, the American College of Obstetricians and Gynecologists and the Association of School Nurses, have issued statements in support of comprehensive school-based clinics.

On the negative side, the National Right to Life Committee, the Eagle Forum, the Christian Crusade and other organizations have raised strong objections to pregnancy prevention interventions in the schools.⁵ The former Secretary of Education, William Bennett, has led a crusade against school-based clinics, calling them a “rotten” idea that constitutes an “abdication of moral authority.”⁶ In late 1987, the National Conference of Catholic Bishops is-

sued a policy statement calling for the enactment of laws to bar the dispensing of contraceptives and the provision of abortion counseling in schools. Nevertheless, the statement acknowledged the importance of school-based clinics to help meet the broader health needs of disadvantaged youth.⁷

In some communities, opposition to school-based clinics, although numerically small, has captured a lot of media attention. A typical newspaper headline, “Pill Goes to School,” triggered an extended controversy over the opening of the DuSable Clinic in Chicago.⁸ Nevertheless, organized opposition has prevented the initiation of clinic programs in only a few places: San Diego, Boston and a community school district in New York City are three areas where plans for clinics are known to have been scuttled because of failure to gain support from school authorities.

The growth in the number of school-based clinics results from the recognition that increasing numbers of young people who live in disadvantaged communities will never graduate from high school and may never enter the labor force unless they are provided with a wide range of services. The Committee for Economic Development, which represents over 200 of the nation’s leading business executives, issued a report acknowledging that the “American Dream . . . is in jeopardy . . .

*The universe of school-based clinics described in this article includes only those sites where family planning counseling (as a minimum) is part of the comprehensive service package. There are many other school health programs not covered by this definition.

when more than one-fifth of our children live in poverty and a third grow up in ignorance."⁹ I have recently estimated that fully one-fourth of this nation's 10-17-year-olds, or about seven million youngsters, are at multiple risks of early unprotected sexual intercourse, school failure, delinquency and substance abuse.¹⁰ This group contains most of the children who are in urgent need of attention.

The link between school achievement and adolescent pregnancy is becoming more clearly articulated. In the past, dropping out of school was viewed as a consequence of teenage pregnancy. However, new data indicate that young people with low basic skills are much more likely than others to become parents, especially if they are in disadvantaged families.¹¹ A recent analysis found no significant differences between white, black and Hispanic teenagers in the probability of parenthood, once basic skills and poverty were accounted for.¹²

The interrelatedness of problems among disadvantaged youth, the crippling effect of school failure and the growing gap between social classes in access to economic opportunities place a heavy burden on school systems. With dropout rates reaching 80 percent in some inner-city schools, school systems are more willing now than in the past to allow programs run by outside organizations to operate in the schools.¹³ School administrators recognize that disadvantaged students need more support services than the schools themselves can supply. As one principal stated, "Anyone who thinks the schools are not social service agencies [is] fighting a rear-guard action."¹⁴ Nathan Quinones, former chancellor of the New York City schools, called for the establishment of a comprehensive health clinic in every city school, because "it is no good to make progress in reading scores while students are psychologically and physically dying."¹⁵

This article summarizes the current status of comprehensive school-based clinics in the United States, focusing on the proliferation of facilities over the period 1985-1988, the lessons learned from this

experience and the outlook for comprehensive school health services in the coming years.

Clinic Services

Currently, there are 138 comprehensive clinics operating in schools in 30 states and the District of Columbia, and at least 65 more clinics are known to be in the planning stage. Table 1 shows, by state, the distribution of the clinics operating in 1985, the clinics operating in 1988 and the clinics reported to be in the planning stage. Because no central authority funds, regulates or monitors school-based clinics, these counts are rough estimates based on the best data available.

As the table indicates, there does not seem to be any regional pattern to the distribution of clinics. Over the past three years, California, Maryland, Michigan, New Jersey, New Mexico, New York and Oregon have all experienced large increases in the number of clinic sites. In California, funds for the new clinics have come from a complex mix of public health and private foundation monies, whereas in the other states, the proliferation of clinics reflects the recent infusion of state health and human services funds and the increased utilization of Medicaid funds. In Arkansas and Louisiana, where there were no school-based clinics in 1985, funds for planning and operating new clinics have come from private foundations. In other states, such as Minnesota, Mississippi and Texas, there has been little or no change in the number of clinics in operation between 1985 and 1988.

