School Health Assessment of Bureau of Indian Education Schools in New Mexico

October 2008

Acknowledgements

This initiative was a collaborative effort of the following organizations:

Bureau of Indian Education

New Mexico Department of Health

Indian Health Service

New Mexico Alliance on School Based Health Care and its 4-Youth Initiative

McKinley County Coalition for Healthy and Resilient Youth

New Mexico School Nurses Association

Northwest New Mexico School-Based Health Care Champions

Author and Project Lead:	Georgina Castro, MPH, MID
Data Collection:	Matthew Slater, MPH
Contributors:	Janie Lee Hall, RN, PNP Judith Wolfe, MSN, PHN Susie John, MD, MPH Sandra Dodge, RN, CNP Linda Hummingbird, RN, BS Lucille Ross, MPH Kimberly Ross-Toledo, BA David Broudy, PhD, MPH Mary Ramos, MD, MPH
Editor:	Patsy Nelson, MA, BSN

For further information on the contents of this document, or for additional copies of the report, please contact Janie Lee Hall, RN, PNP, at janie.hall@state.nm.us or at (505)863-4561.

Table of Contents

Executive Summary

"You can't educate a child who isn't healthy, and you can't keep children healthy who are not educated."

Jocelyn Elders, MD, Former Surgeon General

American Indian people experience the poorest rankings in nearly all social, health, and economic indicators, despite federal efforts to improve the outcomes among this population. Young people are of particular concern. Although disparities are narrowing, American Indian youth are still far behind. Fifty-seven percent of American Indians graduate from high school, compared to 76 percent of the white population.[1] American Indian youth are affected by startling rates of sexual risk behaviors, suicide, substance abuse, unintentional injuries, and violence. These statistics, along with the impact of poor health indicators on educational achievement, demand an examination of the institutions that serve this population.

The Bureau of Indian Education (BIE), the federal agency charged with providing education to American Indians, supports 184 primary and secondary schools in 23 states. These schools serve approximately 50,000 students. The BIE also supports 27 colleges that reach 10,000 students. The Indian Health Service (IHS) is the federal agency that provides health care to American Indians at 594 direct health care delivery facilities in 35 states. In July 2003, the US Commission on Civil Rights released *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*, a review of the six federal agencies with the largest expenditures on Native American programs. The report lends credence to the long-held belief that the federal expenditures nationwide on the health and education of American Indians are significantly less than the expenditures spent on the average non-American Indian individual.

There is no system in place that supports school health programs in BIE schools. Most public schools have the necessary infrastructure to support core school health functions—tending to sick children, screening children for health problems, and ensuring that all children are vaccinated. Some BIE schools struggle to provide health services from their educational budgets; others rely on the IHS for support. Health professionals in New Mexico have been concerned with the access to health services in BIE schools. In February 2006, an effort to assess the school health services in the BIE schools in New Mexico was initiated.

The BIE School Health Assessment was a collaborative effort among several health-related and Native American-serving organizations in New Mexico. A survey to assess school health programs was developed based on the CDC School Health Policies and Programs Study questionnaire and administered to BIE schools that chose to participate; 95% of the schools participated.

This report is intended to (1) serve as a resource document to the BIE by providing standards, guidelines, and recommendations on school health policies, procedures, and programs, and (2) to summarize the findings of the BIE School Health Assessment and provide a 'snapshot' of the school health services, policies, and procedures in the BIE schools in New Mexico.

Main themes and key findings that emerged from the assessment are:

- Core school health infrastructure – health facilities and school nursing – is lagging.
  - Sixteen out of the 39 BIE schools that participated in this survey (41%) do not have a health office or school-based health center.
  - Nine out of the 39 schools that participated in this study (23%) have a school registered nurse at least part-time.
  - The average school nurse to student ratio in BIE schools is 1:916, which does not meet the national recommendation of 1:750 for students in the general population.
- IHS and BIE lack resources and capacity for school health programs.
  - The qualitative information obtained from school personnel illustrates BIE collaboration with the IHS and the need for more services from the agency.
  - In the case of school health programs, one under-funded agency (BIE) is relying on another under-funded agency (IHS) to provide for the neediest young people in the country, thus widening the disparity.
  - The IHS was identified as the primary source for public health nurses and clinical services in the BIE schools; however, services are limited.
- School health policies and procedures are disparate from school to school.
  - Over one-third of BIE schools did not report immunization rates to the New Mexico Department of Health in academic year 2006—2007.
  - One-third of the schools report that there is no policy in place regarding students without the required immunization for entry into kindergarten or first grade.
  - The percentage of schools that allow students to carry and self-administer medications to control asthma and diabetes and for acute allergic reactions is low.
- Behavioral and mental health services are sparse.
  - A range of behavioral and mental health services are provided at BIE schools by trained mental health providers; however, the hours of service range from less than one hour per week to 80 hours per week.
  - Governmental funding and community determination are primary determinants for provision of school health services.
  - Providers that were cited most frequently to service BIE schools—occupational therapists, speech therapists, and physical therapists—are supported by special education funds; their services are not available to the general student population.
  - The IHS was most often cited as the primary source for primary care and dental health providers.
  - Eight out of the nine schools (89%) with school registered nurses are BIE grant schools that have used Public Law 93-638 funds for this purpose.
- Communities are important links to health services.
  - Community agencies and Community Health Representatives contribute to the health education programming in BIE schools.
  - Over one-third of schools refer students to community health clinics, hospitals, or agencies for primary care services.
  - Approximately 40% refer to community agencies for mental health services and 18% of schools refer to tribal health providers for mental health services.

Recommendations:

Based on the findings from the School Health Assessment of BIE Schools in New Mexico, the recommendations for BIE schools in the state are in the following areas of need:

- **School health program direction and oversight**: Create position(s) for persons with experience in school health programs in the BIE and the IHS to provide direction and oversight, including standardized guidelines for school health policies and procedures, for school health programs among all BIE schools.

- **Health facilities**: Increase and improve health facilities by ensuring they contain all components to meet Americans with Disabilities Act minimum requirements.

- **School nursing**: Hire School nurses at a minimum ratio of at least 1:750 students to manage and implement school health services which meet student health care needs and enhance academic success. Appropriate ratios consider level of student health care needs, proximity of school to health care services, and boarding school status. Unlicensed personnel must be appropriately trained and supervised by the nurse.

- **Behavioral health services**: Employ licensed mental health professionals to assess risk, provide early intervention, make appropriate referrals, coordinate with outside mental health providers, and ensure comprehensive crisis response.

- **Policies that are evidence-based and standardized**: Provide policies to ensure appropriate immunization, safe medication access and administration, and care of students with complex health care needs.

- **School Health Advisory Councils**: Ensure that students, parents, staff, health providers, and community members are involved to advise local school boards regarding school health policies and practices.

- **Maximized funding and other resources:** Seek resources from state and federal sources to supplement base funding from the BIE and IHS.

- **Quality school health programs:** Implement programs that meet national guidelines and the national school health objectives from Healthy People 2010 (see Appendix G).

- **Data:** Track indicators of student health and academic success to justify the investment in quality school health programs and to stimulate further improvement.

Based on the findings from the School Health Assessment of BIE Schools in New Mexico, it is also recommended that state agencies conduct tribal consultation to determine what resources they may be able to contribute to BIE schools.

The full report contains rich data and expanded findings that support more specific recommendations found at the end of the report.

I. Introduction

Background:

An assessment of school health programs, policies and practices in BIE schools was initiated because of concerns by Native American serving providers and advocates that American Indian youth have limited access to school health services, and because there is increasing national and state momentum with respect to health disparities and inconsistency in school health programs.

Methodology:

A telephone survey was developed and administered to BIE principals or their designees between October 2006 and April 2007. The survey questions were modified from the School Health Policies and Programs Study developed by the Centers for Disease Control and Prevention (CDC). The BIE approved the assessment and provided a letter of support. Discussions were held with Education Line Offices that support BIE schools and with principals of the schools. The sampling frame included the 41 BIE schools in New Mexico. Thirty-nine (95%) of the schools participated.

Domains assessed included health facilities; school health staffing and collaboration; behavioral/mental health services; health education; student, family and community engagement; school health records; immunization; procedures for student medication and management; acute care management; and care of medically complex and medically fragile students. Special analyses were conducted comparing boarding and day schools, and BIE-operated and BIE grant schools.

The report provides a summary of demographic information on the BIE schools in New Mexico. This is followed by the section describing data obtained in each of the domains structured to provide:

- A description of each domain.
- School health guidelines and standards established by national organizations. The majority of the guidelines were obtained from the *Health, Mental Health, and Safety Guidelines for Schools* website at www.nationalguidelines.org. These guidelines were developed by more than 300 health, education, and safety professionals from 30 different national organizations, as well as, by parents and other supporters. The lead organizations were the American Academy of Pediatrics and the National Association of School Nurses. Resources and funding to develop these guidelines were provided by the federal Health Resources and Services Administration, Maternal and Child Health Bureau.
- A summary of the data.
- Key findings.

The report concludes with the following sections:

- A comparative analysis of school health services that examines: 1) BIE- operated schools vs. BIE grant schools 2) Boarding schools vs. day schools and 3) Student population.

- Perspectives from interviewees regarding their school's strengths and unmet needs regarding school health services and programs.

- A discussion of the 'main themes' that emerged from analysis of the BIE School Health Assessment data.

- Recommendations for the BIE and for state agencies that may have resources to contribute to BIE schools for school health programs.

- Appendices which provide more detailed information.

II. Demographics of BIE Schools in New Mexico

There are 41 primary and secondary schools in New Mexico that are supported by the BIE, reaching approximately 9,800 students. Thirty-nine schools participated in the BIE School Health Assessment (95%). The two schools that did not participate were a BIE grant day school (K-12) with 317 students, and a BIE operated day school (K-6) with 256 students.

It is important to note the variability across the schools when interpreting the findings that are presented in this report. Schools have different needs, depending on several factors. This report provides standards for school health programs, established by expert governmental and non-governmental organizations; however, these standards do not account for the uniqueness of each school. In this section, data are presented on several factors that impact the development and implementation of school health services and programs.

Boarding and Day Schools

The BIE funds and supports boarding schools and day schools. Day schools are similar to public schools. Students attend school during the day and return to their homes in the afternoon. At boarding schools, students reside in dormitories on the school campus Monday through Friday, and most students return to their homes on the weekends. In addition to the dormitories on the boarding school campuses, the BIE operates three separate dormitories in New Mexico. Students reside at these dormitories throughout the school week and attend both BIE and public schools during the day. These three dormitories were not included in the assessment.

Type of School	Number of Schools	Percent
Boarding Schools	17	44
Day Schools	22	56
Total	**39**	**100**

BIE-Operated Schools and BIE Grant Schools

Federal funding for American Indian education supports two primary mechanisms of financing and providing education to students. The BIE may fund and operate the school on tribal lands or the community may elect to be a 'grant school' in which case the community receives funding from the federal government and operates the school.

