

Creating Healthy Opportunities: Conversations with Adolescent Health Experts

ANGELA DIAZ, MD, MPH // SHAY BILCHIK, JD // RICHARD KREIPE, MD // JANE BROWN, PHD // ABIGAIL ENGLISH, JD



INTERVIEWS CONDUCTED BY KAREN BROWN

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PROFILE:

Angela Diaz

PROFESSOR AND VICE CHAIR, DEPARTMENT OF PEDIATRICS
AT MOUNT SINAI SCHOOL OF MEDICINE



"I think the health care system in the US was created for adults, by adults. And then we try to fit teenagers into that system, and it really doesn't work for them. And then we call them non-compliant and hard to reach."

Dr. Angela Diaz believes the first step to keeping teenagers healthy is understanding their culture, but not necessarily 'culture' as we usually think about the word.

"There is a culture of adolescence that in my opinion is stronger for adolescents than the race and ethnicity culture," Diaz says. "And if you understand adolescents and how to work with them, it almost doesn't matter, the color of the kid, or the class of the kid."

Diaz runs the Mount Sinai Adolescent Health Center in Lower East Harlem, New York City. Ninety-one percent of her clinic's patients are teenagers of color, most of them Latino or African-American. Diaz says practitioners and policy makers who want to help these kids should start with their developmental stage, not their sociological or racial background.

"I think the health care system in the U.S. was created for adults, by adults. And then we try to fit teenagers into that system, and it really doesn't work for them. And then we call them non-compliant and hard to reach," says Diaz, who is also President of the Board of the Children's Aid Society of New York, as well as a member of the Institute of Medicine. "If you understand the culture of adolescence and the developmental journey, and you work with them on that basis, I think they are the greatest health care consumers."

That said, Diaz fully acknowledges the uphill health battle facing her mostly low-income clientele when compared with middle class teenagers in other parts of the city and country – a problem she blames mostly on lack of access to health care and health insurance.

Mount Sinai caters to teenagers living in poverty, because that is the population

that most needs help, Diaz says, and in New York City, poverty is closely correlated with minority status. These factors can often predict whether an adolescent is getting the health care she needs. Diaz says African American teenagers are 40 percent more likely to be uninsured than their white counterparts, and Latinos are 300 percent less likely to have health insurance than white teenagers. That's where the disparity starts, with alarming consequences for the health and welfare of those populations.

"People who do not have insurance, or money to pay, have to prioritize food and shelter over health. They don't get any kind of prevention. They don't get any kind of real health education, such as teaching them how to take care of themselves. And they don't go to the doctor early, before something happens. When they are very sick, they will go to an ER, where the care by design is to take care of the immediate problem, not necessarily the whole person."

Not surprisingly, minority teens have higher rates of diabetes, obesity, and heart disease than whites, and these conditions then continue into adulthood. Teen birth rates among Latino and African American youth ages 15 to 17 are 83 and 64 per 1000, respectively – more than two times those of their Caucasian counterparts, according to the Federal Interagency Forum on Child and Family Statistics. "When you look at the charts of the rates of teen pregnancy, African American and Latino teens are way up there in terms of teen pregnancy compared to whites," Diaz says. "But this difference can be reduced by providing access to good care." Good care, she says, involves strong relationships with

providers, easy access to a doctor's office, reproductive information on demand, and basic primary care.

That's what her program aims to provide. The most basic way is both simple and obvious: offer health care for free. Even though a quarter of her patients do have Medicaid, and a smaller percentage have private health insurance, the majority are uninsured, and that means the Center privately raises 10 million dollars a year to make sure that no teenager is turned away for lack of money. "We will not charge them a penny," Diaz says. "And if they need to come a hundred times per year, they will come a hundred times per year. It does not matter. If they need to get whatever work up, the top of the line quality medicine, they will get that."

Once a teenager arrives at the Center, mostly due to word of mouth among peers,

of these issues, but in many cases, Diaz will bring in professionals from the outside to consult.

Diaz is quick to point out that her center goes beyond what people consider traditional health care – to create partnerships with other disciplines. One of the key partnerships is with the legal profession. Because so many of the Center's patients live in poverty, they often find themselves in need of a legal advocate, but unable to navigate the law on their own. So when a social worker from Diaz's clinic (there are 25 social workers on staff) stumbles upon a problem she can't solve on her own, the legal partners are brought in.

"For example, if a kid has asthma, the doctor or social worker may be writing to the landlord that there's a trigger in the apartment," Diaz says. "But the landlord often won't respond, so the kid

doing their part, the health practitioners are helping their teen patients with the social or emotional implications of living in an immigrant community. This is one aspect of 'cultural competency' that Diaz considers key to promoting health for teenagers.

"I think immigration is traumatic," Diaz says. "Even though you are coming to this country for a better life, and for economic or for religious freedom or whatever, it's really traumatic. You are leaving what you are familiar with, your friends, your family, your school, your community, and then placed in a completely different environment."

Diaz is herself an immigrant from the Dominican Republic; she arrived in New York City as a teenager, lived in poverty with a single mother, dropped out of high school at one point, and relied on the Mount Sinai Adolescent Health Center to

"If [policy makers] invest in the front end, in...prevention and wellness, in primary health care and creating a medical home, you can reduce unwanted pregnancies, sexually transmitted infections, and many of the chronic illnesses that develop in adolescence, like obesity or high cholesterol, and diabetes."

or referrals from schools and community programs, he will find himself the center of attention, Diaz says. She only hires staff who honestly like teenagers, and who understand the developmental urge to experiment, take risks, and connect with peers. Although the Center encourages parental involvement, its staff is always willing to see a teenager alone, confidentially if necessary (as permitted under New York law). Diaz considers the promise of confidentiality one of the reasons that teenagers trust the Center and keep coming back.

Another reason, Diaz says, is the Center's integrated approach, which she calls the "under one roof" model. That means teenagers may arrive at the Center with one simple health issue, but they will stay there for a comprehensive health evaluation that includes everything from mental health and reproductive health, sex education and nutrition, HIV prevention, or drug treatment, to counseling for victims of rape, incest, domestic abuse, or sexual exploitation. The Center does have full-time staff that can handle many

keeps getting triggered with asthma. But if a lawyer gets involved, the landlord is much more likely to respond."

On the flipside, some of her patients find themselves in trouble with the law and in need of legal defense. Diaz considers this an extension of her patients' health care, especially when a young person is arrested for a minor infraction, such as drug possession or school truancy, but faces life-long consequences. "If you can help a kid not end up with a criminal record," she says, "you are helping them stay whole."

Diaz says the legal partners will also take on cases to help teenagers stay in high school (she notes that youth of color have much higher drop-out rates than whites), or help them get financial aid for college. Dropping out of school is a predictor of poor long term health, Diaz points out.

Lawyers may also help with immigration or refugee status, securing the rights of a family to stay in America and obtain social services. And while the lawyers are

help get her life back on track. So it's not much of a stretch for Diaz to understand the challenges of many of her patients. However, she says most staff members are not immigrants, nor people of color. While she would like to have more practitioners of color – as role models for minority teens – she considers it much more important to have staff who are culturally competent, who respect and understand the teenagers they treat. And in the case of immigrant families, much of this understanding revolves around their relationship with family.

"Once the teenager is here for a while, the culture of that teenager and the expectations at home, and what the kids are going to get exposed to in school, and in the community, are not always in sync," Diaz says. "So you need to make sure that you help that young person or the family understand and communicate better, to be back in the same wavelength."

Diaz believes that improving family relationships does more than promote harmony at home; it improves teen health.



Take a teenager who comes from a strict Catholic family or community where she is told premarital sex is a sin. “How do you help that kid... get the help that they need to prevent the negative consequences?” Diaz says. “Because they do have the sex, but they don’t want to tell anyone because they think they are going to be judged for doing something wrong.”