While the clinic program in St. Paul, one of the first programs of its kind, is often regarded as the model for school-based clinics, each program is tailored to the needs and resources of the community it serves; consequently, programs differ widely in their organizational structure, operating costs and funding sources. They also vary in the number of clinic sites they operate, the extent of referral arrangements, clinic hours and, most significantly, the range of services they provide.¹⁷ The majority of the programs operate a single clinic; however, a few programs have as many as six clinics. At least 17 of the clinics operating in 1988 are situated in junior high schools.¹⁸ About 85 percent of the clinics are located within school buildings and the remainder are adjacent to school grounds. The great majority of clinics (80 percent) are open during the entire school week, and nearly half maintain summer operations. About 18 percent have evening, weekend or emergency coverage by

staff physicians, and 38 percent have backup arrangements with local hospitals for emergency care.

All school-based clinics have certain common elements: They all provide physical examinations and medical screenings on site; they all offer treatment for minor illnesses and accidents; and they all provide counseling on family planning and personal problems.¹⁹ In addition, most clinics offer gynecologic examinations, refer patients to other providers for family planning and treatment of sexually transmitted diseases, offer prenatal care, refer for vision and hearing problems, provide nutrition and weight control counseling and offer mental health counseling. Some clinics distribute contraceptives on site, provide child care for teenage parents, offer job counseling, organize school remediation and mentoring programs or offer family counseling and social services.

Although the media have focused heavily on the provision of birth control in school-based clinics, in fact only 10-25 percent of all clinic visits are made for family planning services. Most clinic visits are for physical examinations or for treatment of minor medical problems such as colds, menstrual cramps and injuries due to accidents. Physical examinations are detecting a surprisingly high number of vision and hearing problems as well as other medical conditions, such as heart murmurs and respiratory diseases, that require referral to other health care providers. Because of the large number of students who have minor complaints or major problems, clinics are heavily utilized and often have difficulty keeping up with demand.

According to a survey carried out in 1987, 21 percent of clinics dispense birth control pills and condoms on site (following counseling and appropriate medical procedures, such as pelvic examinations and Pap smears); 48 percent offer gynecologic exams and prescribe contraceptives, but refer students to collaborating agencies for contraceptive supplies; and 31 percent provide birth control counseling and referrals only.²⁰ (An earlier survey, published in 1986, had reported that 28 percent of school-based clinics dispensed contraceptives, 52 percent prescribed contraceptives and 20 percent offered birth control counseling and referrals only.²¹)

Organization and Funding

One of the least understood aspects of school-based clinic programs is their organizational structure. With few exceptions, school systems do not directly fund or operate clinics; local agencies establish

*Among women aged 16-19 with low basic skills living in poor families, 21 percent of whites, 23 percent of blacks and 21 percent of Hispanics had given birth to a child; among women in the same age-group with at least average skills living in nonpoor families, three percent of whites, three percent of blacks and five percent of Hispanics had given birth.

+Much of the information about clinics is from a 1987 survey of 35 programs operating 50 clinics. (See: S. Lovick [ref. 17].)

the clinics, typically as satellites of ongoing health and social service programs.* The earliest programs were developed by individuals responding to particular needs in their communities. These pioneer programs were both created and administered by medical schools and their affiliated hospitals (the St. Paul and Dallas programs), by neighborhood health centers (Jackson, Miss.) or by nonprofit youth agencies (Kansas City, Mo.). Increasingly, however, programs are being initiated by local public health departments supported by state funds. The newer programs are often operated by nurse practitioners who double as administrators and clinicians.

A 1986 survey of school-based clinic programs found that 33 percent of grantee agencies are hospitals, 23 percent are health departments, 20 percent are nonprofit youth agencies, 17 percent are community health centers, four percent are schools and three percent are family planning agencies.²² However, the organizing agency often contracts with other community agencies to provide specialized medical services, mental health counseling, substance abuse counseling, health education, family planning or services for teenage parents.