Type of School	Number of Schools	Percent
BIE-Operated	27	69
BIE Grant	12	31
Total	**39**	**100**

Education Line Office

Each BIE school across the nation is assigned to an Education Line Office that supervises and provides technical assistance to the school. In New Mexico, there are four Education Line Offices. Two schools in New Mexico report to the Fort Defiance Education Line Office in Arizona.

Education Line Office	Number of Schools	Percent
Northern Navajo/Shiprock	7	18
Northern Pueblos	6	15
Southern Pueblos	9	23
Eastern Navajo	15	38
Fort Defiance	2	5
Total	**39**	**100**

Student Population

In the academic year 2006—2007, the BIE served approximately 9,751 students in 41 primary and secondary schools in New Mexico. The data below show the number of students in the 39 schools surveyed. It is important to note that a significant majority of these schools, 30/39 (77%), are small, serving less than 300 students.

Number of Students	Number of Schools	Percent
1— 99	8	21
100 — 199	16	41
200 — 299	6	15
300 — 499	5	13
500 and above	4	10
Total	**39**	**100**

Grade Level

The BIE supports 41 primary and secondary schools in New Mexico. Approximately five of the schools also provide pre-kindergarten education. Below is a summary of the grades served in the 39 BIE schools surveyed.

Grade	Number of Schools	Percent
Kindergarten — 3^{th}, 4^{th}, or 5^{th}	5	13
Kindergarten — 6^{th}, 7^{th}, or 8^{th}	25	64
6^{th} — 8^{th}	1	3
7^{th} — 12^{th}	2	5
9^{th} — 12^{th}	2	5
Kindergarten — 12^{th}	4	10
Total	**39**	**100**

III. Results of Assessment by Domain

Ten domains within the BIE schools were assessed. This section provides a description, applicable national guidelines and standards, assessment data and key findings for each of the domains. A compiled document with main themes and key findings is Appendix F.

A. Health Services Facilities

"The primary goal is to provide a safe and welcoming environment that efficiently and effectively meets health needs in the school setting… The ability of the facility to provide privacy, technology, adequate supplies, up-to-date equipment, and storage can create either a gateway or a barrier to prompt and successful interventions."[2]

National Guidelines Published in "School Nursing: A Comprehensive Text"

Functions of the School Health Office[3]:

- A private conference space where the nurse, teacher, student, parent, or others concerned with health counseling and guidance, can discuss specific health issues of individual students in privacy.
- An isolated area for the care of students who become ill or are suspected of having a communicable disease, until they can be placed under their parents' care or return to class.
- A service area for provision of first aid and general health care (treatments and medications).
- A space where students' health records are easily accessible, but secure and within the requirements outlined by relevant laws and policies.
- A service area where health assessments are made; vision, hearing, and other screening procedures are carried out; and where immunizations may be provided.
- A resource center for health education materials.
- A place for those who require a rest period because of specific health needs.
- A storage area for health supplies and equipment.
- A secured area with locked storage for medication which meets state Board of Pharmacy requirements for securing controlled substances.

BIE Schools in New Mexico with a Health Facility

Health Facilities	Number of Schools	Percent
Health office only	17	44
School-based health center (SBHC) only	3	8
Both a health office and SBHC	3	8
Neither	16	41
Total	**39**	**100**
Note: A school-based health center is a place on school property where students can receive primary and behavioral health care, including diagnostic and treatment services.		

"We have no health facilities."

Standard Published in the New Mexico School Health Manual:

Design of School Health Facilities

The health room should be designed so that it is appropriate for the particular school population it serves and meets Americans with Disabilities Act (ADA) requirements. It should be accessible to all students, parents, and staff. The nurse's office should ensure privacy for conferences and should be as soundproof as possible to facilitate audiometric testing and confidentiality. Each health room needs to have a locked storage space where supplies and equipment can be kept and a restroom equipped with hot and cold running water and toilet facilities that meet ADA requirements.[4]

Health Facilities with Recommended Components

Health Facility Component	Number of Health Facilities (N=26)*	Percent
Private exam room	17	65
Wheelchair access	20	77
Running water	20	77
Refrigerator solely for medication	14	54
Restroom	19	73
* The total number of health offices and school-based health centers (20 schools have a health office or a school-based health center; however, three schools have both, equaling 26 health facilities).		

Number of Miles from School to Nearest Clinic or Hospital

Miles	Number of Schools	Percent
0-15 miles	29	74
16-30 miles	7	18
31-45 miles	2	5
Over 45 miles	1	3
Total	**39**	**100**

"If a serious emergency occurs, the hospital is too far away. We are not trained to deal with a serious emergency."

Key Findings

- Twenty-three out of the 39 BIE schools (59%) have a health facility—a health office and/or school-based health center. Nationwide, 81% of schools have a sick room or nurse's office.

- Four out of the 26 health facilities (15%) share space with other school offices or programs and 22 health facilities (85%) are in a separate designated area.

- Overall, the health facilities in BIE schools do not have the minimum recommended components—a private exam room, wheelchair access, running water, a refrigerator, and a restroom.

- The majority of schools are located 15 miles or less from the nearest clinic or hospital; however, 10 schools (26%) are located farther than 15 miles.

National data source: CDC School Health Policies and Programs Study (2000)[5]

B. School Health Staffing and Collaboration

The Critical Role of the School Nurse

For many students, achievement, attendance, and graduation are dependent on access to health and safety-related services at school. Certified school nurses are best equipped to communicate with physicians, dentists, and other health professionals; understand student health and safety needs; and educate individual students and their families on health and safety matters.[6] Nurses manage care and provide services to support and sustain school attendance and academic achievement. In order to meet students' physical and emotional needs, it is recommended that students have daily access to an on-site school nurse.

National Guidelines Published by the National Association of School Nurses:

School nurses should be graduates of a baccalaureate degree program from an accredited college or university and licensed as a registered nurse.[7] It is the position of the National Association of School Nurses (NASN) that school districts should provide a full-time professionally prepared registered nurse all day, every day in each building.[8] NASN also recommends additional school nurse staff to accommodate other student health needs, including but not limited to special education evaluations, nursing services included in individualized education plans (IEPs), nursing services for students with 504 plans (Section 504 federal regulation requires a school district to provide a "free appropriate public education" to each qualified person with a disability who is in the school district's jurisdiction, regardless of the nature or severity of the person's disability), and schools with large populations and large numbers of students with mental health or social concerns.

The National Association of School Nurses recommends minimum ratios of nurses to students depending on the needs of the student populations.

- 1:750 for students in the general population,
- 1:225 in the student populations that may require daily professional school nursing services or interventions.
- 1:125 in student populations with complex health care needs, and
- 1:1 may be necessary for individual students who require daily and continuous professional nursing services.

Key Findings

- Nine out of 39 BIE schools that participated in this survey (23%) have a school registered nurse at least part-time. Nationwide, 77% of schools have a part-time or full-time school nurse (national study did not assess whether nurses were RNs, LPNs, or nurse practitioners).
- Among the nine BIE schools with school registered nurses,
    - seven (78%) have the nurse(s) provide at least 40 hours of service per week, and
    - five (56%) pay the nurses through the BIE. (Other funding sources included: the IHS, tribal funds, the New Mexico Department of Health, and the Innovative Special Education Preparation (ISEP) program).
- Of the 30 BIE schools without school registered nurses, 24 (80%) indicated that there was a public health nurse, physician assistant, or physician available for consultation.

National data source: CDC School Health Policies and Programs Study (2000) [9]

"Not having a school nurse closes a lot of doors."

Average Ratio of School Nurses to Students in New Mexico: BIE vs. Public Education Department Schools

	BIE	Public Education Department (2005-06)
Student enrollment	9,159 *	306,035
Total number of FTE school RNs **	10	408
Students per school RN	916	750

* Student enrollment of 39 primary and secondary BIE schools surveyed
** Full-time equivalent (FTE) positions

Key Findings

- Thirty out of the 39 BIE schools (77%) do not have a school registered nurse on campus.

- The average school nurse to student ratio in BIE schools is 1:916. The average school nurse to student ratio in Public Education Department schools was 1:750 in 2005-06.

- The average school nurse to student ratio in BIE schools does not meet the national recommendation, 1:750 for students in the general population.

"Last year, a nurse came once a month, but then she stopped when Indian Health Service funding was cut. We really need a school nurse and a health clinic. Even one a sporadic basis would be better than what we have now."

Collaboration with Other Health Providers

Schools are the ideal environment for providing a range of health services to students. Specialized health providers may provide assessment, diagnosis, treatment, preventative care, and referrals to community agencies. Providers with interest and experience in school and child/adolescent health may also consult on school health policy and serve as advocates for those students with special health care needs and the broader student population.

Health Providers Serving Bureau of Indian Education Schools in New Mexico

Health Provider	*# of Schools (%) with Indicated Provider*	*Minimum Hours per Week*	*Maximum Hours per Week*	*Provider Paid By/Through:*
Occupational Therapist	26 (67%)	.7	28	Bureau Indian Education, Special education funds
Speech Therapist	23 (59%)	1	64	Bureau Indian Education, Special education funds
Physical Therapist	19 (49%)	1	16	Bureau Indian Education, Special education funds
Public Health RN	23 (59%)	1 hour/year	10	Indian Health Service
Dental Hygienist	15 (38%)	5 hours/year	10	Indian Health Service
Dentist	11 (28%)	8 hours/year	10	Indian Health Service
Physician (MD)	5 (13%)	.75	8	Indian Health Service
License Practical Nurse (LPN)	5 (13%)	4	40	Bureau Indian Education, Indian Health Service
Health Aide	5 (13%)	30	40	Bureau Indian Education, Tribal funds
Nurse Practitioner/ Physician Assistant	3 (8%)	3	8	Indian Health Service, Tribal funds

Several schools had more than one of the specified providers. In these cases, total hours of service may exceed 40 hours/week. See Appendix A for average hours provided.
Hours are provided in hours per week, unless specified.
Hours were calculated on an academic year of 180 days.
'Provider Paid By/Through' refers to source of payment most often cited. See Appendix A for more details.

Key Findings

- Federal legislation and special education funds support the providers that were most frequently cited—occupational therapists, speech therapists, and physical therapists; however, special education services are not available to the general student population.

- Overall, there is a wide range in the hours provided by health providers at the BIE schools.

- The IHS provides a range of clinical support to BIE schools and students.

- The IHS was identified as the primary source for public health nurses by 21 out of the 23 schools (91%).

See Appendix A for additional information on school health staffing and collaboration, including the school health services provided, training of health aides, and the referral process.

"It's hard to find suitable employees in our rural location because they have to live closer than 25 miles from the school."

