Family Practice Grand Rounds

Adolescent Health Care: Improving Access by School-Based Service

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DR. CARLOS GONZALES *(Fellow in Adolescent and School Health, Department of Family, Community, and Emergency Medicine)*: Traditionally, health care for most teenagers has been either poorly accessible or underutilized.[1] The reasons are numerous, most emanating from a teenager's orientation. While the teenager strives for increased independence, such aspirations are rarely matched by independent finances to pay for personal health care.

Teenagers often live for the moment, responding to immediate life stress. Inaccessibility to health care services, either because of delayed scheduling or distance from the provider, can seem an insurmountable obstacle, leading to missed or canceled appointments. Further, teenagers are often intensely private, reluctant to share personal worries. Thus, some of the most important concerns and risks for this population—sexuality, depression, drug and alcohol abuse, contraception, and sexually transmitted diseases—are too often hidden from skilled providers who could counsel and treat effectively.

Finally, the ambience of most clinics and physicians' offices is not conducive to adolescent culture and values. Most family physicians and internists cater primarily to the adult population, display the likes of *Woman's Day* and *Modern Maturity* magazines in their waiting rooms, and may pipe Muzak overhead. Pediatricians usually cater to the younger child. Bright yellow walls may serve as a backdrop to shelves of Sesame Street and Dr. Seuss books. Adolescents may feel alienated.

An ideal service for teenagers would offer immediate services for crises or questions, strict confidentiality (even from parents), ready access to prescribed medications, a full sliding-scale fee scheme, and a staff that is sensitive, caring, and tolerant of divergent values and lifestyles.[2] Unfortunately, such services are almost nonexistent. Instead, physicians usually offer a traditional health service model, requiring the patient to come to their place of practice. While convenient and rational for the provider, it is inconvenient and

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irrational for most teenagers. Those who populate such traditional practices are more often than not brought by parents and come from financially secure families, probably a small number of the entire teenage population. What is needed are programs to serve the much larger denominator population, which is currently badly underserved.[3-6] The University of New Mexico's Department of Family, Community, and Emergency Medicine explored the feasibility of delivering services to the adolescent community on their own turf—the high school.

Two school-based pilot adolescent clinics were established by the department in collaboration with the Department of Pediatrics to test this broader, more accessible, community-oriented health care model. One clinic is an inner-city high school in Albuquerque with 1,400 students, predominantly Hispanic, and the other is in a rural school in New Mexico, where the 410 students are predominantly Pueblo Indian. In both schools most students come from lower income families, and employment and family stress are common in the student's home life. Both on-site clinics provide urgent medical care, family planning, pregnancy testing, psychological counseling, alcohol and drug counseling, and classroom health education at the request of teachers or students. The clinics are staffed by family practice faculty and residents, a fellow in adolescent and school health, a nurse practitioner, and medical students from the University of New Mexico School of Medicine. Team coordination is provided by a school nurse and a health educator or fellow at the inner-city high school and by a health educator and community coordinator at the rural high school.

Establishing school-based programs had the intrinsic appeal of increasing health care access to all of the youth of the high school communities. However, a series of unforeseen problems were encountered, which will be explored as the focus of our discussion. The discussants in this Grand Rounds have participated in different aspects of the program.

The first issue concerns the constraints under which outside health providers must work when treating medical problems within the high schools.

DR. ARTHUR KAUFMAN *(Professor of Family Medicine)*: First, we were limited by financial, ethical, and political constraints. A prime example was the health team's interest in prescribing contraception for teenagers on school grounds. Data from other programs show teenage pregnancy declines when contraception can be not only prescribed but also distributed on school grounds.[3,6] Both administrators in the urban high school were hesitant to deal with this volatile subject because of the dominant religion of the students (Catholic) and its political ramifications (fearing a parental backlash against school physicians "encouraging promiscuity"). Could our clinic ignore the administration's concerns? Are there alternative methods of handling this problem?

DR. GONZALES: At your rural high school program, Ms. Davis and Dr. Kaufman, are you prescribing birth control on campus? If so, has any backlash come from that and how have you dealt with it?