Which is why treating teenagers without judgment is another tenet of Diaz’ health care philosophy – one that she drills into the medical residents who come to train at Mount Sinai in adolescent health. Sometimes that’s a hard lesson to teach, especially when a teenager is coming in for a third pregnancy, having failed to heed the clinician’s previous warnings.

“We are here to help teens, not to mandate, and this is part of adolescent development – to experiment. What we have to do is really create a safe environment around them, whether they try drugs or they try sex or they try whatever. What we really need to do is help them feel connected to a place where they can always come for help. Even the rare teen who comes with a third-time pregnancy, I will try to prevent the fourth one.”

Diaz works with populations others have given up on, including teens involved in the sex trade or addicted to drugs. But she insists her positive youth development approach can work with all teenagers, at clinics that are less comprehensive than hers, as long as administrators put a few key concepts in place. For example, she urges clinics to:

- stay open during the hours that suit a teenager’s schedule, such as evenings and weekends;
- hire staff willing to listen closely to adolescents’ needs;
- respect patient confidentiality within the confines of each state’s parental notification laws; and
- involve teenagers in their own care (e.g., asking teenagers what sort of birth control they are most likely to use, as opposed to telling them which type they should use).

Diaz has also instituted a peer mentoring program, where she trains adolescents to reach out to their friends with health education, and sometimes, to edit the very surveys the clinic sends out to teenagers.

But Diaz says individual clinics can only do so much without support from policy makers and legislators. On this topic, she always comes back to access – an issue that disproportionately affects young people of color. According to the National Alliance to Advance Adoles-

they should be eligible for health care, plain and simple.

If more teenagers had access to government-sponsored insurance, she believes many more health centers would have the resources to focus on the neediest adolescents. Instead, Diaz says, the health care financing in this country works against programs that take more time to engage vulnerable patients, or that follow an integrated, interdisciplinary model. That's true even for insured populations, since most insurance payors only reim-

IV and antibiotics that they have to get... there is no question as to which approach ends up saving money."

As it stands, she says, the only way a program like Mount Sinai Adolescent Center can operate is through constant fundraising by administrators like Diaz – a highly skilled practitioner who, she points out, would much rather be seeing teen patients in her office.

On a societal level, Diaz would like to see more medical students specialize in adolescent health, and she'd like

"People who do not have insurance, or money to pay, have to prioritize food and shelter over health. They don't get any kind of prevention. They don't get any kind of real health education, such as teaching them how to take care of themselves. And they don't go to the doctor early, before something happens."

cent Health, about a quarter of all Latino teenagers and 11 percent of black teenagers are uninsured, compared to only eight percent of white adolescents. And the majority – 72 percent – of uninsured teenagers of color live in low-income households, compared to just 49 percent of the white population.

This disparity is a main reason that Diaz believes legislators need to make sure that every adolescent, into their early 20s, has health insurance. For state-administered programs, like Medicaid, the application process needs to be much simpler because she believes the mounds of paperwork and bureaucracy families are forced to navigate become major obstacles to health care.

"The forms and the requirements are just total barriers," Diaz says. "For example, they ask parents to produce pay stubs. Well, not necessarily all these parents are working in circumstances that they can produce a pay stub. They want leases, but sometimes these people are paying for a room in somebody else's apartment." For some programs, Diaz says, teenagers are required to produce immigration papers or Social Security cards, tasks that often derail the entire process of getting into the Medicaid program. She wants legislators to make Medicaid or other insurance programs an automatic default for all teenagers; if they can prove their age,

burse a very small amount per visit, and may not pay for all preventive services or for the time it takes to connect low-income teens with legal, psychological, educational, or other services. She'd like to see that dramatically shift.

"If [policy makers] invest in the front end, in...prevention and wellness, in primary health care and creating a medical home, you can reduce unwanted pregnancies, sexually transmitted infections, and many of the chronic illnesses that develop in adolescence, like obesity or high cholesterol, and diabetes," Diaz says. "To give you an example, when a kid comes here, we screen them for sexually transmitted infection[s]. Let's say that we find that they have Chlamydia. We give them the pills and a glass of water and they take it here in front of us. We know that they are treated, and then ask them to bring their partner or partners here for treatment. It's a public health approach. Compare that to a kid who has gotten Chlamydia and doesn't know it because they don't have access, they have not been screened, they have not been tested. And, then [they are] sent to an ER with pelvic inflammatory disease, which has spread to their uterus and their tubes and sometimes their ovaries, so that they have to be admitted [to the hospital] at that point. So you have the expensive ER, the expensive inpatient unit, the expensive

to see more minorities enter medical fields, both to improve the overall cultural competency of the health profession, and to become role models for teenagers of color. In the meantime, she believes those who already work in adolescent health and welfare need to become louder, and more unified, advocates. That could mean forming one institution, with representatives from medical, legal, and social disciplines, that is dedicated to furthering adolescent health issues – from juvenile justice reform to health education in public school to reproductive rights. She says the struggling economy makes that type of advocacy all the more urgent.

"Whenever there is not enough money, what gets cut is the money for social services," Diaz says. "So I'm hoping that the people in charge of the country, the leadership, really take a broader view of what's important." ■

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PROFILE:

Shay Bilchik

FOUNDER AND DIRECTOR, CENTER FOR JUVENILE JUSTICE REFORM
AT GEORGETOWN UNIVERSITY PUBLIC POLICY INSTITUTE



"If you don't know that the family with whom you are working had three other children in the system in the last three years who had all been abused and neglected," he says, "and now you're disposing of a case in the juvenile justice system where the young person has committed their first delinquent act, how are you going to possibly order the services that young person and family [are] going to need?"

When a young person is brought handcuffed to a juvenile detention center, people often cannot see beyond the crime the youth has been accused of committing. Most find it hard to look at the factors that first put a child on a path to delinquency, from educational resources in the community, to health services available in the neighborhood, to the age of the parents when the youth was born.

Shay Bilchik, a longtime child welfare and juvenile justice professional, is an exception. By understanding that juvenile delinquency is often a result of life circumstances over which that young person has little or no control, Bilchik believes advocates and policy makers can better focus their efforts and develop strategies that will help the next young person live a healthy, safe, and fulfilling life and stay out of the criminal justice system.

"I think one of the main challenges today is the lack of equity across our society for the 40 million adolescents in terms of the opportunities they have for positive youth development," says Bilchik. [For more information about positive youth development, see box page 12.]

Bilchik has dedicated his professional life to reforming the juvenile justice system and addressing the societal factors that feed into it. Bilchik headed the Office of Juvenile Justice and Delinquency Prevention (OJJDP) under President Clinton. He went on to become President/CEO of the Child Welfare League of America, and now runs the Center for Juvenile Justice Reform at Georgetown University's Public Policy Institute.

His reformist outlook began during his early career as an intern in the Public Defender's Office in central Florida and

then as a prosecutor in Miami working mostly in the juvenile court. When he looked into the background of the young defendants his agency represented, he found a number of worrisome influences and missed opportunities.

"I could trace back into their early childhood years either experience with the child welfare or the juvenile justice system," Bilchik says. "It was my first real eye opener that there was a very long path that a lot of offenders in our criminal justice system had followed. It wasn't that they turned to crime as adults but rather there was a developmental path that could be studied and understood."

Among Bilchik's early actions as an Assistant State's Attorney was to focus on "diversion," a concept that aims to keep young people who get in trouble for minor infractions out of the justice system entirely. "Our realization was that if we could keep kids out of the system, that we'd likely be doing ... better [for them] in the long run than if we brought them into it," he said.

And if that approach does not work for a particular child or offense, the next challenge would be to keep youth from penetrating too deeply into the system. Bilchik would try to keep young people in the least restrictive setting possible and keep them away from adult offenders to improve their chances of integrating back into the community once released.