C. Behavioral and Mental Health Services

The school plays an important role in promoting healthy emotional and social development for all students. A positive self-concept is critical to the success of all students, in and outside of the classroom. The school can also play a role in the early screening process to identify students with emotional, behavioral, and mental health concerns, and ensure that they get proper referral for assessments and appropriate individualized interventions. Mental health concerns have a variety of causes and can exacerbate the current state of function caused by underlying medical issues, psychosocial stressors, past abuse/unaddressed trauma, unaddressed alcohol/substance abuse issues, physical health needs, and learning disabilities. Whatever the cause, there is compelling reason for the school to be alert to these issues. It is important to forge a collaborative effort among the school, parents, and community mental health providers. School professionals such as guidance counselors, "at risk" counselors, social workers, psychologists, and nurses are in a position to bridge the gap between these groups.[10]

American Indian Youth are in Need of Behavioral Health and Mental Health Services

- In New Mexico, suicide is the second leading cause of death among American Indians ages 15 to 24 years.[11]

- Nationwide and in New Mexico, American Indian youth have the highest rate of suicide among youth ages 15 to 24 years.[12]

- In New Mexico, nearly 40% of American Indian youth in grades 9 to 12 reported feeling sad or hopeless for two weeks in a row in the past year, an indicator of depression.[13]

- Approximately 24.7% of American Indian youth in grades 9 to 12 on the Navajo Nation reported having engaged in binge drinking in the past 30 days.[14] Alcohol abuse is a risk factor for suicide.

- Approximately 10.5% of American Indian youth in grades 9 to 12 on the Navajo Nation reported having at least one drink of alcohol on school property in the past 30 days.[15]

- Historical and intergenerational trauma (genocide, colonization, removal from traditional homelands, and the forced removal of children from their families into boarding schools) is believed to be a major contributing factor of poor mental health outcomes among today's American Indians. It is believed that unresolved grief in this population manifests itself in depression, substance abuse, and other maladaptive behaviors.[16]

National Guidelines Published in US Department of Health and Human Services: Health, Mental Health, and Safety Guidelines for Schools [19]

- Provide a multidisciplinary team individualized to assist each student experiencing problems (educational, behavioral, developmental, or and health- or safety-related problems). At a minimum, include a school nurse, mental health professional, the student's teachers, and school administrator on the team.

- Have the capacity to identify students with, or at risk for, mental health problems, to refer them for assessment and interventions appropriate to their needs, and to monitor and manage their behavioral, mental health, and emotional needs at school.

- Establish a crisis response protocol to manage a crisis and its aftermath, including recovery. Schools need to be prepared to address crises that have physical, emotional, social, and spiritual effects on all members of the school community.

- Assess students who are frequent users of health services (any recurring symptoms such as abdominal pain and headaches), who are suspended or expelled, or who demonstrate concerning behaviors. Use a school-based multidisciplinary assessment team to assess for potential learning, emotional, and physical health problems that often underlie such behaviors.

- Ensure that social services and mental health support are available to all students and staff in the school setting and integrate this support into other school programs.

- Implement prevention programs that focus on recognition of stressful life situations and interventions to help students deal with those stressors.

- Make accommodations and/or adjustments for students during and after experiences of psychological trauma or loss.

- Actively prevent suicidal behavior by training staff and having programs that identify high-risk students and link them to therapeutic and preventive community services.

- Provide opportunities in a variety of context-specific ways for students to model and practice social skills that are important for implementing positive decision making. These include interpersonal communication, goal setting, anger management, and advocacy skills.

Behavioral and Mental Health Services in BIE Schools in New Mexico

Thirty-five schools, 90% of the 39 schools surveyed, indicated that behavioral health services, such as substance abuse counseling, or mental health services, including individual or group therapy, were provided at the school.

The chart below summarizes the health providers serving BIE schools in New Mexico, the hours each provider spends providing services, and the primary payment source.

Behavioral and Mental Health Providers Serving BIE Schools

Health Provider	# of Schools (%) with Indicated Provider	Minimum Hours per Week	Maximum Hours per Week	Provider Paid By/ Through
Psychologist (PhD)	24 (62%)	1	32	BIE, Special education funds, IHS
Licensed Counselor	22 (56%)	3	80	BIE
Social Worker	13 (33%)	.6	40	BIE
School/Guidance Counselor	11 (28%)	20	120	BIE
Tribal Health Provider	4 (10%)	8 hours/year	8	Tribal Funds IHS
Psychiatrist	3 (8%)	1*	1*	BIE IHS

* Based on data from one school.
Several schools had more than one of the specified providers. In these cases, total hours of service may exceed 40 hours/week. See Appendix B for average hours provided.
Hours are provided in hours per week, unless specified.
Hours were calculated on an academic year of 180 days.
'Provider Paid By/Through' refers to source of payment most often cited. See Appendix B for more detailed chart.

Key Findings

- Overall, there is a wide range in the hours provided by behavioral and mental health providers in the BIE schools, demonstrating that students lack access to mental health services and licensed mental health professionals.

- Psychologists and licensed counselors were identified most frequently as providing behavioral/mental health services.

- Special education funding is an important source of support for psychologists; however, special education services are not available to the general student population.

- Other health providers that were identified as providing behavioral/mental health services included public health and school registered nurses, health aides, physicians, and teachers.

"We have access to mental health services through two other schools."

Behavioral and Mental Health Services Provided in BIE Schools in New Mexico

Service	Number of Schools	Percent
Crisis intervention	31	79
Peer counseling/peer support	30	77
Individual therapy	30	77
Group therapy	25	64
Screening for depression	25	64
Substance abuse counseling	24	62
Family therapy	18	46
Telehealth services	4	10
'Other' services	4	10
Note: The survey did not assess the quality and effectiveness (evidence-base) of services.		

Key Findings

- A range of behavioral and mental health services is provided in BIE schools. The following services were identified by the majority of schools: crisis intervention, peer counseling/peer support, and individual therapy.

- Traditional healing forms of behavioral/mental health services included art therapy and sweat lodge ceremonies.

"We offer traditional crafts and bead classes to get kids' emotions out."

"Though it hasn't actually happened yet, we need to be ready for students on meth and those who overdose."

Behavioral and Mental Health Providers in BIE Schools in New Mexico vs. Public and Nonpublic Schools Nationwide

Access to Providers	BIE (%)	National (%)
Schools that have access to a psychologist*	62	66
Schools that have access to a social worker*	33	44
National data source: CDC School Health Policies and Programs Study (2000) [17] * See key findings for detailed explanation.		

Key Findings

- Nationally, schools have greater access to psychologists and social workers.

- Nationally, 66% of schools employ a part-time or full-time school psychologist trained in mental health, child development, school organization/administration, learning, behavior and motivation. Sixty-two percent of BIE schools reported that a psychologist (not necessarily a school psychologist) provides behavioral and mental health services, ranging from one hour to 32 hours per week.

- Nationally, 44% of schools employ a part-time of full-time social worker. Thirty-three percent of BIE schools reported that a social worker provides behavioral and mental health services, ranging from .6 to 40 hours per week.

See Appendix B for additional information on behavioral and mental health services, including information on student referrals.

D. Health Education

Schools play a critical role in helping youth develop the knowledge and skills they need to be healthy. Health education is defined as "the continuum of learning which enables people, as individuals and as members of social structures, to voluntarily make decisions, modify behaviors, and change social conditions in ways which are health enhancing."[18] Many schools in the United States implement school-based comprehensive health education curricula which provide education on core topics.

National Guidelines Published in US Department of Health and Human Services: Health, Mental Health, and Safety Guidelines for Schools [19]

- Hire health education teachers who have appropriate qualifications for teaching health and safety classes in secondary schools. At the elementary level and for anyone who is assigned to teach health and safety but is not certified, require at least 6 hours of academic course work or 30 hours of in-service training on health and safety content and pedagogy. Training must include content of the health and safety topics the person is being assigned to teach and methods of teaching relevant social skills.

- Provide health/safety education as a core academic subject in grades kindergarten through 12.

- Provide planned, sequential, comprehensive health and safety education (K-12) that is culturally, linguistically, developmentally, and age appropriate and is consistent with state and national health education standards. Content should include community, personal, environmental, mental and emotional health; prevention of substance abuse, diseases, injury, and violence; family life; human sexuality; media literacy; nutrition; and first-aid and basic emergency lifesaving skills.

Health Education in BIE Schools in New Mexico

Key Findings

- Thirty-eight out of the 39 schools (97%) offer health education and/or health promotion activities.

- Twenty-six out of the 39 schools (67%) use a comprehensive health education curriculum.

- Nearly all of the BIE schools (36-38 schools) provide education on the following topics: violence prevention; alcohol, tobacco and other drugs; and nutrition and physical activity.

- Thirty-two schools (84%) provide education on growth and development.

- Twenty-three schools (59%) provide education on stress reduction.

- Twenty-five schools (64%) provide education on STD/HIV/AIDS.

- Less than 50% of the schools provide education on the following topics: smoking cessation, parenting, and pregnancy prevention.

Note: The survey asked if the schools provided ‘education and/or counseling’ on the topical areas stated above; therefore, the term ‘education’ as used in the bullets above refers to education and/or counseling.
See Appendix C for a detailed chart on health education in BIE schools.

Providers of Health Education in BIE Schools in New Mexico

Professional	Number of Schools	Percent
Teachers	26	67
Licensed Counselor	22	56
Social Worker	14	36
Public Health RN	13	33
School/Guidance Counselor	11	28
Certified Health Educator	10	26
Tribal Health Provider	10	26
School RN	9	23
Psychologist	9	23
'Other'	15	38

Key Findings

- Overall, health education is provided by a range of school personnel and health providers.
- Teachers were most frequently identified as providing health education to students.
- Certified health educators provide health education in ten BIE schools (26%).
- Other health education providers included the following: dorm managers, counseling technicians, health coordinators, counseling interns, Community Health Representatives, community agencies (i.e. Planned Parenthood and the Rape Crisis Center).

Note: The survey asked if the schools provided 'education and/or counseling'; therefore, the term 'education' as used in the bullets and chart above refers to education and/or counseling.

E. Student, Family, and Community Engagement

Families and students can be remarkably powerful advocates when they are also decision-makers.[19] They can be helpful in setting reasonable goals, planning and implementing evaluations of school health and safety programs, and communicating results of programs. Engagement in decision-making processes can occur through participation in venues such as advisory committees or councils. A health and safety advisory committee or council that includes a diversity of family and community members can help build broad community support for a comprehensive school health program.

National Guidelines Published in US Department of Health and Human Services: Health, Mental Health, and Safety Guidelines for Schools [19]

- Involve parents, families, students, and community members in the decision-making process for the selection of health and safety messages, curricula, learning activities, and policies. Inform them of characteristics that make these programs/policies effective.