MS. SALLY DAVIS *(Coordinator of School Health, Department of Pediatrics)*: We can prescribe and give medications on site. There's been no backlash. Only one mother telephoned, angry that her daughter had received birth control pills. Actually, she had obtained them from another clinic. Nevertheless, the center physician invited the mother to come in and talk over the issue because the mother was denying that her daughter was sexually active. Another approach to the birth control issue is to ask for written parental consent for health services without itemizing specific services. Simply say that care provided will include preventive services, acute care services, health promotion services, whatever, but keep it general. Don't say "lab tests for pregnancy" or "prescriptions for birth control pills." We don't ever make a secret of what we are doing, but we also don't play it up as being any different from doing sports physical examinations or testing for diabetes.

DR. NORTON KALISHMAN *(Director of School Health, Albuquerque Public Schools)*: At the first meeting we had with the urban school's parents and the administration, the issue of contraception came up. We knew we couldn't simply start the clinic and then wait for a parent to object. They asked us whether we would provide birth control? They asked whether parents would be notified?

MS. DAVIS: How did you respond?

DR. KALISHMAN: We asked the parents and administration how they saw the issue and how comprehensive they thought the services should be. They seemed to feel the presence of a general parental consent form would ease the potential conflict.

DR. KAUFMAN: We also itemized "medications" and "referrals" on our parental consent form, and I think that helped to cover us.

MR. KEN HUNT *(Coordinator for Community Adolescent Projects)*: Any school-based clinic must be concerned about the concerns of the school administration, which reflect concerns of parents, students, and the community, and those concerns cannot be ignored.

DR. GONZALES: At our urban high school clinic we were prohibited from distributing contraceptives on school grounds. We could do all the counseling we wanted. Yet, we have seen so many young girls who want birth control and they want it immediately! They don't want to go a half-mile to the university clinic. It is unfamiliar, it costs money, and it is inconvenient. It is difficult to determine when responsibility to the adolescent patient requesting contraceptives on campus exceeds my responsibility to the school principal.

DR. KAUFMAN: Dr. Gonzales makes an important point. Our role is ambiguous. We're volunteers and seen as outsiders. Thus, we can more easily bend rules while caring for students because we are not employees of the school system. We can often take this too far by not including school personnel in planning the clinic's activities. In one sense we're more vulnerable to being closed down if we challenge the rules because of our "outside" status.

DR. KALISHMAN: I think we may be missing an opportunity to bring the administration and parents closer to our position on contraception. In Albuquerque there are ten high schools, all with the same central administration. This particular urban school administration didn't want to be identified as the school whose students needed birth control. They were having enough problems as the inner-city school serving low-income students with lower grades. So if we could encourage other schools to provide contraceptive services, the stigma might diminish, as would resistance to contraception on campus.

DR. KAUFMAN: In retrospect I was suprised; we got the most parent opposition, not from birth control prescriptions, but from failing to break our confidentiality with our adolescent patients. Parents weren't aware that adolescents have rights to confidentiality.[7,8]

DEBORAH MULLIGAN *(Albuquerque Public School Nurse)*: Regardless of the law, parents feel their trust in the school is violated when they perceive a health team "conspiracy" to keep their child's problem from them. For example, a young pregnant student had not decided whether to keep the child or have an abortion. We encouraged her to discuss the options with her parents, but she refused. After three frustrating weeks of counseling with her, I decided to call up her mother and discuss her daughter's predicament. The mother lost control and the father ended up calling us, yelling and screaming because we had "waited so long" to notify him! It appeared to be a no-win situation for the health team. As a school nurse I believe those parents do have rights, but then the students as my patients have rights too, and they don't always mesh.

MS. DAVIS: I think what we see here are two separate systems housed under one roof: the first, a school with its written policy and responsibilities, and the second, a clinic run by an outside agency with separate values, orientation, and responsibility.