Bilchik also began to spend time in communities to see how young people were living. He would accompany social workers, public health nurses, police officers, and others into housing projects, schools, and homes. He also went along on public health nurse visits to teenage

parents. From those visits, he began to understand more about the roots of criminal behavior, especially among youth living in poverty.

“What would be most helpful to prevent delinquency would be to make sure [youth] have an opportunity for education, after school programs, and for cultural advancement,” he says. “Their schools should be well staffed with teachers who are excited about teaching and have good teacher to student ratios. And when [adolescents] are looking for general health prevention

in which nurses made regular home visits to teen parents. The practitioners would counsel the new parents about health-related behaviors, including the effects of parental smoking or drug use on fetuses and babies; they would help the young parents manage their anger and depression in order to reduce child abuse; and they would try to steer the mothers and fathers into a better life course through education and skills-building.

That intensive intervention, Bilchik says, “reduced abuse and neglect

for example, where they may feel involved, respected, and included in a way they did not feel in mainstream institutions.

“They will look to gangs who will give them skills, albeit negative skills such as committing crimes, and who will give them the opportunity to use those skills and who will give them recognition for their ‘achievements.’ They will turn the positive youth development frame 180 degrees in a negative way, but use the same construct.”

Wouldn’t it be better, he says, for community leaders to step in instead and

“I could trace back into [criminal defendants’] early childhood years either experience with the child welfare or the juvenile justice system. It was my first real eye opener that there was a very long path that a lot of offenders in our criminal justice system had followed. It wasn’t that they turned to crime as adults but rather there was a developmental path that could be studied and understood.”

or health care, they should be able to find it within their community. If we provide young people these opportunities and the stage to use their newfound skills and get recognition for them, we’ve really moved way down the path in terms of reducing delinquency and getting better outcomes for our young people.”

From a policy perspective, Bilchik believes program administrators, legislators, and advocates need to both create opportunities for young people, such as mentoring, tutoring, or arts programs, and provide wrap-around services to ensure that young people get the help they need in a way that promotes their success.

“It has to be in an environment where [adolescents] are surrounded by adults who will support that type of positive youth development,” he says. “They can’t be put in the vacuum-like environment that a program provides and then come back home again to parents and other adults who will not support them. There also needs to be a focus on the family and ways to strengthen the home to which the young person will return after completion of the program.”

Bilchik is a great believer in intervention with teen parents, both for the sake of the young parents, but also for their babies, who are less likely to grow up delinquent if their parents are given strong supports. Bilchik supported a program while at OJJDP, the Nurse Family Partnership (NFP),

committed by the young teen moms who were involved in the program by 50 percent. It was cost effective, so for every dollar spent, several dollars were saved in long-term costs. Fifteen years later, it also reduced the delinquency population by 50 percent for the children of the families that took part in the program.”

What’s more, he says, a study released by the Robin Hood Foundation found that the NFP program helped delay the teen mothers’ second births, which was shown to have an impact on the future prison population. According to the study, the children of older mothers are less likely to engage in the kind of negative behavior that leads them into the criminal justice system. (For more information about NFP, visit www.nursefamilypartnership.org.)

“If you’ve got parents who aren’t prepared to nurture you, who have created a chaotic environment in the home where there’s not the stability that you need; you have a higher risk of ending up in the juvenile justice system and eventually into the adult criminal justice system,” he says.

Bilchik says communities that invest in programs that support families in the home will likely see long-term rewards – and those that do not will encounter the opposite. Without positive influence from responsible adults, he says, young people will seek, and find, support in much less savory environments, on street corners,

use what we already know about how the adolescent brain works to help at-risk kids stay out of trouble?

“We all know the way adolescents in our own homes rebel and detach, but if you combine that with the brain development research we have now, we see that during the same period of rebelling and independence-seeking, adolescents have a limited ability to resist peer pressure.”

“I think that is what’s happening with a lot of young people in today’s society. They’re going through normal adolescent development, but they’re experiencing it in an environment that makes it hard to stay on the right side of the law,” he says, highlighting the particular challenges facing teenagers who have been abused, neglected, or raised in foster care as a result of abuse or neglect – or otherwise been exposed to dysfunctional communities or families. “I don’t want to suggest that young people not be held accountable for their behavior, but I think we as a society and as adults need to understand what that pathway looks like, and feels like, in the societal environment in which it takes place and then consider those factors as we determine an appropriate sanction. We have a responsibility to make sure our families and communities are ones that can actually support adolescent development in a healthy way.”

Bilchik says this positive approach to delinquency prevention has been an

uphill battle, especially over the last two decades when “zero tolerance” has been the dominant attitude, at the expense of positive youth development. Young offenders have often been thrown into the justice system for minor infractions, in many cases, he says, more for the sake of the community who does not want them around, than for the youth themselves. As a result, young people are immediately stigmatized and considered bound for a life of crime, which often becomes a self-fulfilling prophecy.

“Once it’s on their record and they’ve been labeled in their community, in their family, in their peer group, in their school as a trouble maker, as a delinquent, as a kid who went into the juvenile justice system, it’s hard to remove that tag,” Bilchik says. “I think we need to avoid such stigmatization as much as we can.”

For instance, schools should think twice before sending young people to the juvenile detention center for minor misbehavior, forcing the parents to travel to what may be a distant and intimidating location, fill out paperwork, and then take the child home. That is likely to lead to great tension in the family, he says, “when it is behavior that doesn’t really require an arrest, like a jostling in the school hallway, maybe even a punch back and forth that traditionally has been handled by a school counselor or a school principal sitting the kids down and saying, ‘Okay, we’re going to work this out.’”

Once a young person does end up in the justice system, Bilchik wants them to get as much education, health screening, and emotional support as possible with an eye toward both rehabilitation and teaching consequences. When they get out, one of the best ways to stop the cycle of delinquency, he says, is to welcome them immediately back into the school system. However, he says there has been resistance to this, especially since the passage of the No Child Left Behind Act, which Bilchik believes gives an incentive to school systems to expel troubled youth rather than work with them.

“If some of these kids who are getting into trouble are borderline academic performers, you now have another layer of concern in the school. Administrators say, ‘I don’t really want him back because he’s a potential trouble maker and he isn’t going to contribute to my scores.’”

“But that’s a sad commentary on the barriers we put in the way of our young people when they do get involved in some misbehavior.” Bilchik continues, “The road we seem to be following is the one governed by the zero tolerance mentality. This means we’re turning young people away from the positive youth development pathway, which absolutely has to include engagement with school and an academic future.”

Even simple access to health care can set a young person on a safer path. He says youth need to be able to find doctors and community clinics in their neighborhoods, they need a way to pay for the health care (through Medicaid, CHIP, or free clinics), and the providers need to know how to interact effectively with the adolescents. Something as simple as regular eye exams can prevent a decline in school performance that eventually leads to disruptive behavior. Counseling about reproductive health can prevent unwanted pregnancies. Mental health screenings can lead to effective treatment for small or serious problems, problems that may have otherwise been mistaken for willful disobedience, a precursor to entering the juvenile justice system. By teaching healthy behaviors, reinforcing youth strengths, and following a positive youth development model, providers can help set young people on a path that bypasses the legal system altogether.

“It all comes down to whether you have a provider who is taking the time to talk to an adolescent and explore what’s going on in their life,” Bilchik says. “There may be a tip from the parent or an issue that is relatively obvious such as cutting or an eating disorder. However, it may be something more subtle such as anxiety that has risen up in a child’s life.”