Community Engagement in School Health in BIE Schools in New Mexico

Activity	Number of Schools	Percent
Provide families information on school health services	31	79
Meet with Parent Teacher Association to discuss school health services	27	69
Invite family members to visit school health facilities	22	56
Maintain a school health advisory council	17	44
Collect student suggestions about health services	13	33

Key Finding

- Families are provided with information on school health services at 31 out of the 39 BIE schools (79%); however, a lower percentage of schools involve students, families, and communities in school health planning and programming.

"There is no input from the community about the health needs of students."

F. Student Health Records

Maintaining up-to-date assessments is necessary to identify students' unique health and safety needs and to anticipate and meet the need for special or emergency services. Untreated health, mental health, and oral health problems are common and may impact students' attendance, attention to schoolwork, or safe participation in school activities.[20]

National Guidelines and Standards Published by American School Health Association [21]

- Maintain, assess, and share health records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

- Collect and assess student health information that pertains to students' functioning and safety in school prior to school entry, every one to two years thereafter, and whenever a significant change in health status has occurred.

- Share information with staff members whose access to health information is necessary for maintaining student health and safety. Obtain parents' informed written consent to share information.

- Include the following in school assessments: health, family and social history that relates to student functioning and safety in school, growth and development, allergies, medications, special needs, disabilities, vision and hearing screens, past problems, immunization status, and physical findings.

- Utilize a comprehensive records management system, either electronic or paper-based, for student health and safety information.

- Keep health records of students and staff confidential and in a secured environment.

- Make publicly available on an annual basis clear explanations of policies, procedures, and practices regarding the collection, use, storage, release, and destruction of personally identifiable health information.

- Protect student health information in education records from unauthorized access by using reasonable security measures appropriate to the sensitivity of the record.

Student Health Records in BIE Schools in New Mexico

Key Findings

- Each of the 39 schools reported that they maintain current records with information on immunization status and emergency contact information.

- Nearly all of the schools (36-38 schools) maintain current records with the following information: authorization for emergency treatment, severe food and other allergies, dietary needs or restrictions, medication needs, and screening records (i.e. vision and hearing).

- Twenty schools (51%) maintain current records with an emotional/mental health history.

- Twenty-one schools (54%) maintain current records with the following: tuberculosis screening results and health insurance coverage.

- Fifteen schools (38%) reported that health records were stored in an electronic database. Nine of these schools reported to use the Native American Student Informational Systems. Other software listed by the remaining schools included: Health Office, Infinite Campus, Power School, SBHC (School-Based Health Center) Pro, School Master, and the Resource and Patient Management System (IHS).

- Each of the 39 schools indicated that student health records were kept in a secure and confidential location.

See Appendix D for detailed information on student health records.

G. Immunization

It is in the best interest of individual students, the entire student body, and the population as a whole to have all students up-to-date with recommended immunizations. New Mexico law requires that all students be immunized against certain communicable diseases. In the school setting, the school nurse is usually the person best qualified to determine which children require vaccination and notify parents/guardians.

National Guidelines Published in US Department of Health and Human Services: Health, Mental Health, and Safety Guidelines for Schools

- Develop a mechanism to obtain documentation of immunizations from families, to store immunization records, to notify families of children not in compliance, and to recommend how students can obtain immunizations.

- Assess and document immunization status when a student enters school, transfers to another school, or advances to the next level of school.

- The national target for 2010 is ≥95% vaccination coverage among children in the kindergarten or first grade.

- The national target for 2010 is ≥90% vaccine coverage among adolescents 13-15 years.

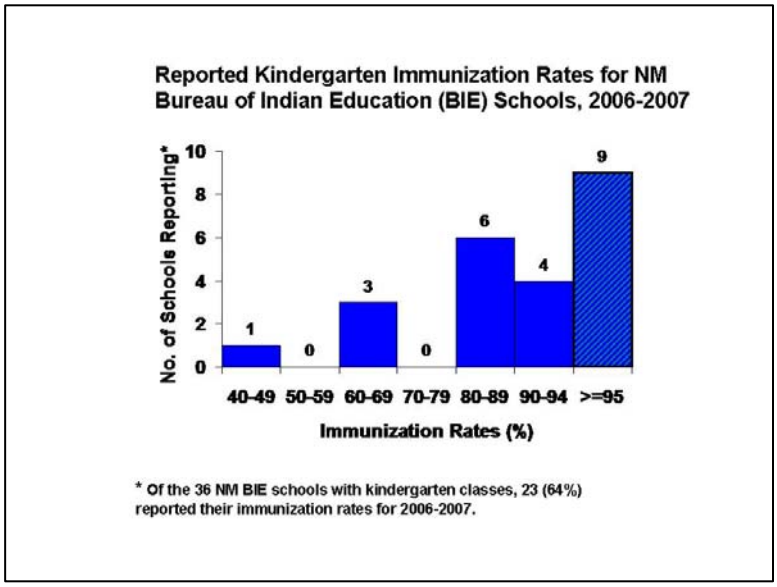
Vaccine coverage among children enrolled in kindergarten in NM, 2006-2007 school year (MMWR 2007;56(32):819-821):

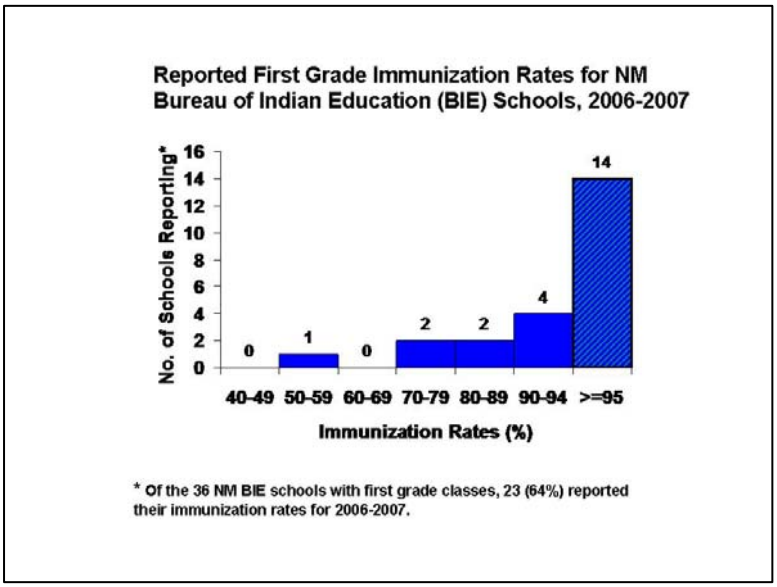
- 99% of schools reported their immunization data.

- Estimated vaccine coverage was ≥98%.

Immunization Rates in BIE Schools in New Mexico

Self-reported data from the BIE schools in New Mexico was provided by the New Mexico Department of Health Immunization Program.



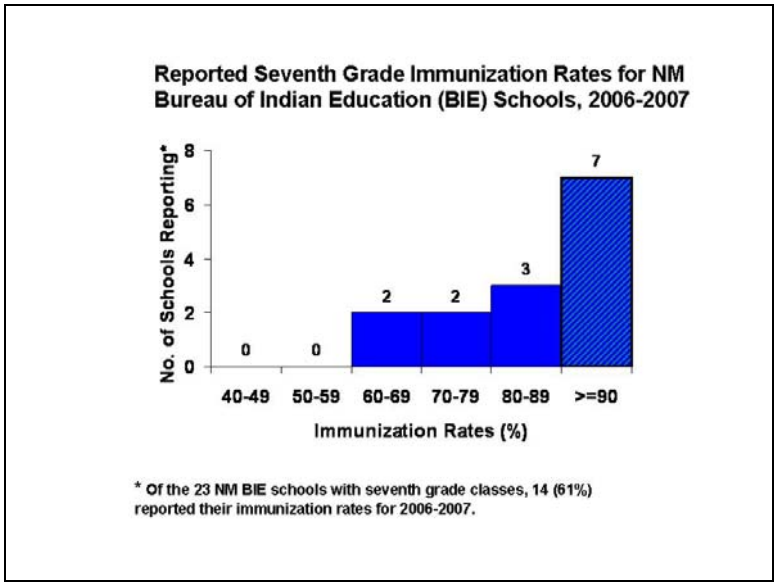


Key Findings: Kindergarten and First Grade Immunizations

- Over one third of BIE schools with kindergarten or first grade classes (13 of 36 schools [36%]) did not report immunization rates to the New Mexico Department of Health in academic year 2006—2007.

- Of the 23 BIE schools that reported their kindergarten immunization rates, 9 (39%) met the national target of 95% immunization coverage.

- Of the 23 BIE schools that reported their first grade immunization rates, 14 (61%) met the national target of 95% immunization coverage.



Key Findings: Seventh Grade Immunizations

- Over one third of BIE schools with seventh grade classes (9 of 23 schools, [39%]) did not report immunization rates to the New Mexico Department of Health in academic year 2006—2007.

- Of the 14 BIE schools that reported their seventh grade immunization rates, 7 (50%) met the national target of 90% immunization coverage.

Immunization Policy in BIE Schools in New Mexico

Policy	Number of Schools	Percent
Students who have not received the required immunizations are immediately excluded from class.	10	29
Students who have not received the required immunizations are allowed to attend class indefinitely.	4	12
Students who have not received the required immunizations are allowed to attend class for a specified number of days.*	8	24
There is no policy in place.	11	32
Do not know policy.	1	3
Total	**34****	**100**

Note: The policy above is for students who have not received the required immunizations for entry into kindergarten or first grade.
***** See Appendix E for specified number of days.
** Total number of schools that participated in assessment with a kindergarten or first grade class.

Key Finding

- There is not a uniform policy across the BIE schools regarding the disposition of students who have not received the required immunizations for entry into kindergarten or first grade.

> In reference to a student that did not receive the required immunization…
> *"This happened a few weeks ago and the student is still in class."*

H. Procedures for Student Medication and Management

Clear policies on medication administration and management are necessary to avoid misunderstandings, oversights, and medication errors so that students remain safe.

National Guidelines: The National Association of School Nurses recommends the following for school nurses[22]:

- Keep medication in the original container if over-the-counter (OTC) or in a properly labeled prescription container, subject to state Board of Pharmacy regulations. Include the following information on the container: the student's name, the name of the drug, dosage amount, route of administration, the time interval of the dose, and the name of the prescribing licensed health care provider.

- Obtain parent/guardian request in writing that the medication be administered at school.

- Determine (based on nursing assessment) that the medication can be given at school.

- Store medications in a locked cabinet or refrigerator solely for medications.

- Develop and adopt procedures for receiving, administration of, and accountability for all medications in the school setting.

Procedures for Student Medication in BIE Schools in New Mexico

Key Findings

- Nine out of the 39 BIE schools (23%) have a part-time or full-time school nurse. Medication administration is a core function of school nursing.

- Fourteen schools (37%) indicated that teachers are allowed to assist students with their routine medications.

- Twenty-nine (76%) of schools indicated that other school staff (principals, secretaries, dormitory aides, and department heads) are allowed to assist students with their routine medications.