School systems have begun to play a more assertive role in the initiation of clinics in response to the complex needs of their students. School principals play the key role in gaining approval for the project, allowing program operators to come into the schools and ensuring acceptance and utilization of the clinic.²³

Almost all school-based clinics require that parents sign a consent form. In most cases, consent covers all services available through the clinic. In some clinics, the consent form advises parents that state laws prohibit clinic staff from informing parents of particular treatments, but in a few other sites, the consent form allows parents to prohibit certain treatments.²⁴ Although most programs actively encourage the participation of parents in the planning stage and attempt to keep parents informed of clinic activities, few parents actually attend information meetings. (Several polls show a high level of support for school-based clinics. Of 1,000 adults surveyed in North and South Carolina, nearly four out of five favor the establishment of health clinics in public schools, with the strongest support coming from minorities [91 percent] and lower income adults [84 percent].²⁵ The Harris Poll has reported that 69 percent of all parents favor requiring public schools to establish links with family planning clinics so that

teenagers can learn about contraceptives and obtain them.²⁶ In New York City, 98 percent of the parents of students in schools with clinics said they wanted a health clinic in their child's school; 85 percent said they wanted the clinic to provide family planning counseling; and 61 percent said they wanted the clinic either to supply contraceptives or to provide prescriptions for contraceptives.²⁷)

On average, an estimated 71 percent of the students in schools that have clinics are enrolled in the clinics.²⁸ In the Dallas program, 85 percent of the eligible students were enrolled in the clinic, and a total of 11,000 visits were recorded in a recent year.²⁹ Costs per client at school-based clinics are roughly estimated to be between \$150 and \$250 per year, and caseloads average about 1,000, yielding an annual estimated cost of about \$200,000 for clinic operations.³⁰ However, the range of expenditures varies considerably according to the services offered, the size and location of the school, state policies on reimbursement and the amount of contributed staff time and equipment. One study found that the average cost of a routine physical examination in a Delaware school-based clinic was \$11, compared with \$45 for a visit to a private physician's office.³¹ In contrast, a clinic in New York City anticipated a cost of \$75 per clinic encounter.³²

Many of the earlier clinics were launched with private foundation support but were forced to seek public funding after they grew out of the demonstration phase. Funding for other clinics has shifted from the public to the private nonprofit sector; for example, the St. Paul program, formerly part of the hospital-based St. Paul Maternal and Infant Care Project, has incorporated privately as Healthstart in order to have more flexibility in applying for grants. At the same time, some foundations are funding new school-based programs with substantial multiyear grants that generally require matching funds from the community. The Robert Wood Johnson Foundation, for example, has divided up \$16.8 million for comprehensive services among its 23 new grantees, which averages about \$730,000 per grantee spread over five years.³³ The Annie E. Casey Foundation recently launched a program that awarded five cities \$10 million each to develop "an integrated assault on the major problems of at-risk youth . . . dropout rates, youth unemployment, and adolescent pregnancy."³⁴ And a number of other private organizations, including the Carnegie Corporation, the Willam T. Grant

Table 1. Distribution of comprehensive school-based clinics in the United States by state, 1985 and 1988

State	Year and status		
	1985 operational	1988 operational	1988 planning stage
Alabama	0	1	1
Arizona	0	3	0
Arkansas	0	0	2
California	0	7	2
Colorado	0	5	0
Connecticut	3	5	4
Delaware	0	1	0
District of Columbia	0	0	0
Florida	0	1	2
Illinois	1	5	1
Indiana	1	2	0
Louisiana	0	3	0
Maine	0	2	0
Maryland	0	7	0
Massachusetts	0	2	5
Michigan	4	8	15
Minnesota	8	10	0
Mississippi	5	6	0
Missouri	3	4	0
Montana	0	2	0
New Jersey	0	19*	0
New Mexico	0	9	0
New York	5	14	20
North Carolina	0	3	1
Ohio	0	1	0
Oregon	0	8	0
Pennsylvania	0	1	3
South Carolina	0	1	0
Tennessee	0	3	0
Texas	2	2	0
Virginia	0	1	0
Washington	0	1	3
Wisconsin	0	1	5
Total	32	138	65

*Nineteen of 29 programs include family planning.

Sources: **All states except Massachusetts and New Jersey**—W. F. Wesson, Support Center for School-Based Clinics, personal communication, June 7, 1988; **Massachusetts**—J. Gorbach, Massachusetts Department of Health, personal communication, Apr. 26, 1988; **New Jersey**—Handout at *School Based Youth Service Program: Profile of Funded Projects*, meeting prepared by the New Jersey Department of Human Services.