On a more sociological level, Bilchik believes providers need to be made aware of the racial disparities that are glaring in the juvenile justice system but that may originate elsewhere. He says the data clearly show that a disproportionately large number of youth of color end up having contact with the juvenile justice and/or foster care systems compared to whites. He says that is partly a result of the lack of community supports and opportunities as well as high levels of poverty in many minority communities. But he maintains it is also a result of decisions that are made in large-

Shay Bilchik, on ways to improve the foster care system:

- Improve support of the child welfare and protection workforce through training, supervision, higher salaries and additional tools to help them do their job
- Put resources into recruiting and retaining foster families
- Provide more behavioral health and education services for children in foster care
- Increase support for young people after they “age out” of the foster care system
- Exhibit a stronger commitment to family and youth engagement – including the use of family-finding technology and methodologies



scale systems – from law enforcement and intake workers to schools and courts. As a result, he says it is likely that minority youth are punished more harshly than whites, especially for low-grade misbehavior.

“At every step a decision is made, more and more kids of color are penetrating deeper into the system. It is a matter of how those decisions are made and what to do about addressing structural, institutional, or individual bias or racism that

may exist,” Bilchik says. “So I want to do training with various people, law enforcement, intake workers, detention workers, prosecutors, public defenders, case workers, parole workers, probation workers, on what biases we may bring to our work and how to offset them so we make more culturally competent, equitable, and race and ethnically neutral decisions. But I also want to make sure that we have programs and structures in place that look at where there may be disparities in treatment and what we can do structurally to address it.”

“I think that when you do your work in this manner, you are engaged in cross-systems field building,” Bilchik says. “You are building a field of professional workers who think outside of their own discipline. That takes time to truly build and it will ebb and flow as you run into better or worse economic times during which time people tend to be more protective of resources, turf, and control.”

Moreover, he says it requires a certain enlightened self-interest by stakeholders. They may have to let go of some of their

case in the juvenile justice system where the young person has committed their first delinquent act, how are you going to possibly order the services that young person and family [are] going to need?”

Similarly, he says, why not coordinate information between the schools and the foster care system, or between caseworkers and the police department?

“I’d like to see a worker in the child welfare system come into work in the morning, turn on their computer and see an alert if one of their clients has been

“I think one of the main challenges today is the lack of equity across our society for the 40 million adolescents in terms of the opportunities they have for positive youth development.”

All of this points to Bilchik’s overarching paradigm of putting resources into preventing delinquency and keeping adolescents out of the criminal justice system, in order for more young people, and, by extension, adults, to become contributing members of society.

Implementing this paradigm on the scale it requires, he admits, could well take a social movement, and for that to happen, he cites four critical components:

- political leaders willing and able to speak out on the need for prevention programs;
- education for the community about the need for strong programs;
- the availability of staff and infrastructure to set up programs in a community; and
- funding to carry them out.

Instead of any one group launching this movement, he prefers what he calls a multi-systems approach – gathering representatives from different disciplines and institutions, from the child welfare department and the schools to the local police department and state legislature. Some states have created “children’s cabinets” made up of representatives from multiple governmental departments including public health, transitional assistance, substance abuse and prevention, or education, among others.

programmatic territory, and even some control over funding, in order to create a pool of money and staff ready to institute community-wide changes. He says there is precedent for this model, such as a grant program he helped launch as part of the Clinton administration that required collaboration.

“We asked for the schools, the justice system, and the health system in a local community to come together and jointly apply for this money, showing how they would work in a coordinated fashion to reduce school violence. And today, almost 10 years later, that program, called Safe Schools/Healthy Students has funded over a billion dollars worth of local programming. It [moved] from the Clinton to the Bush administration and the evaluations show that there have been effective multi-system strategies jointly funded across systems of care that were implemented as a result [of the funding]. We need to shout this stuff from the mountain tops.”

By the same token, he says, different institutions should also be encouraged to share information when it might help a young person. For instance, a judge is better positioned to hand down a sentence or an alternative to sentencing if he knows something about the defendant’s history in the child welfare or foster care system and has full access to education records.

“If you don’t know that the family with whom you are working had three other children in the system in the last three years who had all been abused and neglected,” he says, “and now you’re disposing of a

arrested the night before,” he says.

Bilchik has considered re-entering government to put these ideas into practice, but he ultimately decided he could do as much good in the nonprofit sector. One of his main goals at the Center for Juvenile Justice Reform at Georgetown University is to train and inspire the next generation of leaders, in and out of government, who can take the positive youth development approach back to their communities to improve outcomes for young people.

“I’m talking about the county commissioners, the directors of Children and Family Services and Juvenile Justice, the city councilors, the state legislators. Those are leaders who can impact appropriations, can impact state law, and can set the stage to do this work in a more meaningful way.” With a unified approach to prevent delinquency and reform the juvenile justice system, he says, it is possible to make America a safer and stronger place for the next generation to grow up in, and by doing so, future generations will be stronger and healthier. ■

Creating Healthy Opportunities: Conversations with Adolescent Health Experts

PROFILE:

Richard Kreipe, MD

PROFESSOR OF PEDIATRICS, DIVISION OF ADOLESCENT MEDICINE,
GOLISANO CHILDREN'S HOSPITAL AT STRONG



"What I really try to focus in on, especially with this strength-based, youth development approach, is that inside every person there is good, and what we have to do is really bring it out."

Dr. Richard Kreipe assumes the best about people. That's not just a social attitude; it's a medical framework. And he says it's served him well as a national leader in the field of adolescent health.

"Focus on the positive qualities of youth," he says. "Try to reinforce in an intentional way factors that protect against a number of high-risk behaviors, but do that in a context of actually working with young people, so that they're a part of the process of determining what happens."

This "positive youth development approach" to adolescent health is one Kreipe has practiced for three decades. [For more information about positive youth development, see box page 12.] He directs the training program for adolescent medicine at the University of Rochester, New York, and he is past president of the Society for Adolescent Medicine. He also sees patients in his clinical practice at Golisano Children's Hospital in Rochester, and advocates for adolescent health programs on the state and national level.

"Adolescents are a very important population to focus on because they have unique needs," he says. "They are no longer children, they're not yet adults, and also they are going through some tremendously important developmental changes during that time."

Positive youth development (PYD) is an approach that recognizes the adolescent's need to experiment, try new things, and stretch the limits of what's acceptable (sometimes to their detriment), but at the same time, it's an approach that embraces rather than fears those things. PYD accepts that adolescents have a need for healthy relationships with their peers and with adults, and that they have the right to

give input into their own life choices. While PYD may be implemented in many different ways, it's generally based on a belief that, with appropriate supports linked to normal adolescent growth and development, teens have much to offer society. Most importantly, when adolescents feel involved in their own health, and respected for what they bring to it, they are more likely to grow up with higher self-esteem, a respect for their physical and mental well-being, and the skills to make wise behavioral decisions.

"What I really try to focus in on, especially with this strength-based, youth development approach, is that inside every person there is good," says Kreipe, "and what we have to do is really bring it out."

As reasonable as this approach may seem to many in the field of adolescent health today, it hasn't always been universally accepted in the broader field of medicine, which Kreipe says has sometimes been too mired in the patriarchal style of dictating choices from a doctor in a white coat, and a sense that adolescents need to be reigned in rather than celebrated.

Kreipe has spent much of his professional life trying to build bridges between those schools of thought – to make the case that treating adolescents with a positive approach is not only humane, but it improves their health outcomes. While Kreipe is a pediatrician by training, he says this approach can be used successfully by many other professionals who cross paths with adolescents, including social workers, nurses, youth advocates, lawyers, and school administrators.

"Focus on adolescents' strengths instead of just focusing on their risks and

liabilities. We need to increase protective factors for kids. It's not that we don't try to decrease risk factors, so we do try to eliminate poverty and other kinds of things, but we also need to realize that when a young person feels like there is an adult in their life who listens to them – other than their parents – that's good, and if they have many adults like that, it's even better. Kids who go to school and feel like they're not connected to school at all, they drop out. Kids who somehow feel like they're connected to school do much better."

Kreipe began to advocate for a posi-

The first step, he says, is to learn how young people communicate with each other, using methods that many health professionals of his generation, from all disciplines, might find alien. That means accepting the trends and habits of adolescents in a positive way rather than resisting them. In some cases, it might require adult professionals becoming more skilled in communication technology.