- School policies on medication administration require the following from school staff:

    - To document each time the medication is administered (32 schools/86%)*.

    - To obtain written request from the parent or guardian before administering the medication (35 schools/95%)*.

    - To ensure that the medication is labeled in its original container before administering the medication (35 schools/95%)*.

* Percentage calculated from 37 schools.

See Appendix E for more detailed information on procedures for student medication.

Procedures for Self-Administration of Medication in BIE Schools in New Mexico

In 2005, the state of New Mexico enacted a law which allows students to self-administer bronchodilators, inhaled corticosteroids, auto-injectable epinephrine, and prescribed medication for asthma or anaphylaxis. By allowing students to self-administer, the chances for asthma episodes, emergency department visits, and school absenteeism are greatly reduced. The chart below illustrates the variability in BIE schools' policies on medication self-administration.

Students are permitted to carry and self-administer	Number of Schools	Percent
• a prescription quick-relief inhaler.	26	67
• an epinephrine auto-injector, such as EpiPen.	14	36
• insulin or other injected medications.	10	26
• any other prescribed medication.	4	11

Key Finding

- Overall, the percentage of schools that allow students to carry and self-administer life-saving medications to control asthma and diabetes control and for acute allergic reactions is low.

I. Acute Care Management

To ensure student safety and to reduce the liability of the school, procedures should be in place for handling emergencies that occur on the school property and at off-site school-sponsored activities.

National Guidelines Published in US Department of Health and Human Services: Health, Mental Health, and Safety Guidelines for Schools [19]

- Ensure that at least one adult with current training in basic first aid and lifesaving techniques is available to students and staff on-site and at all off-site school-sponsored activities. Skills include cervical spine protection, Heimlich maneuver, cardiopulmonary resuscitation (CPR), use of an automated external defibrillator, and specialized emergency procedures for those who need them.

- Develop a written plan, including follow-up procedures, for handling medical and dental emergencies.

Acute Care Management in BIE Schools in New Mexico

Key Findings

- Thirty-seven out of the 39 schools (95%) reported that there was at least one person trained to respond to medical emergencies and who is also certified in CPR and First Aid.

- At each school of the 39 schools, the staff complete a report after a student experiences a serious illness or injury at school.

- Twenty-five schools (64%) indicated that during the past 12 months, the school reviewed the reports to identify ways to prevent further occurrences of serious illness or injury.

"Our entire staff has CPR and First Aid training."

J. Care of Medically Complex and Medically Fragile Students

Federal legislation supports participation in the public schools by children who are medically complex and medically fragile. Some of these children may require specialized technological health care procedures for life support and/or health support during the school day. Inclusion in safe school environments that facilitate effective learning requires careful planning by a coalition of educational and medical personnel.

National Guidelines Published in US Department of Health and Human Services: Health, Mental Health, and Safety Guidelines for Schools [19]

- Provide case management for families of students who have complex health or safety needs, who have difficulty accessing required services, or whose needs preclude optimal participation or achievement at school.

- Develop a system to identify, prior to school entry, those students who require assistance with a special health or safety need (e.g., new students, those returning from an extended absence, those experiencing a recent health or mental health problem, and those with one or more chronic illnesses). Reassess these students' needs at least annually and modify individualized health and safety care plans accordingly.

- Provide written, individualized health services plans for students with special health care needs. Plans must be developed with a multidisciplinary team and comply with federal laws.

- Adopt and maintain a set of up-to-date protocols for specialized medical procedures to include as a part of students' individualized health services plans. Allow modifications on a student-by-student basis when there is school nurse endorsement and written consent of the parent and of the prescribing health care provider.

Care Provided to Medically Fragile/Complex Students in BIE Schools in New Mexico

Procedure Provided in Past 12 Months:	Number of Schools	Percent
Oxygen saturation measurement	6	15
Peak flow measurement	4	10
Nebulizer treatments	4	10
Blood glucose monitoring	4	10
Oxygen delivery	3	8
Suctioning	2	5
Catheterizations	2	5
Tracheostomy care	1	3
Respirator care	1	3
Tube feedings	1	3
Stoma care	1	3
Intravenous medication	0	0

Overall, the previous findings reflect the low prevalence of health conditions that would require the provision of specialized health services to students in a school setting. However, the data regarding the provision of peak flow measurement, nebulizer treatment, and blood glucose monitoring in BIE schools provides important insight.

Peak flow measurement and nebulizer treatments are used to evaluate and treat asthma. Asthma is one of the most common chronic illnesses in children and adolescents and is a major reason for school absences and hospitalizations in this age group. The prevalence of asthma is higher among poor populations. Blood glucose monitoring is used to monitor diabetes. American Indians have the highest rate of diabetes in the nation compared to other racial/ethnic groups. In children and youth, increasing rates of type II diabetes, a condition that was once diagnosed exclusively in adults, parallel the increasing trends in obesity.

Four out of the 39 schools (10%) indicated that peak flow measurement, nebulizer treatment, and blood glucose monitoring were provided at the school during the past 12 months. Nine schools (23%) indicated that these services were not provided. Twenty-six schools (67%) indicated that the services were not provided because there were no students that required these services. In this population, it is likely that more students require these services than the data reflect. There are several possible reasons for these findings. It is possible that screening and diagnosis of asthma and diabetes in this population is low due to far proximity to health clinics, lack of transportation, and economic factors. Additionally, conditions such as asthma and diabetes may be first observed by a school nurse who then refers the student for diagnosis; however, only nine schools (23%) reported having a school nurse. Other possibilities include inaccurate or incomplete medical histories reported to the schools by parents and/or guardians, inaccurate or incomplete health records at the school, or students in need of specialized health services are not attending the school.

IV. Special Analyses of Results

A. Boarding Schools versus Day Schools

Attending boarding school presents numerous challenges to the development of children and adolescents—challenges that are often not faced to the same degree when a young person is still living at home.[23] The most obvious health services that should be provided for students living in residential dormitories include the provision of immunizations as a preventive measure and treating acute illnesses, such as the cold, that are common in school settings. Boarding school students also face emotional stressors because they are living away from home and separated from their families. Underage drinking and smoking, drug use, and eating disorders persist in most high school environments; however, these behaviors may manifest differently in the boarding school environment.

It is also important to consider the history of boarding schools for American Indians. In an effort to assimilate American Indians into mainstream culture, young children were forcibly removed from their families and placed into boarding schools. These institutions were designed to eliminate the culture, language, and spirituality of this population. Today, many youth attend the same boarding schools that their parents and grandparents were forced to attend. The belief is that the trauma experienced during the boarding school era has contributed, in part, to the psychosocial issues that persist among American Indians today.[24]

Of the 39 schools that participated in the BIE School Health Assessment, 22 are day schools and 17 are boarding schools. Day schools are similar to public schools. Students attend school during the day and return to their homes in the afternoon. At boarding schools, students reside on the school campus in dormitories Monday through Friday, and most return to their homes on the weekends.

Health Facilities in BIE Boarding and Day Schools in New Mexico

Health Facilities	Boarding School	Day School
Health office only	9 (53%)	8 (36%)
School-based health center (SBHC) only	3 (18%)	0 (0%)
Both a health office and SBHC	1 (6%)	2 (9%)
Neither	4 (24%)	12 (55%)
Total	**17 (100%)**	**22 (100%)**

Key Finding

- Boarding schools are more likely to have a health facility compared to day schools (77% vs. 45%).

School Health Staffing and Collaboration in BIE Boarding and Days Schools in New Mexico

Provider	Boarding School (N=17)	Day School (N=22)
School nurse (RN)	4 (23%)	5 (23%)
Public health nurse (RN)	10 (59%)	13 (59%)
Dentist	5 (29%)	6 (27%)
Dental hygienist	7 (41%)	8 (36%)
Occupational therapist	9 (52%)	17 (77%)
Psychologist (PhD)	12 (71%)	12 (55%)
Social worker	8 (47%)	5 (23%)
Licensed counselor	11 (65%)	11 (50%)

Key Findings

- Boarding and day schools are equally likely to have a school nurse or a public health nurse.
- Boarding schools are more likely to receive mental health services from a psychologist, social worker, and licensed counselor, compared to day schools.
- Boarding schools are more likely to receive services from a dentist or dental hygienist compared to day schools.

School Proximity to Nearest Clinic or Hospital, Boarding and Days Schools

School proximity to the nearest clinic or hospital is an important factor in the development of school health programs.

Miles	Boarding School	Day School
0-15 miles	11 (65%)	18 (82%)
Over 15 miles	6 (35%)	4 (18%)
Total	**17 (100%)**	**22 (100%)**

Key Finding

- More boarding schools are located farther than 15 miles from a clinic or hospital compared to day schools.

B. BIE-Operated Schools and BIE Grant Schools

Federal funding for American Indian education supports two primary mechanisms of financing and providing education to students. The BIE may fund and operate the school on tribal lands or the community may elect to be a 'grant school' in which the community receives the funding from the federal government and operates the school. 'Grant schools' have more flexibility in how the government funding is expended and may independently determine priorities for the school.

Of the 39 schools that participated in the BIE School Health Assessment, 27 schools were BIE-operated and 12 were BIE grant schools.

Health Facilities in BIE-Operated and BIE Grant Schools

Health Facilities	BIE-Operated School	BIE Grant School
Health office only	10 (37%)	7 (58%)
School-based health center (SBHC) only	0 (0%)	3 (25%)
Both a health office and SBHC	1 (4%)	2 (17%)
Neither	16 (59%)	0 (0%)
Total	**27 (100%)**	**12 (100%)**

Key Finding

- Each of the 12 BIE grant schools has a health facility, whereas 11 out of the 27 BIE-operated schools (41%) has a health facility.

School Health Staffing and Collaboration in BIE-Operated and BIE Grant Schools in New Mexico

Provider	BIE-Operated School (N=27)	BIE Grant School (N=12)
School nurse (RN)	1 (4%)	8 (67%)
Public health nurse (RN)	19 (70%)	4 (33%)
Dentist	6 (22%)	5 (42%)
Dental hygienist	9 (32%)	6 (50%)
Occupational therapist	18 (67%)	8 (67%)
Psychologist (PhD)	17 (63%)	7 (58%)
Social worker	7 (26%)	6 (50%)
Licensed counselor	13 (48%)	9 (75%)

Key Findings

- BIE grant schools are more likely to have a school nurse, while, BIE-operated schools are more likely to receive services from a public health nurse.

- BIE grant schools are more likely to receive services from a dentist or dental hygienist compared to BIE-operated schools.

- BIE-operated and BIE grant schools are equally likely to have an occupational therapist.

- BIE grant schools are more likely to receive mental health services from a licensed counselor or social worker, while BIE-operated school are more likely to receive these services from a psychologist.

C. Health Services by Student Population Size

Student population is an important factor in the planning and administration of school health services.