Foundation, The John D. and Catherine T. MacArthur Foundation and the Henry J. Kaiser Family Foundation, are developing broad programs that address high-risk adolescent behaviors. Many of these programs include pregnancy prevention as one of their goals, and school-based clinics as the preferred delivery mechanism.

In recent years, several states have initiated comprehensive programs directed at high-risk youth, and other states have made appropriations specifically earmarked for funding school-based clinics. For example, the New Jersey Department of Human Services is providing funds to

*The Gary (Ind.) Community School Corporation is one school group that operates its own clinic.

29 communities to operate school-based youth services programs in order to address such problems as high teenage unemployment rates, family breakup and mental illness, suicide, teenage pregnancy, welfare dependency, high school dropout rates and health problems, including drug and alcohol use.³⁵ Nineteen of the projects offer family planning services. The proposed strategy emphasizes early intervention, family involvement and the provision of comprehensive services in a single accessible site. Many agencies in Oregon are involved in the state's Initiative on Youth, which focuses on education to prevent school dropout and alcohol and drug abuse and on provision of health and mental health services, family services and services to teenage parents.³⁶ As part of the Initiative on Youth, the Oregon State Health Division is currently funding eight school-based clinics, with more expected to open in the future. Michigan probably leads the country in stimulating the development of clinics; its Task Force on Adolescent Pregnancy is promoting the establishment of 100 clinics throughout the state,³⁷ 23 of which are already in operation or are being planned.

Most of the state-funded school-based clinics either prohibit the use of funds for contraceptive supplies and abortion referral or allow grantees to decide what to do about the issue of pregnancy prevention. For example, the New Jersey program description states, "Family planning services may be provided at local option. However, state funds under the School Based Youth Services Program cannot be used to pay for contraceptives and abortion services."³⁸ The Oregon Initiative on Youth announcement says, "[School clinics] counsel and care for pregnant teens. They do *not* perform abortions. They do *not* dispense contraceptives."³⁹ In Michigan, the legislature simultaneously approved \$1.25 million for school clinics and imposed a 25 percent state aid penalty on clinics that dispense contraceptives or make referrals for abortion.

The current total level of public funding for school-based clinics is unknown, but in 1986, prior to several of the new state initiatives, almost two-thirds of all funding came from public sources.⁴⁰ About 27 percent of the funds came from federally funded, state-operated Maternal and Child Health Services block grants, 16 percent came from state health demonstration projects and 14 percent were from the Early and Periodic Screening, Diagnosis and Treatment program of Medicaid. Other sources of federal funding that were being

used at the local level included the Community and Migrant Health Centers program, the Social Services Block Grant program (Title XX) and the Family Planning Services program (Title X). Although in every year since 1985, bills have been introduced in Congress to set aside \$50 million for demonstration projects of school-based comprehensive health services, none of these bills have moved out of committee thus far, despite support from a long list of national youth service organizations.

A prospective funding source for school-based clinics is the Youth 2000 program, the current administration's effort "to assist young people at risk of not making a successful transition" from school to work.⁴¹ The program, a joint undertaking of the Department of Health and Human Services and the Department of Labor, awarded grants totaling \$3.48 million to selected state and local grantees. None of the projects funded were focused on primary pregnancy prevention; however, the New Jersey School-Based Youth Services Program received funds to establish a Youth Technical Assistance Center (to support the comprehensive school centers) and 12 other states received grants for planning efforts, policy analysis, data collection and state and local conferences. Many states are in the process of planning comprehensive youth-at-risk initiatives, and school-based clinics are one of the program models under consideration.

Program Evaluation

Three years ago, no conclusions about the efficacy of school-based clinic programs as pregnancy prevention interventions could be drawn because of the lack of reliable impact evaluation data. Unfortunately, the situation has changed little since then, mainly because evaluating the impact of school-based clinics on changes in reproductive behavior presents difficult methodological problems. An evaluation of clinic programs in seven sites was launched in 1985 by the Center for Population Options; unpublished preliminary findings suggest that those selected school-based clinic programs had no significant effect on pregnancy rates or birthrates.⁴² There is, however, an increasing body of data from other sources about students' sexual activity, contraceptive use, substance abuse and other behaviors.