"I think there is much more resistance for adults to learn about youth, than for youth to learn about adults. If we want to get together with other adults, we

the teenager was actually reading a book aloud to the child.

Family dynamics are also central to Kreipe's approach, and that includes encouraging parents to let their children start making their own health care decisions. "This may be the last chance we really get to change people's health behavior," he says. "So what I like to point out to parents when we first see a kid who's maybe 10, 11 years of age, is that, as time goes on, we are going to be spending more time with your son or daughter and less time with you as parents. Because by

"I think there is much more resistance for adults to learn about youth, than for youth to learn about adults. If we want to get together with other adults, we schedule a meeting or a conference call. Adolescents will IM [instant message] each other or blog. So, I think we need to realize that ...young people communicate in different ways. And rather than saying, 'they have to learn our ways,' I think we have to say, 'we have to learn their ways.'"

tive youth development approach in the late 1970s. Fresh out of a pediatric residency in Philadelphia, he came to realize that adolescent health deserved its own sub-specialty because adolescents have unique needs and challenges, but it too often got subsumed in pediatrics or internal medicine.

Since then, the field has come into its own. As of 1994, doctors can become board certified in adolescent medicine. But Kreipe says he has struggled for decades to attract enough medical school graduates into the specialty (there's a notion – incorrect, he maintains – that they don't get paid as well, or don't need as much additional training as is required.) He has also worked to establish a due respect for the field commensurate with other specialties, and to standardize the training requirements. Kreipe oversees a three-year adolescent medicine fellowship program that stresses both clinical and research abilities, as well as the significant challenge of getting through to teenagers.

"I think that one of the major elements lacking in the training of physicians... is the ability to communicate effectively with adolescents," he says. "Both expressing oneself and listening, and having an adolescent express and listen, [are skills] that really need work and a lot of practicing."

schedule a meeting or a conference call. Adolescents will IM [instant message] each other or blog. So, I think we need to realize that ...young people communicate in different ways. And rather than saying, 'they have to learn our ways,' I think we have to say, 'we have to learn their ways.'"

Kreipe says another prerequisite for professionals, of all types, who want to help adolescents is to actually like them and care about their well-being – qualities that you can't always teach. "I think adolescents tend to be the most misunderstood group of individuals," he says. "What we as professionals don't understand, we fear."

Kreipe says he's met colleagues over the years who openly admit that they don't like teenagers. One incident in particular made him realize how doctors can let their own fears and preconceptions shape their clinical abilities, not to mention their bedside manner. It was a Saturday morning at the hospital, and a 16-year-old girl had been admitted to an adolescent unit with a pelvic inflammatory disease, which is often associated with sexual activity. When the hospital staff put her in a shared room with a severely retarded girl, another doctor protested because the doctor felt a sexually active teenager would be harmful to the more vulnerable child. But when Kreipe arrived on the scene, he found that

the time he or she is 18 years of age, he or she can go see a doctor and you might not know anything about it. So, what we need to be working on is gradually helping the young person become a better consumer of health care."

At the same time, Kreipe says that all teen-oriented professionals would do well to open their minds to what adolescents have to teach. Kreipe says he's learned as much about health care from the young patients themselves as from reading books or attending conferences. For instance, he says he developed his treatment for anorexia nervosa, one of his key areas of clinical practice, by listening to his patients.

"With my very first patient, I didn't know what to do. And I said, this is a fascinating young lady though. She's got serious medical problems as a result of her starvation. She also has serious family conflict issues. She has no self-confidence, her identity is totally not what I would think it would be like and yet she's extremely bright. What's this all about? And so, rather than going right to the books, I spent a lot of time listening to patients and trying to understand where patients are coming from."

From there, he's been able to fine-tune his approach to look at the illness from a more developmental perspective, rather than as a strict mental illness.



“Yes – they have depression, yes – they have anxiety, yes – they have some obsessive compulsive traits,” he says. “But other people have those things and don’t develop an eating disorder. So the way I like to look at it is there [are] biological underpinnings, and I think that over time, we will learn that people who develop eating disorders are biologically different, possibly related to...hard-wiring in the brain.”

If more professionals take this approach, looking more closely at normal adolescent development as it informs behavioral choices, they can steer blame away from the parents while making families more sensitive to developmental issues. That in turn would, ideally, lead to partnerships – with the patient, with the family, and with schools. That’s not always an easy sell, especially when the would-be partners are not used to working together. For instance, he believes educators and physicians should be in frequent contact about troubled young people, and yet they rarely share information with each other. “I think everybody feels absolutely overwhelmed with the things they have to do,” he says. “What we’re trying to do is to work more efficiently so that we can actually reduce the number of problems overall.”

He remembers one case in which a high school girl was having unexplained

fainting spells. The episodes mimicked seizures, but the doctors couldn’t figure out any medical cause for them. So Kreipe, who was brought in as a consultant, decided to talk to the school nurse. She told him that the girl got a lot of attention from a principal whenever she had spells, thereby reinforcing them. That information allowed the doctors to change the treatment protocol (the principal stopped coming to help) and work on underlying stresses and conflicts. “If we can develop a system of communication where we can talk to each other and listen to each other,” Kreipe says, “that really makes things go much better.”

When Kreipe is not consulting on the hard-to-solve clinical cases, he’s working as an advocate for better adolescent health policies and programs. He strongly encourages advocates to push policy makers in their own states towards a more positive youth development approach and to use a model adopted in New York State. He says advocates in New York were able to link the strength-based development model to state funding.

“The implication was that any program in New York State that had to do with youth had to have a positive youth development approach to it,” says Kreipe. “So it couldn’t be ‘risk aversion’ programs, or just the old ‘open up a rec

room for Friday nights.’ It really had to have the components of youth development. It has to include youth in an early, early stage. It focuses on character, and competence, and confidence, and all of those kinds of things.”

Without that approach, he worries that states will continue with a “risk reduction” approach, shown to be much less effective in promoting good decision-making among teens – in part, because that approach is so fragmented.

“So you have a teen pregnancy prevention program; you have a sexually transmitted infection reduction program; you have a violence reduction program; you have things that are all in silos that don’t necessarily talk to each other.”

Instead, he supports integrative programs that involve partnerships with hospitals, clinics, schools, and community groups, and he fights against programs that have mostly ideological roots.

“I think we need to advocate against policies that would set adolescent health backwards,” says Kreipe. “I think the best example of this is the issue of abstinence-only education.” He says that approach to pregnancy prevention – when used on its own, without a more comprehensive educational approach – has been proven ineffective, and yet many school systems still use it.

Kreipe’s most immediate goal, however, is getting more medical students to enter the adolescent medicine specialty, to shore up the ranks of well-trained clinicians and researchers. Currently only about 500 physicians are board-certified in adolescent medicine, but he thinks that’s starting to increase. He’s particularly optimistic about the young generation that’s now graduating from medical school – a generation that is, of course, closest in age and experience to the adolescents they will treat.

“I think they are more idealistic. So I’m very encouraged that we’re going to start seeing an influx of people doing adolescent health, especially if we can put the positive spin on it that it deserves.” ■

Positive Youth Development

By Kristin Ware

What is Positive Youth Development?

- A positive youth development (PYD) model creates programs for youth focused on constructive assets that can be developed rather than negative behaviors that should be avoided.

What are the main attributes of Positive Youth Development?

- Focus on strengths, rather than problems or risk factors.
- Youth voice and true engagement of youth as leaders, partners, and contributors, not simply “clients,” and giving them key roles in actions or organizations.
- Focus on relationships between adults and youth as an essential outcome.
- Involvement of all community members not just those with specific ties to youth.
- A long term approach that “recognizes the importance of ongoing, positive opportunities and relationships to help young people succeed as adults.”

What does Positive Youth Development look like?