Health Facilities by School Population in BIE Schools in New Mexico

	1 - 99 students	**100 - 199 students**	**200 - 299 students**	**Over 300 students**
Health facility *	2 (25%)	8 (50%)	5 (83%)	8 (89%)
No health facility	6 (75%)	8 (50%)	1 (17%)	1 (11%)
Total	**8 (100%)**	**16 (100%)**	**6 (100%)**	**9 (100%)**
* Denotes schools with a health office, a school-based health center, or both.				

Key Finding

- The likelihood that a school has a health facility increases with size of student population—larger schools are more likely to have a health facility compared to smaller schools.

School Health Staffing and Collaboration by Student Population in BIE Schools in New Mexico

Provider	1 - 99 students (N=8)	100 – 199 students (N=16)	200 – 299 students (N=6)	Over 300 students (N=9)
School nurse (RN)	0 (0%)	3 (19%)	1 (17%)	5 (56%)
Public health nurse (RN)	5 (63%)	12 (75%)	2 (33%)	4 (44%)
Dentist	0 (0%)	5 (31%)	2 (33%)	4 (44%)
Dental hygienist	4 (50%)	4 (25%)	4 (67%)	3 (33%)
Occupational therapist	5 (63%)	12 (75%)	2 (33%)	7 (78%)
Psychologist (PhD)	2 (25%)	9 (56%)	4 (67%)	9 (100%)
Social worker	0 (0%)	5 (31%)	3 (50%)	5 (56%)
Licensed counselor	4 (50%)	6 (38%)	4 (67%)	8 (89%)

Key Findings

- Larger schools are more likely to have a school nurse compared to smaller schools; whereas, the smaller schools are more likely to rely upon a public health nurse.

- There is not a trend when examining the schools that receive services from an occupational therapist by student population. The most plausible reason for this is federal law and funding support special education services. Schools are required to provide services from an occupational therapist to students in need. Therefore, the numbers in the chart simply represent the need for these services across the different student population categories.

- Larger schools are more likely to receive mental health services from psychologists, social workers, and licensed counselors, compared to smaller schools.

"Because we're a small school, we don't have the same services on campus that larger schools have."

"We do lack many services because we're such a small school, but we also have many resources to tap in from the community."

IV. Perspectives of School Personnel

The telephone survey incorporated open-ended questions that allowed interviewees to elaborate on what they believed their school was doing well regarding school health services and programs and the school's unmet needs. Following is a summary of comments from those who chose to respond.

School Strengths

School Health Staffing

- Six schools (15%) identified improved school nurse coverage and usage.

"Our school has been quite supportive of our nurse instituting new procedures."

"The school nurse program is only two years old and our nurse has been developing policies and procedures for immunization. Now, the nurse checks the records at the time of registration as a system of catching problems early and following up efficiently."

Collaboration and Health Services

- Six schools (15%) identified collaboration with and referrals to community programs to provide such services as primary care, oral health care, and vision screening to students and staff.

- Three schools (8%) identified support from the IHS.

- Two schools (5%) identified support from tribal resources.

"Between collaboration between the tribe, BIE, and the Department of Health, we do many things and are not limited by the finances of staffing."

"We lack many services because our school is so small, but many resources in the community are contributed."

Health Education

- Seven schools (18%) identified providing strong health education programs.

- Five schools (13%) identified providing nutrition and physical activity programs.

- Two schools (5%) identified providing education on emotional wellness and mental health.

"We are providing education to all kids in basic areas as part of a comprehensive education program."

Emergency Response

- Ten schools (26%) identified management and reporting of emergencies, accidents, and injuries.

"The staff is very good about following procedures in place."

Immunizations

- One school (3%) identified that their vaccination coverage improved.
- Two schools (5%) identified that strong immunization policies and procedures were in place.
- One school (3%) identified that "immunization updates" were coordinated with local health agencies.

"There is good response to immunizations after talking to parents."

"Our vaccination coverage has vastly improved."

Communication with Parents and Community

- Three schools (8%) identified strong communication with parents.
- One school (3%) identified the importance of communication between school and community.

Unmet Needs

Health Facilities

- Four schools (10%) identified the need for a health room or health clinic on campus.

School Health Staffing

- Twelve schools (31%) identified the need for a school nurse on campus.
- Three schools (8%) identified the need for a health aide.

"We need a school nurse. The only reason we don't currently have one is because of BIE funding and support."

Collaboration and Health Services

- Five schools (13%) identified the need for services from the IHS or public health offices, including mental health services and vision/hearing screenings and services.

- Three schools (8%) identified barriers faced with the IHS, including transportation, Medicaid, and long waiting periods for appointments.

"Access to a consulting physician for each school should be ensured."

"We are not meeting the goals of our school-based health center contract, 16 hours of service. IHS won't come to our schools without a full time nurse here to assist the providers."

Health Education

- Two schools (5%) identified the need for a health educator, recommending a school nurse or Community Health Representative.

- Four schools (10%) identified weak health education, including on parenting and puberty.

- Two schools (5%) identified weak physical education and the need for organized physical activity.

- Two schools (5%) identified poor nutrition programs and dietary supports.

"We have a weak nutrition program and nothing for obese students. And weak physical education. There is no playground equipment."

"We need a health educator. The school nurse wants to do more in the classroom. However, we need a health aide to do filing, so the school nurse can get into the classroom."

Emergency Response

- Five schools (13%) identified the lack of trained personnel for emergency response.

"We do not have the facilities to tend to a child that is severely injured."
"If a serious emergency occurs, the hospital is too far away. We are not trained to deal with serious emergencies."

VI. Discussion of Main Themes from BIE School Health Assessment Results

The BIE School Health Assessment garnered a breadth of information on the state of school health services in BIE schools in New Mexico. The following themes emerged from the analysis of the quantitative and qualitative data.

Core School Health Infrastructure—Health Facilities and School Nursing—is Lagging

Appropriate school health facilities and staffing of these facilities by a school registered nurse are the cornerstone of ensuring the safety and health of the school community, impacting the design and implementation of all school health and safety procedures, policies, and programs.

Most BIE schools in New Mexico have a health office, school-based health center, or both. Yet there are 16 out of the 39 schools (41%) that do not have a health facility.

Further, schools with health facilities lack the minimum recommended design features—a private exam room, wheelchair access, running water, a refrigerator, and a restroom. Only nine out of the 39 BIE schools (23%) have a school registered nurse. The average school nurse to student ratio in BIE schools (1:916) is lower than the national recommendation (1:750). However, the average school nurse to student ratio would be 1:1084 if the school of exception—the school with two full-time nurses—was not included in the analysis. Schools without school nurses must rely upon public health nursing services from the IHS.

IHS and BIE Lack Resources and Capacity for School Health

The IHS is charged with providing health care to American Indians in 35 states. Most American Indians are uninsured and thus rely upon the IHS. In September 2004, *Broken Promises: Evaluating the Native American Health Care System* was released by the US Commission on Civil Rights.[25] This report reviewed the financial limitations of the IHS. Since the BIE has no system in place for providing basic school health services to students, schools turn to the IHS for these services. *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country,* another report of the U.S Commission on Civil Rights, established that both the BIE and IHS were grossly under-funded.[26] In the case of school health programs, one under-funded agency is relying on another under-funded agency to provide for the neediest young people in the country, thus widening the disparity.

Out of the 23 schools that indicated that public health nurses provided services at the school, 21 are served by the IHS. The IHS was also cited as the primary source for other types of primary care and dental health providers that serve the schools. Furthermore, the qualitative information gained from school personnel confirmed the collaboration with the IHS and the need for more services from the agency.

While the IHS provides clinical services to BIE students, there remains a critical need for these schools to expand their school health functions and capacity. School health policies, procedures, and programs must be in place to ensure and promote the health of the school community.

School Health Policies and Procedures are Disparate

Public schools benefit from being part of a larger system in which funding and technical assistance are provided directly to the schools by a centralized agency. Public schools receive technical assistance on school health programs from public education and/or public health departments. In New Mexico, both of these departments are accountable for providing direction to schools related to school health services and program implementation. In the BIE schools, there is no system in place to support school health programs.

The data on immunization rates demonstrate that school health policies are disparate across the BIE schools in New Mexico. Approximately one-third of the schools did not report immunization rates to the New Mexico Department of Health in the academic year of 2006-2007. One-third of the schools also reported that there is no policy in place regarding students who have not received the required immunization for entry into kindergarten or first grade. Further, the percentage of schools that allow students to carry and self-administer live-saving medication for control of asthma, diabetes and acute allergic reactions is low.

Despite the lack of a centralized and coordinated effort around school health, BIE schools have basic processes in place to ensure the safety and protection of students. Nearly all of the schools reported to maintain current student health records with the recommended information. All of the schools indicated that these records were kept in a secure and confidential location. Although, only nine out of the 39 schools have a school nurse, the majority of schools report following the recommended procedures for the administration of student medication. Finally, 95% of the schools have at least one person trained to respond to medical emergencies and at all of the schools the staff complete a report after the serious illness or injury of a student.

Behavioral and Mental Health Services are Sparse

The mental health status of American Indian youth is a grave concern to educators, health professionals, parents, students, and communities. The startling mental health outcomes among this population require a response at all levels—including at the school level, where students spend a majority of their waking hours.

A range of behavioral and mental health services are provided at BIE schools. However, a limitation of the BIE School Health Assessment is that there is no way to assess the quality and effectiveness (evidence-base) of the services provided. Although trained mental health professionals serve the BIE schools, the variability in hours of service (from less than one hour per week to 80 hours per week) demonstrates that BIE schools and their students lack consistent and adequate access to mental health services and licensed mental health professionals. Psychologists were most frequently cited by the schools (24 schools, 62%) to provide mental health services; however, it is likely that these psychologists are primarily funded through special education programs and their services are limited to special education students.

Governmental Funding and Community Determination are Primary Determinants in School Health Services

Frequently, institutions that serve the general public struggle financially and find themselves tied to specific funding sources. Public education and health institutions typically report to state and/or federal governmental agencies and are required to follow governmental mandates. Consequently, the decisions around the selection of services and programs are often made based upon funding and legislation. Another determinant in program and service delivery is strong community consensus, decision-making and advocacy. Historically, it is the fierce grassroots efforts that have realized tremendous social reform.

Federal mandates and funding support special education services. The providers that were cited most frequently to serve BIE schools—occupational therapists, speech therapists, and physical therapists—are supported by these funds and, therefore, their services are not available to the general student population. Additionally, the IHS was most often cited as the primary source for primary care and dental health providers. Eight out of the nine BIE schools with schools nurses are BIE grant schools, meaning that these eight communities have utilized Public Law 93-638 to make their own choices in health care administration. (The 1995 Indian Self-Determination and Education Assistance Act, Public Law 93-638, gave Tribes the authority to contract with the federal government to operate programs serving their tribal members and other eligible persons.)