One of the concerns raised by opponents of school-based clinics is that the existence of clinics in the schools might encourage adolescent sexual activity. However, research to date has yielded no evidence that rates of sexual activity increase among

students who participate in clinic programs. A survey carried out in Kansas City two years after the opening of a school clinic there revealed almost no change in reported sexual activity among clinic users.⁴³ An evaluation of a three-year school and clinic demonstration project in Baltimore found that students exposed to the program for three years postponed first intercourse an average of seven months longer than did those not exposed to the program.⁴⁴

Growing evidence suggests that participation in school-based clinics may have a positive impact on contraceptive practice. A survey carried out in a Houston school found that compared with students who did not attend the school clinic, those who did attend were more than twice as likely to use contraceptives every time they had sex and were less than half as likely never to use contraceptives.⁴⁵ Among sexually active students in Kansas City, clinic enrollees showed higher rates of contraceptive use than did those not enrolled; further, there was a striking increase in the use of condoms among male clinic patients.⁴⁶ In the Baltimore demonstration project, younger students in the experimental schools were much more likely than those in the control schools to use birth control.⁴⁷ And in St. Paul, there was an extremely high rate of method continuation among female students who obtained contraceptives at school clinics: After one year of clinic services, 91 percent were still using the method prescribed at the clinic (mostly the pill), and after two years, 78 percent were doing so.⁴⁸ (In comparison, freestanding family planning clinics report a 12-month program dropout rate of close to 50 percent.⁴⁹)

Although there is no conclusive evidence showing that school-based clinic utilization lowers pregnancy rates or birthrates, three years ago, data based on the experience of students in the high schools participating in the St. Paul program showed a decline in fertility rates from 59 births per 1,000 female students in 1976-1977 to 26 per 1,000 in 1983-1984. More recent data show that the birthrate rose to 37 per 1,000 in 1984-1985, and then decreased slightly in 1985-1986, to 35 per 1,000.⁵⁰ Thus, the sharp decline in the birthrate observed during the early years

(Continued on page 198)

*According to local sources, the rise in the birthrate in St. Paul reflected the immigration and school enrollment of Hmong from Vietnam, many of whom have babies at young ages. (L. Edwards, director of Healthstart, Inc., personal communication, 1986.)

(Continued from page 196)

of the program has been maintained, with relatively low annual birthrates ever since. The only program evaluation to date that has linked a school-based program to reductions in pregnancy rates was the one carried out in Baltimore.⁵¹ However, in this demonstration project, medical services were not provided in the schools—students were counseled in school and referred to a nearby clinic. The study found that pregnancy rates among students in program schools dropped by 30 percent during the same period that the rates rose by 58 percent in control schools.

Lessons Learned and Future Issues

School-based clinics present a number of organizational problems. Organizing a school clinic is a long and complex process involving consultation with and approval from officials of the school system and the principal at the school site; packaging of services, usually from several agencies; formation of a community advisory board; performance of a needs-assessment survey of students; remodeling of school space; securing of funding; hiring of appropriate staff; establishment of medical protocols; and receipt of parental consent. Since very few communities are able to put all of these components together without assistance from the outside, a number of organizations that provide technical assistance to new programs have been established. Among these are the Support Center for School-Based Clinics (Center for Population Options) in Houston, the Center for Reproductive Health Policy at the University of California, San Francisco, and the School-Based Adolescent Health Care Program organized by the Robert Wood Johnson Foundation in Washington, D.C.

Community support is so essential to clinic success that initiators are advised to spend a minimum of one year in preparation.⁵² Advisory committees must be established that include parents, community leaders, school personnel and others. Within the school itself, personnel must be given a sense of clinic "ownership." Although school nurses have felt displaced by the clinics in some systems, about half of the programs have enlisted their active participation and incorporated them into their activities.⁵³ Clinic staff need to expend considerable effort to involve other school personnel—school counselors, special-education teachers, regular teachers and custodians—in the program as advisers, referral agents and supporters.

Administrators report difficulty recruit-

ing nurse practitioners and social workers, the primary staff team for most clinics. Qualifications for employment in school clinics may include the ability to speak a second language, clinical experience, sensitivity to cultural differences and a strong commitment to working with teenagers. Although the salary scale for clinic staff nurses is generally higher than that for school nurses, the responsibilities of the nurse practitioner may include administration, research, community relations, parent outreach and other nonnursing duties. Further, the intensity and immediacy of the problems encountered by clinic staff often create unanticipated demands on their time. The high reported incidence of sexual abuse, for example, requires intensive counseling, family involvement and collaboration with the appropriate social agencies.