PYD emphasizes positive outcomes:

- **Traditional:** Programs geared towards prevention tend to focus on common negative outcomes in the lives of teenagers – drug use, pregnancy, suicide, homelessness, and truancy.
- **PYD:** While prevention is still a desirable outcome, these programs focus on highlighting the positive things that youth can accomplish. For example, programs may encourage youth to take on leadership roles, volunteer in the community, or explore their abilities in the arts. These programs focus on highlighting and developing qualities that youth already possess – motivation, compassion, and creativity.

PYD involves all youth in the community:

- **Traditional:** These programs tend to target youth that have been identified as having risk factors. Examples include programs aimed at youth in foster care or youth who have been truant or involved in the juvenile justice system.
- **PYD:** Programs that are available to all youth promote positive social interaction, encourage leadership, and give youth a chance to feel as though they belong. These programs not only help youth develop confidence and social competency, but they also avoid some of the harmful stigmatization that can occur in traditional programs.

PYD enables resiliency by providing a network of support:

- **Traditional:** Frequently programs for youth have been run by just one stakeholder in the community, for example, D.A.R.E., a program run by local law enforcement designed to prevent teen drug use.
- **PYD:** These programs aim to make youth more resilient by providing them with a community-wide support network. The programs are not run by one entity, but involve collaboration between schools, law enforcement, businesses, and private citizens. For example, a community could create a young entrepreneurs program that utilizes the support of schools, local businesses, and private citizens and is aimed at encouraging youth to recognize their strengths and interests.

What does the research say?

A 1998 review of evaluations of positive youth development programs found that many of these programs were able to demonstrate “positive changes in youth behavior, including significant improvements in interpersonal skills, quality of peer and adult relationships, self-control, problem solving, cognitive competencies, self-efficacy, commitment to schooling, and academic achievement.” The programs also led to reductions in unhealthy behaviors including aggression, risky sexual activities, drug and alcohol use, smoking, and violence.

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PROFILE:

Jane Brown, PhD

JAMES L. KNIGHT PROFESSOR, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL
SCHOOL OF JOURNALISM AND MASS COMMUNICATION



"[People think that] 'at least when I have my child sitting inside watching TV, I'm not concerned that they're going to be shot walking down the street or dealing drugs, or getting pregnant.' What I say is, the media influence all these other issues."

Jane Brown has been monitoring sexuality in the media since the 1980s, when MTV first started using gyrating, scantily-clad actors to sell music albums. Since then, the amount of sexuality-soaked fare in the media, either targeted at or accessible to teens, has been steadily rising. Look no further than popular sitcoms, teen dramas, or clips on YouTube. Even seemingly innocuous advertising can be steeped in sex; a recent Burger King advertisement shows a seductive customer enjoying a whopper to an exaggerated degree, and teen star Miley Cyrus set off a firestorm of media commentary when she appeared wearing nothing but bed sheets on the cover of *Vanity Fair*.

"Sex is used to sell everything," says Brown, a professor at the School of Journalism and Communication at the University of North Carolina, Chapel Hill.

The more young adolescents are exposed to these images of unbridled sexuality, Brown maintains, the more likely they are to have sex at an early age. By studying a group of one thousand 12 to 14 year olds, Brown's research team found that those with a heavy sexual media diet were twice as likely to have sex before age sixteen than their counterparts who hadn't been exposed to those images to the same degree.

"I think the media are putting unprotected, risky sexual behavior high on an adolescent's agenda. 'Look – everyone else is doing it, why aren't you?'" she says. "What we know from social learning theory is that if attractive, familiar, similar models are engaged in behavior from which they reap rewards, or they aren't punished, then young viewers will be more likely to engage in similar behavior."

"Young people... are not ready to have happy sexual relationships," says Brown. "It's too emotionally charged for who they are, where they are in their maturation."

She says adolescents are primed, developmentally, to start creating their own self-identity around their sexuality, so they are vulnerable to messages in the media, but the media do not always treat their power responsibly. Quite the opposite, in many cases.

"The media portray sex, but rarely portray commitment, or even love," she says. Nor does the popular media portray or discuss the risks of sexually transmitted diseases or unwanted pregnancy – both of which could derail a young person's entire life path. Brown cites a Rand Corporation study that shows higher rates of teen pregnancy among 12 to 17 year olds who watched sexually graphic media earlier. "What the initial longitudinal studies have shown is that there is a connection," says Brown. "And now we need to spend more time trying to figure out exactly how that happens."

Since Brown started her research in the 1980s, the media landscape has exploded well beyond TV, movies, and magazines. Digital media has revolutionized adolescents' relationship with the media. Social networking sites like Facebook and MySpace have given power to adolescents to create their own media and connections, but the Internet has also given them much wider access to potentially harmful messages.

One notable example is online pornography. Brown's most recent study looked at the relationship between exposure to pornography and adolescent behavior. "Kids who had seen pornogra-



“One of the key questions is: what’s missing in this? Especially in the persuasive messages, what aren’t they telling you? So, for example, we want adolescents to know that the advertisements leave out that if you use this credit card you’re going to go into debt, or if you drink this beer, you’re going to get a beer belly, or if you smoke these cigarettes, you’re going to get cancer.”

phy by the time they were 12-14, were more likely to have engaged in oral sex and sexual intercourse by the time they were 16,” Brown says. “And the boys who had seen it by the time they were 14 were more likely to also have perpetrated sexual harassment in their schools, like pulling a bra strap, or calling girls and boys sexual names.”

Adolescents may be vulnerable to negative media messages, Brown says, but they are also smart enough to immunize themselves against them – if given the right tools. One of the most hopeful tools is media literacy: teaching young people how to deconstruct the media, to look at it skeptically, to tease out what’s real and what’s not.

Brown points to two organizations that are developing media literacy materials – National Association of Media

Literacy Education (NAMLE), and American Coalition of Media Education (ACME). She says they’ve created media guides around such topics as body image, gender roles, and substance abuse, among others, and they encourage young people to look critically at all media, from dramas to advertising. “One of the key questions is: what’s missing in this? Especially in the persuasive messages, what aren’t they telling you? So, for example, we want adolescents to know that the advertisements leave out that if you use this credit card you’re going to go into debt, or if you drink this beer, you’re going to get a beer belly, or if you smoke these cigarettes, you’re going to get cancer.”

Advocates would like media literacy to become integrated into regular school curricula, but that’s been particularly challenging in recent years. “The schools

are so beleaguered and so full of things they need to do, especially teaching to the end-of-grade tests, that we’re having better success getting into after school programs and youth serving agencies and associations,” Brown says. “Other countries, such as Canada, Britain, and Australia, have mandated media literacy education from kindergarten to high school. They talk about it as ‘teaching young people to read Baywatch as well as Beowulf.’”

That said, Brown can understand why schools and communities don’t put media literacy at the top of their priority list. “It seems as if the media are the least of our worries. [People think that] ‘at least when I have my child sitting inside watching TV, I’m not concerned that they’re going to be shot walking down the street or dealing drugs, or getting pregnant,’” Brown



says. “What I say is, the media influence all these other issues. The research that I and others are doing shows that the media are implicated in violence, teen pregnancy, tobacco smoking, beer drinking, body problems, eating disorders, as well as obesity.”

Another form of “media vaccination” starts in the home with the relationships young people have with their parents. In this area, Brown’s research made a notable discovery: that African American adolescents were more likely to have conversations with their parents about sexual values, and that those conversations served as a protective factor against

media pressure to engage in early sexual behavior. At the same time, however, she says that media targeted to black adolescents tends to be even more sexualized than that targeted to whites.

In all demographics, this generation of parents does not have an easy job keeping up with the media their children are exposed to. Just when you’ve learned about Facebook or MySpace, along comes Twitter and Hulu. Brown herself relies on updates from her 18-year-old daughter and her college students, some of whom admit that they can barely keep up with what their younger siblings are doing. “One mother

told me recently that she discovered that her daughter was so tired because she’d been going to sleep with her cell phone on, underneath her pillow, and her friends were texting her all night.”