Communities are Important Links to Health Services

Communities are abundant in resources, both tangible and intangible. Schools, hospitals, parks, markets, financial institutions, and other public and private institutions, provide communities with essential goods and services. Collectively, individual community members provide the intangible—social cohesion, guiding visions, and opportunities. Community resources play an important role in health service delivery; however, assessment findings reveal that community involvement in the planning of school health programs may be minimal.

Overall, school health services are sparse in BIE schools in New Mexico. Schools depend on their communities to provide health services. Community agencies and Community Health Representatives contribute to the health education programming in the BIE schools. Moreover, approximately one-third of schools refer students to community health clinics, hospitals, or agencies for primary care services. Thirty-eight percent of schools refer students to community organizations for mental health services and 18% of schools refer students to tribal health providers for these services (see Appendices A and B).

Those schools that have been successful in obtaining an on-site school nurse have been grant schools. Eight of the nine BIE schools with school nurses are grant schools. These eight communities devoted a portion of their Public Law 93-638 funds to securing school nursing positions.

The BIE School Health Assessment had four questions regarding community involvement in school health programming. Further assessment is necessary to provide an accurate account of community involvement related to school health programming in BIE schools. Forty-four

percent of schools maintain a school health advisory council and 33% of schools collect student suggestions about health services. School health advisory councils bring community voice to the school health planning process. Membership typically includes students, parents, tribal leaders, teachers, school officials, health providers, and other important stakeholders. Student voice is especially important since students are the 'clients' of the BIE schools.

VII. Recommendations

Based on the findings from the School Health Assessment of BIE Schools in New Mexico, the following are recommendations for BIE schools:

1. Establish position(s) for persons with experience in school health programs through the BIE and the Indian Health Service to provide direction and oversight of school health programs among all BIE schools. The position(s) would provide standardized guidelines for school health policies and procedures.

2. Provide and/or maintain designated health facilities (in accordance with the American with Disabilities Act minimum requirements) with a private exam room, wheelchair access, running water, a refrigerator solely for medications, and a restroom.

3. Hire school nurses at a minimum ratio of at least 1:750 students to manage and implement school health services which meet student health care needs and enhance academic success. Consideration should be given to level of student health care needs location of school/proximity to health care services, and boarding school status. School nurses should be graduates of a baccalaureate degree program from an accredited college or university and licensed as a registered nurse.

4. Assure that all unlicensed personnel who assist in the care of students are appropriately trained and are supervised by a school registered nurse.

5. Hire licensed mental health professionals to assess risk, provide early intervention, make appropriate referrals, coordinate with outside mental health providers, and ensure comprehensive crisis response.

6. Establish policies regarding immunizations consistent with state requirements.

7. Establish policies to ensure safe medication administration and immediate access to life-saving medications, e.g. self-carry medication.

8. Establish policies regarding the care of students with complex health care needs. Use the New Mexico School Health Manual, which is continually updated on-line, as a reference. The manual may be accessed at www.nmschoolhealthmanual.org.

9. Establish school health advisory councils, which include students, parents, staff, health providers, and community members to advise local school boards regarding school health policies and practices.

10. Explore and maximize funding sources (such as Medicaid) to supplement base funding from the BIE and IHS.

11. Contact the state education agency and other state agencies to access resources they have to support school health programs in BIE schools.

12. Establish and/or maintain policies related to the national school health objectives from Healthy People 2010 (see Appendix G).

13. Track indicators of student health (individual and population-based health outcomes) and academic success (attendance, grades, dropout, graduation) to justify the investment in quality school health programs and to stimulate further improvement.

In October 2006, a working group of the federal Emerging Leaders Program, released the *Indian Health Service—School Health White Paper*. The report addressed the collaborative efforts between the BIE and IHS regarding school health and concluded with three recommendations. Consideration of these recommendations should be given as both institutions address the disparities in school health among the American Indian population.

1. Build on the effort initiated in New Mexico to assess the school health programs and services in BIE schools nationwide. The BIE and IHS should collaborate with the Centers for Disease Control and Prevention to develop a survey that includes questions on school reimbursement practices that can be distributed to all BIE schools every five years.

2. Sustain collaboration between the BIE and the Indian Health Service through the formation of a cross-agency workgroup. Consider launching a national campaign surrounding an important health issue that the BIE and IHS identify as a high priority.

3. Collaborate to hire a nursing specialist at the headquarters level to address the shortage of nurses currently in BIE schools. An independent consultant approved and hired by the BIE and IHS could assist in identifying effective strategies for funding BIE school nurses.

Based on the findings from the School Health Assessment of BIE Schools in New Mexico, it is also recommended that state agencies conduct tribal consultation to determine what resources they may be able to contribute to BIE schools for school health programs.

School Health Staffing and Collaboration in Bureau of Indian Education Schools in New Mexico

					Provider Paid by:					
Health Provider	**Number of Schools (%) with Indicated Provider**	**Minimum Hours/ Week of Service**	**Maximum Hours/ Week of Service**	**Average Hours Provided**	**Bureau of Indian Education**	**Indian Health Service**	**Tribal Funds**	**Volunteer**	**Other**	**Other detailed**
School RN	9 (23%)	16	40	41	5	1	2	--	1	Grant from NM Department of Health and Innovative Special Education Preparation (ISEP) Program
Public Health RN	23 (59%)	1 hr/year	10	2	--	21	2	--	--	
Nurse Practitioner/ Physician Assistant	3 (8%)	3	8	6	1	2	--	1	--	
Physician	5 (13%)	0.75	8	6	--	4	--	--	--	
LPN	5 (13%)	4	40	21	3	2	--	--	--	
Health Aide	5 (13%)	30	40	38	3	2	--	--	--	
Dental Hygienist	15 (42%)	0.14	10	2	--	12	1	--	1	
Dentist	11 (28%)	0.22	10	2	--	7	1	--	3	Medicaid
Speech Therapist	23 (59%)	1	40	17	14	2	2	--	--	Educational Assessment Systems Incorporated (EASI), special education funds, Medicaid Part B
Physical Therapist	19 (49%)	1	16	0.5	12	1	1	--	5	Educational Assessment Systems Incorporated (EASI), special education funds, Individualized Education Program (IEP)
Occupational Therapist	26 (67%)	0.7	28	10	16	2	2	--	6	Educational Assessment Systems Incorporated (EASI), special education funds, Individualized Education Program (IEP), Medicaid Part B

Note: Calculation based on 39 schools that participated in the survey.

Health Aides Required to Work Under Supervision of School RN

- Two schools out of six schools (33%) with health aides indicated that the health aides are required to work under the supervision of a registered nurse.

Required Training of Health Aides

Type of Training	Number (%) Schools
Orientation by public health RN	4 (67%)
Orientation by school RN	2 (33%)
NM school health assistant training	3 (50%)

Note: School could choose more than one answer. Calculation based on six schools with health aides.

On-Site Services and Referrals

Health Service	Number (%) Schools Providing Service On-site	Number (%) Schools Providing referrals	Neither
Immunizations	14 (36%)	20 (51%)	5 (13%)
Oral health care	20 (51%)	19 (49%)	0 (0%)
Case management for students with disabilities	24 (62%)	11 (28%)	4 (10%)
Management of chronic health conditions	15 (38%)	18 (46%)	6 (15%)
Management of acute illness	10 (26%)	20 (53%)	8 (21%)
Prescriptions for medications	6 (15%)	19 (49%)	12 (31%)
Reproductive health services	7 (18%)	19 (49%)	12 (31%)

Note: Schools were only asked if referrals were provided if it was indicated that the service was not provided on-site. Calculation based on 39 schools that participated in the survey.

Agencies Referred to for Medical Services

Referred to:	Number (%) Schools Referring to Agency/Provider
Indian Health Service	39 (100%)
Community health clinic or hospital	11 (28%)
Private physician or physician group	11 (28%)
Public health office	4 (10%)
Other community health agency	2 5%)

Note: Schools were allowed to choose more than one referral agency/provider. Calculation based on 39 schools.

Frequency of Written Referral Process

Frequency	Number (%) Schools
Always	13 (33%)
Sometimes	11 (28%)
Rarely	11 (28%)
Never	4 (10%)
Total	39 (100%)

Note: Calculation based on 39 schools that participated in the survey.

Type of Feedback Received after Referring Student

Type of Feedback	Number (%) Schools
Written notice	10 (26%)
Phone call/verbal communication	6 (16%)
Both	10 (26%)
No feedback	11 (29%)
'Other' feedback	1 (3%)
Total	38 (100%)

Note: Calculation based on 38 schools that responded to this question.

APPENDIX B

Behavioral and Mental Health Staffing and Collaboration in Bureau of Indian Education Schools in New Mexico

					Provider Paid by:					
Health Provider	**Number of Schools (%) with Indicated Provider**	**Minimum Hours/Week of Service**	**Maximum Hours/Week of Service**	**Average Hours Provided**	**Bureau of Indian Education**	**Indian Health Service**	**Tribal Funds**	**Volunteer**	**Other**	**Other detailed**
Psychologist	24 (62%)	1	32	15*	11	5	2	--	6	Educational Assessment Systems Incorporated (EASI), Individual with Disabilities Act (IDEA), and the University of New Mexico
Licensed Counselor	22 (56%)	3	80	30**	18	--	1	--	1	Grant from federal government
Social Worker	13 (33%)	0.5	40	31***	7	1	2	--	3	Educational Assessment Systems Incorporated (EASI) and grant from federal government
School/Guidance Counselor	11 (28%)	0.6	120		10	--	--	--	--	
Psychiatrist	3 (8%)	1	1	1	2	1	--	--	--	
Tribal Health Provider	3 (8%)	8 hours/year	8	3	--	1	2	--	--	
School RN	3 (8%)	40	40	40	--	--	--	--	--	
Physician	2 (5%)	8	8	8****	--	--	--	--	--	
Public health RN	1 (3%)	Not provided			--	--	--	--	--	
Health Aide	1 (3%)	30	30	30	1	--	--	--	--	

* Calculated on hours provided by 22 schools

** Calculated on hours provided by 21 schools

*** Calculated on hours provided by 12 schools

****Calculated on hours provided by one school.

Percentage of schools with indicated provider based on 39 schools that participated in the survey.

Student Referrals to Outside Agencies

- Thirty-seven out of the 39 schools (95%) refer students to an outside agency, clinic, or provider for behavioral and mental health services.

Agencies Referred to for Behavioral and Mental Health Services

Referred to:	**Number (%) Schools Referring to Agency/Provider**
Indian Health Service	34 (92%)
Community health clinic or hospital	10 (27%)
Tribal health provider	7 (19%)
Public health office	5 14%)
Other community health agency	5 (14%)
Private provider or provider group	4 (11%)

Note: School could choose more than one answer. Calculation based on 39 schools that participated in the survey.