Parental consent is another thorny issue. According to a statement prepared by the National Conference of Catholic Bishops, "The threat posed to parents' rights by school-based contraceptive clinics seems evident, since one reason for locating these clinics in schools is to gain access to teenagers without their parents' involvement."⁵⁴ On the other side of the issue, reproductive health care advocates have expressed concern that the parental consent requirement represents a step backward for reproductive rights. As one legal authority stated, "Parental involvement should not be mandated, legislated or coerced because doing so creates unacceptable barriers to necessary and beneficial health care."⁵⁵

In fact, one of the problems frequently encountered by clinic personnel is the *lack* of parental involvement. Although clinic staff report that few parents deny their consent for clinic services of any kind, parents' failure to return consent forms has resulted in low clinic enrollment rates in some communities. Interviews with the parents of eligible students who failed to enroll in a New York City program revealed that 81 percent said they never received the consent form or thought they had signed it, 10 percent were satisfied with their current health providers and only three percent did not enroll their child because they did not like the clinic.⁵⁶

In addition to organizational difficulties, a number of problems have been encountered in the evaluation of school-based clinics. Because school-based clinics are controversial, the issue of their impact appears to receive more attention than it does in other programs. For example, we do not know how effective the "just say

no" antidrug program is. In fact, there are very few model health or juvenile delinquency prevention programs for which long-term impacts have been reported.

The "ideal" research design for measuring program-related changes in pregnancy rates would include random assignment of students to treatment and nontreatment groups with longitudinal pretesting and posttesting among both groups. However, random assignment is not possible in school clinic settings, and it is often difficult to match experimental schools with control schools on important dimensions such as student achievement levels and dropout rates. Although pretests and posttests are relatively simple to design, administering questionnaires in school settings has turned out to be a much more difficult assignment than expected.

A number of researchers involved in the evaluation of school clinics report that the major problem in measuring program impact is the small proportion of the student body who actually utilize specific clinic services.⁵⁷ For example, if only 20 students use the clinic for weight reduction, 10 might be successful, yielding a high success rate for those students. But if the number of students who lose weight in the program during a year were used as the numerator, and the entire student body were used as the denominator, no effect would be shown. Studies that compare changes among clinic users with those among clinic nonusers in the same school are more likely to show positive results (as was the case in the Kansas City program discussed above).

In the near future, more descriptive data on school clinic programs are expected from a standardized management information system that will produce a wide range of information about patients, visits and diagnoses. This data base was developed by the Center for Population Options for nationwide use and is already being used in Illinois and California. Due to the difficulties in accurately measuring long-term outcomes (pregnancies prevented, for example), clinic goals may have to be redefined in terms that can be more easily documented. Suggested outcome measures include the increase in the proportion of students using clinics who seek contraceptives prior to the onset of sexual activity; the improvement in consistency of contraceptive use; the decrease in reliance on hospital emergency rooms; and the likelihood of seeking treatment for medical conditions detected through clinic screenings.⁵⁸

Despite the continuing debate over school-based clinics, the movement to

make comprehensive health, social and family services accessible to school populations is very strong. The drive toward more coordinated, linked services, with schools as the central focus, is propelled by new, large-scale youth-at-risk initiatives sponsored by states and foundations. Further, a consensus is forming around the concept that disadvantaged high-risk children need access to better health care in order to succeed in school.

It is important to acknowledge, however, that public funding for comprehensive school health services may result in diminished support for contraceptive services in the schools. The more recent cohort of clinics are less likely to dispense contraceptives or even to prescribe them than were the earlier models. According to David Gurule, former program manager of the Oregon State Health Division, "Many school-based clinics have a very broad mandate for the amelioration of adolescent health and social problems, while the services available are often severely restricted because of community sensitivity to issues, most notably teenage sexuality and birth control."⁵⁹ In Oregon, Gurule found the differences between the level of family planning effort in the clinics and the demand for birth control "startling": In the four school clinics that offered contraceptive prescriptions, 9–19 percent of the service requests were for family planning services, whereas in the four clinics that were allowed to provide only information and counseling, but no prescriptions, fewer than three percent of the visits included requests for family planning information.⁶⁰