Brown doesn’t think parents need to panic. In most cases, she says, young people are coming up with their own social etiquette around new forms of communication. For instance, although “sexting” – where teens send sexual photos of each other by text message – is gaining popularity, she believes most teens understand what’s appropriate or not. Nevertheless, parents would be wise to counsel their children on the long-term consequences



of sharing explicit digital images of themselves or others in cyberspace. Brown also thinks parents should help their children navigate the media in healthy ways, teaching them how to access the good stuff and avoid the bad stuff, not to mention encourage them to spend less time in front of a screen, period.

"Parents have to start early, setting limits, realizing that knowing where your child is in the media is as important as knowing who their friends are, who they are hanging out with, and where they are in 'real life,'" Brown says.

That goes for everyone who works with adolescents, from social workers and teachers, to doctors and even policymakers. Brown wants them to do more than just monitor what's out there, and actually create the useful material themselves.

Advocates and institutions have an opportunity to use new media for the good of adolescents, to disseminate constructive information and positive messages. This can mean setting up websites with health information that teenagers can use about topics like substance abuse, reproductive health, or sex education. Brown offers one example: the nonprofit organization Advocates for Youth developed a website to help gay and lesbian youth connect with each other and navigate adolescence from their perspective. Some policymakers also have a presence on Facebook, Twitter, and other social network sites to connect with constituents and young people. More and more advocacy groups are starting to interface with social networking sites like Facebook and MySpace by setting up 'affinity'

or 'fan' groups that link to their websites. Brown also knows of one health-oriented organization, the Adolescent Pregnancy Prevention Campaign of North Carolina, that is developing a texting service where teenagers can get honest answers to their questions about sex.

In other words, Brown says, don't underestimate the power of media, and don't fear it, either. Take a cue from the entertainment and advertising industries, which have already figured out how to hook the attention of adolescents, but offer teens something they can really use: realistic information about sex, about building relationships, and about staying healthy. ■

PROFILE:

Abigail English, JD

DIRECTOR OF THE CENTER FOR ADOLESCENT HEALTH & THE LAW



“Adolescents are neither like little children or like full adults... they are capable of acting at times in adult ways, but they also have very real vulnerabilities that are particular to their developmental stage, and their age.”

Long before she became a renowned legal advocate for adolescents, Abigail English had a deep empathy for children in peril. It started with the children of classic literature – think Charles Dickens’ David Copperfield – and expanded as she took jobs as camp counselors and tutors for poor, orphaned, or otherwise disadvantaged children.

“It somehow spoke to something in my heart and in my head, and appealed to my sense of justice, and my desire to be helpful,” says English, who now directs the Center for Adolescent Health & the Law in Chapel Hill, North Carolina.

And like the Dickens novel that first inspired her, English’s life path would go through a few plot twists before she settled down as a legal champion for vulnerable youth. She came of age during the 1960s, graduating from college at the height of the social justice movement and joining a non-profit that helped street youth. While writing a book on runaways, she met numerous social workers, judges, and probation officers who came into contact with her young subjects, as well as the runaway teens themselves and their parents. “That exposure to the way in which adolescents encountered the legal system when they ran away from home, made me very aware of the fact that there were serious deficiencies in how young people were treated by the law,” English says.

That experience catapulted her into law school, at a time when the U.S. legal system was just beginning to recognize the legal rights of children and adolescents – in the words of a 1967 Supreme Court case: “Neither the Fourteenth Amendment nor the Due Process Clause

is for adults alone.” While other lawyers focused on the needs of the very young, English was pulled to the older set.

“I think it had something to do with the fact that adolescents are neither like little children or like full adults,” English says. “They are capable of acting at times in adult ways, but they also have very real vulnerabilities that are particular to their developmental stage, and their age. So I think I found it both intellectually fascinating and emotionally compelling to think about how to make life better for these young people at that stage of their development.”

English says adolescents have a harder time attracting advocates, so she went where she was most needed. “They’re perceived as basically healthy and therefore not needing much, and as not very appealing because they act out, because they get involved in behaviors that we wish they didn’t get involved in – like sex, and drugs, and rock and roll,” she says.

English’s training was in law, not health, but she soon put the two together after meeting several young doctors who were leaders in the then-nascent field of adolescent health. They came to her for legal advice on issues facing their patients– issues around consent, confidentiality, and financial access, all of which were preventing adolescents from getting the care they needed. At that point a partnership was born.

“I very quickly realized that when teenagers can’t get health care, they don’t talk to lawyers. They don’t go to the legal aid office,” she says. “When they need health care, they either go to a clinic, or go to a doctor’s office, or

"I very quickly realized that when teenagers can't get health care, they don't talk to lawyers. They don't go to the legal aid office. When they need health care, they either go to a clinic, or go to a doctor's office, or they don't get care at all. So I realized as a lawyer working on legal issues that affected adolescents' access to health care, it would be very important to partner with the community of health care and medical professionals."



they don't get care at all. So I realized as a lawyer working on legal issues that affected adolescents' access to health care, it would be very important to partner with the community of health care and medical professionals."

Throughout English's career – including 20 years at the National Center for Youth Law in San Francisco, 10 years at the Center for Adolescent Health & the Law, and a one-year term as president of the Society for Adolescent Medicine – she's focused on distinct legal barriers that prevent adolescents from getting the health care they need.

One of her key areas is "consent and confidentiality." In the 1960s and 70s, the first state and federal laws were passed to give adolescents some rights to confidential health care – without parental permission. English began her career in California, litigating for the rights of minors—all the way to the California Supreme Court—to receive confidential reproductive health care.

"I think that intuitively a lot of people say, 'Well, I have to give permission for my daughter to get her ears pierced. Why shouldn't I have to give permission for her to get health care services?'" says English. "Why shouldn't I be able to know about all of the information concerning whatever health care services she gets?"

English's response is that not giving teens some privacy around their health care has been shown, through research studies, to affect the ways in which they seek health care – sometimes delaying or avoiding it altogether. In some cases, teenagers fear punishment from their parents, or just don't want to worry them, so they may not admit to risky health behaviors. Lack of privacy also influences how candidly teens interact with health care providers and disclose essential information to them about problems like substance use, mental health concerns, and sexual activity.

The consequences, she says, can be damaging to individual and public health. "If adolescents are discouraged from seeking health care that would allow them to be screened, diagnosed, and treated for sexually transmitted disease, that can have very serious consequences for their own health," English says. "Untreated Chlamydia, a sexually transmitted disease that is very common in adolescents, can lead to infertility." And if adolescents are unaware of their diagnosis, she adds, they could end up spreading the disease and contributing to a public health problem. Similarly, adolescents with untreated substance abuse problems may drink and drive, endangering themselves and others.

She does stress that the research shows most adolescents choose to involve parents in their health care decisions. But there are exceptions. "Adolescents at certain points in their development have a need for a greater sense of...autonomy and privacy. That's a normal part of adolescent development."

English also believes that most parents ultimately want their adolescents to be able to receive the health care they need. "Many parents support the possibility of confidential care for adolescents, in order to protect their health," she says. "Also, many health care professionals are helpful in assisting adolescents to talk with their parents, even when it's hard to do so."

A related legal issue that evolved from English's work on confidentiality is financial access to health care; if teenagers have no way to pay for their own health consultation, they're unlikely to get it in private. Here, English has seen some creative approaches. For instance, sometimes health facilities agree to "write off" the bill for teens' confidential care. In other cases, parents themselves have agreed to foot the bills of medical visits for their children, without insisting on knowing the details of what transpired on those visits.