DR. KAUFMAN: Another strategy we might use is to deemphasize the clinic's focus on birth control and focus instead on problems that the administration, parents, and students feel are very important. When I began working in the high school, I thought our primary task was to reduce unwanted pregnancy. But after two years of work there and after reviewing students' responses to a health survey we conducted, it is clear such issues as family disruption, depression, and uncertainty about the future dominate students' concerns far more than pregnancy. These other issues are certainly safer, less volatile topics for us to discuss with parents and administrators.

MS. DAVIS: We conducted a similar survey before we set up our project in the rural school and found that each group—students, tribal people, school officials, and health team—had different perceived needs. For example, the tribal council was concerned with student absenteeism and school dropouts. The school administration was concerned about students smoking "dope" on campus. The students were overwhelmingly concerned with the lack of recreational facilities. And the health care providers initiated the program because they were concerned about teenage pregnancy.

DR. KAUFMAN: You're right, we often don't understand the needs of the school. To many teachers it seems we keep kids out of class too long, we send them home too easily, or we give them an excuse not to participate in gym for some minor complaint. If we are to build up trust among faculty, what we say must make sense to them; we have to explain why we're making that recommendation. Students we don't know well can be charming and seductive. We become their advocates and find out later they are quite manipulative. In fact, teachers, counselors, and administrators have a wealth of information about the students that we often don't bother to tap into early enough.

MS. DAVIS: Teachers are the most important persons with whom to negotiate time for students. Even though the administration sanctions health care for the students, the decision is ultimately the teachers'. To get the students out of class, we need that teacher's permission. We have had an incredibly difficult time getting students out of class in the rural school. They could be dying, and the teacher would respond, sorry, typing class is more important than going to see the counselor or physician. So we agreed to all kinds of controls to make sure that that these students are not "abusing the system."

DR. GONZALES: Let me summarize this issue. First, it is important to survey the constituent parties in a school-related population: parents, administrators, teachers, and the students themselves. It is important to address those needs as opposed to focusing solely upon our own preconceived agenda. Trust and support can thereby be generated. The second major consideration is that we should develop an alliance among the health team and the school administration, the parents, and the students. Third, we should start slowly and not expect to be a success overnight. It takes time to develop trust and support among so many diverse parties in this kind of effort.

The second major question I would like the

group to address concerns the pattern of clinic use by high school students. Even though placing the clinic in the high school should have increased the teenagers' access to health care, we discovered that only a selected patient population was utilizing the clinic. When the health team works in the classroom, many concerned students are found who are as needy of clinic services as those who do attend the clinic. How can the clinic further increase the attractiveness of its services to a broader representation of the school body?

MS. MULLIGAN: One problem we've discovered is simply a lack of public awareness. Lots of students don't know about the clinic and never consider getting health care in school. We get the most exposure, which is our best advertisement, when we go into the classroom. But in a school of 1,400 students, that process takes a long time. Beginning next year we plan to bombard each ninth grade class during freshman orientation so that in four years the school population will really know about us.

NINA WALLERSTEIN *(Coordinator, Occupational Health Programs, Department of Family, Community, and Emergency Medicine)*: Have you found a difference between students who come and those who don't? Is it simply a matter of who knows and who doesn't, or are there barriers that you haven't been able to identify?

DR. KAUFMAN: We don't know yet. We're going to review clinic charts to see whether the sample of students using the clinic reflects the school as a whole. One study conducted by Lewis and others[9] looked at elementary school students' self-initiated utilization of school nurses' services. It found a significant difference by gender. From an early age girls are conditioned to express their discomfort, while boys are conditioned to suppress it. If this is true for our high school groups, we need to find strategies to target the population least likely to reveal their concerns—boys. That's why going out into classrooms or out into the playing fields may be important adjuncts to our work in clinic.

DR. KALISHMAN: This highlights the consideration that we should look at meeting the needs of adolescents in ways other than just providing medical services. It's true that we're most comfortable providing direct services, but what are other ways to reach teenagers? Besides advertising, a number

of schools have tried to involve students in creative ways. They have developed theater groups that can work around health issues. They have encouraged efforts at peer counseling and helped develop health-oriented student-run community services. So there are indirect, yet substantial, ways to raise adolescents' awareness of their health. We don't reach them if we wait for them in clinic. We have to focus more broadly on the things that affect people's health. Those teenagers who are working in theater groups are coming to the group with a lot of ideas concerning health-related issue. As professionals we need to think of ways to get students involved other than expecting them to come to see us if something is wrong.