It is difficult to predict how the level of family planning effort in school-based programs will be affected by the rising threat of AIDS. Clearly, attitudes toward the delivery of sex education and reproductive health care are undergoing rapid changes as a result of the AIDS crisis. At least 17 states now mandate instruction in AIDS prevention, and the majority of the remaining states are in the process of developing curricula.⁶¹ Only a few weeks after the National Conference of Catholic Bishops released a statement strongly advocating the teaching of abstinence, the group issued a new statement acknowledging "that some people will not act as they can and should; that they will not refrain from the type of sexual or drug abuse behavior which can transmit AIDS. In such situations, educational efforts . . . could include accurate information about prophylactic devices or other practices proposed by some medical experts as

potential means of preventing AIDS."⁶²

Because of AIDS, every community will soon have to make hard decisions about giving young people accurate information and access to the means of prevention. School-based clinics may be well-positioned to take on this responsibility by developing programs that combine sexuality education, counseling and comprehensive health services, including the provision of condoms.

Attention must also be paid to developing the management skills of clinic personnel, because assuring the continuity of programs and funding demands a great deal of time and expertise. Currently, there are no programs to train school clinic administrators, although it has been recommended that all clinics hire an administrator for at least the first year of operations.⁶³ Nursing schools and schools of public health may have to develop specialized curricula to meet these emerging needs. In the meantime, technical assistance workshops will have to expand their scope to respond to growing demand.

Whereas the pioneer clinic programs were developed by individuals responding to particular needs in their community, increasingly, programs are being initiated in response to state or foundation requests for proposals. Despite this push toward a kind of conformity, the most significant characteristic of school-based clinics remains their diversity and the decentralization of authority. Only one organizing principle prevails—the urgent need for a multitude of services aimed at disadvantaged young people in schools.

There is no consensus among advocates of school-based clinics about what kind of bureaucratic structure would further the expansion of this model. Should there be a new federal categorical program for school-based health services? Should school-based clinics be part of a larger program, both inside and outside of schools, that addresses adolescent health needs in general? Or should all of these health efforts be subsumed under broad youth-at-risk initiatives that link school remediation, health and social services, and job training and employment? In any or all of these structures, would family planning be a mandated service?

A strong case can be made for noninterference in a diffusion process that is working well, assuming that states and foundations will increase their levels of funding. On the state level, the leadership and support of the governor may be the key to clinic expansion. However, a case can also be made for moving toward a more cen-

tralized federal program that could provide long-term funding and legitimation. Such a program could promulgate national standards to maintain quality of services, ensure that funds are distributed according to needs, address training issues and facilitate uniform data collection. Whatever approach is taken, it is probable that school-based clinics will increasingly be recognized as a viable model for service delivery.

After several years of experience, the question still remains: Do school-based clinics hold promise for pregnancy prevention? Evidence from the field suggests that the performance of clinics in regard to sexuality issues varies widely. Many clinics pay only a minimum of attention to family planning because of perceived or actual school or community constraints, state funding restrictions or ambivalent attitudes on the part of the staff. Where family planning is perceived as a service integral to comprehensive clinics and the staff is committed to the prevention of pregnancies, utilization of school clinics for family planning services is much higher. However, even when programs are heavily utilized for birth control services, counseling and referral, it has proven difficult to document their impact on pregnancy rates.

Based on the enthusiastic response to school-based clinics among students, school personnel, parents, health professionals and community leaders, it is clear that such programs hold promise for enhancing the quality of life for disadvantaged youngsters. In this broad sense, access to a wide range of needed health and social services may strengthen students' chances of succeeding in school, entering the labor force and delaying parenthood until a later time. Nevertheless, those who are concerned specifically with the issue of pregnancy prevention must bear in mind that school-based clinics are not the only appropriate vehicle for birth control services. Adolescents and others still need access to community-based family planning services, community education on sexuality issues and other kinds of family planning programs.

The focus on collaborative health and social service projects in the schools is a function of the heightened concern about the deteriorating social environment and its consequences for disadvantaged children. In light of current preoccupations and past experience, it appears that the future of comprehensive school-based clinics does not hang on the ability of the opposition to block their development.

Rather, the future rests on the adequacy of funding, the resolution of policy issues at the local level and the availability of trained managers and health practitioners. The continued growth of the school-based clinic movement will require strong advocacy, documentation of benefits, coalition-building and leadership. Although the incipient movement has not yet fully developed all of these attributes, the potential clearly exists.

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