APPENDIX C

Health Education and Counseling Services Provided in Bureau of Indian Education Schools in New Mexico	
Topical Area	**Number of Schools (%) (N=39)**
Violence prevention	38 (97%)
Alcohol, tobacco, and other drugs	36 (92%)
Nutrition and physical activity	36 (92%)
Growth and development	32 (84%)
STD/HIV/AIDS awareness	25 (64%)
Stress reduction	23 (59%)
Smoking cessation	19 (49%)
Parenting classes	19 (50%)
Pregnancy prevention	15 (38%)
Other	11 (39%)
Other health education areas and activities identified included: life skills, diabetes, hygiene, media literacy, positive behavioral education, anger management, sexual abuse prevention, wellness programs, student walking, and health fairs.	

Student Health Records

Health Records Maintenance

Obtain and Keep Current Records on…	Number (%) Schools
Immunization status	39 (100%)
Emergency contact information	39 (100%)
Screening records i.e. vision or hearing	38 (97%)
Authorization for emergency treatment	36 (92%)
Medication needs	36 (92%)
Dietary needs or restrictions	36 (92%)
Severe food or other allergies	36 (92%)
Physical health history	33 (85%)
Physical activity restrictions	31 (79%)
Asthma action plans	28 (72%)
Tuberculosis screening results	21 (54%)
Emotional/mental health history	20 (52%)
Insurance coverage	20 (51%)

Note: Calculation based on 39 schools that participated in the survey.

Utilization of Electronic Database

- Fifteen out of the 39 schools (39%) store health records in an electronic database.
- Nine of these schools (23%) reported using the Native American Student Information System.
- One school reported using Resource and Patient Management System (Indian Health Service software).
- Other software listed by the remaining five schools included: Health Office, Infinite Campus, Power School, SBHC (School-based health center) Pro, and School Master.
- Each of the 15 schools (100%) that store health records in an electronic database reported that the user must enter a password in order to access the database.
- Each of the 39 schools (100%) report that the student health records are kept in a secure and confidential location.

Immunizations

Number of Days Non-Immunized Students Allowed to Attend Class

Days	**Number of Schools***
Three	1
Five	4
Ten	1
Thirty	1
Don't know	1

* Total of eight schools.

Procedures for Student Medication Administration

Staff Allowed to Assist Students with Routine Medication Administration

Staff Member(s)	**Number (%) Schools**
School staff (principals, secretaries, dorm aides, department heads)	29 (74%)
Teachers	14 (36%)
School RN	12 (31%)
Health Aide	6 (15%)
LPN	3 (8%)
Physician	2 (5%)
Certified Medication Aide	1 (3%)

Note: Calculation based on 39 schools that participated in the survey.

Summary of Main Themes and Key Findings

Core Health Infrastructure—Health Facilities and School Nursing—is Lagging

- Sixteen out of the 39 Bureau of Indian Education (BIE) schools (41%) do not have a health office or school-based health center.
- Schools with health facilities lack the minimum recommended design features—a private exam, wheelchair access, running water, a refrigerator, and a restroom.
- Nine out of the 39 schools (23%) have a school registered nurse.
- The average school nurse to student ratio in BIE schools is 1:916, lower than the national recommendation of 1:750.
- The average school nurse to student ratio in Bureau of Indian schools would be 1:1084 if the school of exception—the school with two full-time nurses—was not included in the analysis.
- Schools without school nurses rely upon services from the Indian Health Service.

Indian Health Service and Bureau of Indian Education Lack Capacity for School Health

- The qualitative information obtained from school personnel illustrates BIE collaboration with the Indian Health Service and the need for more services from the agency.
- In the case of school health programs, one under funded agency (BIE) is relying on another under funded agency (HIS) to provide for the neediest young people in the country, thus widening the disparity.
- The Indian Health Service was identified as the primary source for public health nurses providing services in the BIE schools.
- The Indian Health Service provides clinical services to BIE students; however, there remains a critical need for these schools to expand their school health functions and capacity. School health policies, procedures, and programs must be in place to ensure the safety and health of the school community.

School Health Policies and Procedures are Disparate

- Over one-third of BIE schools did not report immunization rates to the New Mexico Department of Health in academic year 2006—2007.
- Of the schools that did report immunization rates, the percent of schools reporting immunization rates less than 90% follows:
    - 43% of schools with a kindergarten class
    - 22% of schools with a first grade class
    - 50% of schools with a seventh grade class

(The national target for 2010 is ≥95% vaccination coverage for children in the kindergarten or first grade.)

- One-third of the schools report that there is no policy in place regarding students who have not received the required immunization for entry into kindergarten or first grade.

- The percentage of schools that allow students to carry and self-administer medications to control asthma and diabetes and for acute allergic reactions is low.

Behavioral and Mental Health Services are Sparse

- A range of behavioral and mental health services are provided at BIE schools by trained mental health providers; however, the hours of service range from less than one hour per week to 80 hours per week.

Governmental Funding and Community Determination are Primary Determinants in School Health Services

- The providers that were cited most frequently to service BIE schools—occupational therapists, speech therapists, and physical therapists—are supported by special education funds; however, their services are not available to the general student population.

- The Indian Health Service was most often cited as the primary source for primary care and dental health providers.

- Eight out of the nine schools (89%) with school registered nurses are BIE grant schools. These eight communities have utilized Public Law 638 funds to make their own choices in health care administration. BIE-operated schools are more likely to rely upon services from a public health nurse from the Indian Health Service.

Communities are Important Links to Health Services

- Community agencies and Community Health Representatives contribute to the health education programming in BIE schools.

- Over one-third of schools refer students to community health clinics, hospitals, or agencies for primary care services.

- Approximately 40% of schools refer students to community organizations for mental health services and 18% of schools refer students to tribal health providers for these services.

- Forty-four percent of schools maintain a school health advisory council and 33% of schools collect student suggestions about health services. Further assessment is necessary to provide an accurate account of community involvement related to school health programming in BIE schools.

Healthy People 2010

Healthy People 2010 is a set of health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. It can be used by many different people, states, communities, professional organizations, and others to help them develop programs to improve health. The following are the objectives directly related to school health.

Those objectives listed as "developmental" were determined to be of national importance but did not have baseline data or targets established in the November edition of Health People 2010.

Objective 7-2

> Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy; HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Objective 7-4

> Increase the proportion of the Nation's elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.

Objective 8-20

> (Developmental) Increase the proportion of the Nation's primary and secondary schools that have official school policies ensuring the safety of students and staff from environmental hazards, such as chemicals in special classrooms, poor indoor air quality, asbestos, and exposure to pesticides.

Objective 14-23

> Maintain vaccination coverage levels for children in licensed day care facilities and children in kindergarten through the first grade.

Objective 15-31

> (Developmental) Increase the proportion of public and private schools that require use of appropriate head, face, eye, and mouth protection for students participating in school-sponsored physical activities.

Objective 19-15

> (Developmental) Increase the proportion of children and adolescents aged 6 to 19 years whose intake of meals and snacks at school contributes to good overall dietary quality.

Objective 21-13

(Developmental) Increase the proportion of school-based health centers with an oral health component.

Objective 22-8

Increase the proportion of the Nation's public and private schools that require daily physical education class for all students.

Objective 22-10

Increase the proportion of adolescents who spend at least 50 percent of school physical education class time being physically active.

Objective 22-12

(Developmental) Increase the proportion of the Nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations).

Objective 27-11

Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events.

REFERENCES

[2] Selekman, J. (2006). *School Nursing: A Comprehensive Text.* (p. 1013) Philadelphia: F.A. Davis Company.
[3] Selekman, J. (2006). *School Nursing: A Comprehensive Text.* (p.1014) Philadelphia: F.A. Davis Company.
[4] New Mexico Department of Health. *New Mexico School Health Manual.* (2007). Available: http://nmschoolhealthmanual.org
[5] Brener N. et al. (2001). Journal of School Health. *Health Services: Results from the School Health Policies and Programs Study 2000*, 71(7), 294-304.
[6] US Department of Health and Human Services: Health, Mental Health and Safety Guidelines for Schools. (2007). Available: http://www.nationalguidelines.org
[7] National Association for School Nurses. (2002). *Position Statement: Education, Licensure, and Certification of School Nurses.*
[8] National Association of School Nurses. (2006). *Position Statement: Caseload Assignments*.
[9] Brener N. et al. (2001). Journal of School Health. *Health Services: Results from the School Health Policies and Programs Study 2000*, 71(7), 294-304.
[10] New Mexico Department of Health. *New Mexico School Health Manual.* (2007). Available: http://nmschoolhealthmanual.org
[11] Centers for Disease Control and Prevention. (2004). Web-based Injury Statistics Query and Reporting Systems (WISQARS). Available: http://www.cdc.gov/nicpc/wisquars/default.htm
[12] New Mexico Department of Health. (2006). *Racial and Ethnic Health Disparities Report Card.* Available: http://www.health.state.nm.us/opmh/ReportCard.pdf
[13] New Mexico Department of Health. (2006). *New Mexico American Indian Health Status Report*. Available: http://www.health.state.nm.us/pdf/health_status_report_final.pdf
[14] Centers for Disease Control and Prevention. *Youth Risk Behavioral Surveillance System, United States 2005*. Youth On-line Comprehensive Results. Available: http://apps.nccd.cdc.gov/yrbss
[15] Ibid
[16] Duran, B., Duran, E., & Brave Heart, M. (1998). Native Americans and the Trauma of History. In R. Thornton (Ed.), *Studying Native America: Problems and Prospects*. (pp. 60-76). Madison: University of Wisconsin Press.
[17] Brener, N., Martindale, J., & Weist M. (2001). Journal of School Health. *Mental Health and Social Services: Results from the School Health Policies and Programs Study 2000*, 71(7), 305-312.
[18] McKenzie, J. & Smeltzer, J. (1997). *Planning, Implementing, and Evaluating Health Promotion Programs.* Boston: Allyn & Bacon.
[19] US Department of Health and Human Services: Health, Mental Health and Safety Guidelines for Schools. (2007). Available: http://www.nationalguidelines.org/
[20] Ibid.
[21] American School Health Association. (2005). *Protecting and Disclosing Student Health Information: How to Develop School District Policies and Procedures.*
[22] National Association of School Nurses. (2003). *Position Statement: Medication Administration in the School Setting.*
[23] Massachusetts General Hospital for Children. *Boarding School.* Available: http://www.massgeneral.org/children/adolescenthealth/articles/aa_boarding_school.aspx
[24] Duran, B., Duran, E., & Brave Heart, M. (1998). Native Americans and the Trauma of History. In R. Thornton (Ed.), *Studying Native America: Problems and Prospects*. (pp. 60-76).
[25] U.S. Commission on Civil Rights. (2004). *Broken Promises: Evaluating the Native American Health Care System*.
[26] U.S. Commission on Civil Rights. (2003). *Quiet Crisis: Federal Funding and Unmet Needs in Indian Country.*