DR. KAUFMAN: Some of the biggest concerns emerging from the student health questionnaire were "feeling down" and a great "uncertainty about the future." A student with either of those concerns may not connect them with a solution to be found in the clinic. He might go to a job counselor or talk to some friends. For many students, since they're not hurting physically, they believe their distress is not appropriate to bring up with a physician or nurse. We can't hope to address the epidemic of teenage suicides unless we can bridge this gulf.

MR. HUNT: Your comments relate to our experience at the rural clinic. We wanted to broaden our image. The clinic should be "owned" by the students, seen as a place where not only physical and serious psychological problems are tended to, but where a student who is well can check out some of his ideas about handling a minor home problem or working on a science project. We want the students to define the breadth of that service. To do that, we have to keep coming back at them, ask their advice, mold the clinic on the basis of their feedback and consultation.

MS. DAVIS: To reinforce student participation and ownership, we have sponsored fun runs, put out newsletters, handed out clinic T-shirts, and had a teen health awareness day involving students, parents, and teachers. We had students working with staff members on a particular project to make it as nonthreatening as possible. All those things contribute toward the image of a broader concern by the clinic and a real partnership with the students. Students are increasingly just drop-

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ping into the clinic. Even if they have just a few minutes to eat their lunch, they still end up at the center.

DR. KALISHMAN: As we try to expand our role, I think we ought to do health promotion activities in the school that also serve the adult population. Whether it is fitness screening, health risk appraisals, or blood pressure screening, we should do things that get adults more involved in their own health care. By seeing that we are not wanting just the teenagers to come to clinic sick sends an important message to adults. It says we are open for a different kind of service.

MS. DAVIS: In-service training provides another way of addressing a major need perceived by the school and is an excellent way to alert teachers to the kinds of things they should refer students for and how to go about it. The day following such an in-service program at the rural school, the referrals to the counselor doubled and tripled because the teachers were suddenly aware of which students were at risk.

MS. WALLERSTEIN: Teenagers' feelings of alienation and fear of the future aren't widely viewed as "medical problems" until they lead to suicide, attempted suicide, or an immediate, acute, dangerous situation. The clinic somehow needs to work more creatively with teachers to develop a center for positive activity. The fun run you spoke of, sponsored by the clinic, is an example of a positive activity. There could be activities that lead to even more empowerment of students, such as encouraging the teenager to do something actively for his or her own future. The clinic should be a vehicle for this kind of activity.

DR. KALISHMAN: One important way of getting the school administration involved is to see whether there might be a way to get academic credit for students for their involvement in some of the health promotion activities. It will be gratifying for the students, who can get credit and think about career options, and the administration won't have to worry about taking a student out of class for a nonacademic activity.

DR. KAUFMAN: This issue is very important because the future health of that student, his or her income status, and access to jobs will have a more profound impact on health than the clinic treatment we provide.[10] Along a similar line, we've discovered that an important service provided by the clinic is economic relief for working parents who are living on marginal incomes. It's very costly for them to leave work and take their kids to a physician's office, where they may wait for several hours and may be docked pay. We therefore provide them with significant direct and indirect economic relief by having a school-based clinic.

DR. GONZALES: In conclusion it seems public relations, getting out of the clinic and into the classroom and community, are very important. At the same time it is important to provide services that are needed by the teachers and administration By teaching teachers, the quality and number of referrals of teenagers to the clinic will increase. Then, we should seek creative ways to involve teenagers in their clinic—by activities (eg, fun runs, newsletters) and by empowerment (eg, teenage advisors to clinic). We should deepen and broaden the concept of what health means so teenagers can participate in health promotion activities, not just receive curative services. And finally, it is critical that the clinic carefully nurture the trust of the students.

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