But financial access to health care is a struggle that stretches beyond the issue



“Adolescents at certain points in their development have a need for a greater sense of...autonomy and privacy. That’s a normal part of adolescent development.”

of confidentiality. English has worked for years to expand Medicaid programs to include more low-income teenagers. In the 1990s, she helped push through the State Children’s Health Insurance Program (formerly S-CHIP, now CHIP), which provides health insurance to children and adolescents who do not meet the income requirements to qualify for standard Medicaid. CHIP was recently renewed in early 2009 and expanded to cover an additional 4.1 million children and adolescents.

Now, English is focusing on extending the age of eligibility for those programs – so that adolescents will no longer “fall off a cliff” at age 19, when they generally lose Medicaid or CHIP eligibility. She also wants to make sure public programs cover a comprehensive set of benefits that are particularly important for adolescents – including reproductive health, mental health, substance abuse, and dental care. She believes safety net programs should be easily accessible by the most vulnerable adolescents – for example, homeless youth who “may find it difficult or even impossible to enroll in a health insurance plan...simply because of the way the requirements are structured for who can sign an application, whether they have to have a fixed address, and what kind of documentation they need to provide for their income.” She also advocates for adolescents growing up in the foster care system, and those who have aged out of the foster care system with little or no family support. In the latter case, she wants all states to sign onto the option in the Foster Care Independence Act of 1999, which allows states to extend Medicaid coverage to former foster youth.

For the general adolescent population, English would like to see more attention directed toward preventive care – including vaccinations for teenag-



"Many parents support the possibility of confidential care for adolescents, in order to protect their health. Also, many health care professionals are helpful in assisting adolescents to talk with their parents, even when it's hard to do so."

ers. In recent years, more vaccinations have been developed and recommended for this age group – for instance, those that protect against HPV and cervical cancer, meningitis, Hepatitis B, and influenza. The challenge is letting families know these vaccinations exist and making them part of the annual health care routine.

English would also like the nation's vision of preventive health care to include an annual physical for adolescents. "If they don't get in and have a comprehensive health assessment, then there may be no recognition that they need some preventive mental health services," says English. "There may be no recognition that they're sexually active and need sexual and reproductive health services. There may be no acknowledgement until very far down the line that they are using substances and need some treatment services or counseling in that arena."

The challenge does not stop at comprehensive benefits. Eligible adoles-

cents still need to find out about those programs and enroll in them. When CHIP was reauthorized in early 2009, more funds were included for outreach and enrollment. Finding ways to target the use of those funds to adolescents, especially the most vulnerable ones, is an important challenge. "I think there's been much less attention to outreach to the adolescent age group so far than there needs to be in the future," she says. "And I think social workers have a role to play, youth-serving programs where adolescents congregate have a role to play, schools have a role to play in disseminating information about the options and the services and the potential coverage that's available."

In this vein, she believes that different professional groups could work together better to combine their resources and reach their overlapping constituents – groups such as social workers, doctors, schools, families, and, of course, lawyers. "Whether by representing individual

adolescents (to get services they need), or advocating with state legislatures and the Congress to change laws in beneficial ways. Or whether it be health care professionals and social workers educating lawyers about what kinds of services adolescents really need and what can be provided to them that will promote their health. I think all those kinds of collaborative efforts could be very beneficial."

But aside from the specifics of health care financing and legal rights for adolescents, what English would most like to see is a sea change in public attitudes towards health care – for adolescents and everyone else. "It's really quite shocking that in the United States of America, in 2009, health care is not considered a guaranteed right," says English. "I think we need to shift our perspective and recognize as a nation that health care is a human right, and a legal right, and I think we need to make sure that right is extended to adolescents, as well as other age groups in the population." ■

Creating Healthy Opportunities: Conversations with Adolescent Health Experts

Author and Interviewee Biographies

KAREN BROWN

Karen Brown is a public radio reporter and freelance writer who specializes in health care. Her work frequently appears on NPR and in national magazines and newspapers. She has also produced several radio documentaries on mental health topics, including childhood bipolar disorder, siblings of the mentally ill, and post-traumatic stress disorder. She has won numerous national awards, including the Edward R. Murrow Award and Daniel Schorr Journalism Prize, as well as journalism fellowships, most recently the 2008-09 Kaiser Media Fellowship in Health. Her work is featured online at www.karenbrownreports.org.

SHAY BILCHIK, JD

Shay Bilchik is the founder and Director of the Center for Juvenile Justice Reform at Georgetown University's Public Policy Institute in Washington, DC. The Center's purpose is to focus the nation's public agency leaders, across systems of care and levels of government, on the key components of a strong juvenile justice reform agenda. This work is carried out through the dissemination of papers on key topics, the sponsorship of symposia, and a Certificate Program at Georgetown providing public agency leaders with short, but intensive study, and ongoing support in their reform efforts. Prior to joining the Institute on March 1, 2007, Mr. Bilchik was the President and CEO of the Child Welfare League of America, a position he held from February of 2000. Shay led CWLA in its advocacy on behalf of children through his public speaking, testimony, and published articles, as well as collaborative work with other organizations. Prior to his tenure at CWLA, Shay headed up the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the U.S. Department of Justice, where he advocated for and supported a balanced and multi-systems approach to attacking juvenile crime and addressing child victimization. Before coming to the nation's capital, Mr. Bilchik was an Assistant State Attorney in Miami, Florida from 1977-1993, where he served as a trial lawyer, juvenile division chief, and Chief Assistant State Attorney. Mr. Bilchik earned his B.S. and J.D. degrees from the University of Florida.

JANE BROWN, PHD

Jane Brown is the James L. Knight Professor in the University of North Carolina, Chapel Hill School of Journalism and Mass Communication,

and an expert in the effects of the media on sexual health and the use of media to promote health. She has been involved with a number of interventions using mass media to improve public health, including a 10-city evaluation of a media campaign to keep adolescents from starting to smoke cigarettes, and a state-wide campaign to reduce sexual violence among adolescents. She just completed a NICHD-funded R01 longitudinal assessment of the influence of the sexual content in American media on North Carolina adolescents' sexual beliefs and behaviors. Brown is the co-editor or co-author of four books, including *Sexual Teens*, *Sexual Media* (Erlbaum, 2002) and is on the editorial board of six journals in communication research, adolescent and sexual health. She has served on the national boards of Advocates for Youth, the Trojan Sexual Health Advisory Council, and the CHHD-W Population Sciences Committee (PSC) study section. She currently is on the Research Advisory Committee for The National Campaign to Prevent Teen and Unplanned Pregnancy, and the Board for Children, Youth and Families of the Institute of Medicine.

ANGELA DIAZ, MD, MPH

Angela Diaz, is the Jean C. and James W. Crystal Professor of Pediatrics and Community Medicine at Mount Sinai School of Medicine and Director of the Mount Sinai Adolescent Health Center in New York, NY and Director of the Mount Sinai Adolescent Health Center, a unique program of free, integrated, interdisciplinary primary care, reproductive health, mental health, and health education for teens. She is President of the Children's Aid Society. Dr. Diaz has been a White House Fellow, a member of the FDA, and a member of the Board of the New York City Department of Health and Mental Hygiene. She reviews grants and serves on advisory panels for the NIH and the CDC and has received several NIH grants. In 2003, she chaired the National Advisory Committee on Children and Terrorism. In 2008, she was elected to the Institute of Medicine. Dr. Diaz is active in public policy and advocacy and has conducted many international health projects in Asia, Central and South America, Europe and Africa.

ABIGAIL ENGLISH, JD

Abigail English is Director of the Center for Adolescent Health & the Law in Chapel Hill, North Carolina. The Center is a nonprofit legal

and policy organization that works nationally to promote the health of adolescents and young adults and their access to comprehensive health services. Ms. English has worked on legal and policy issues affecting adolescents' access to health care for more than three decades. She has advocated for the legal rights of adolescents in the health care system, participated in major litigation affecting the legal rights of children and youth, authored numerous publications, taught courses in adolescent health and the law, and lectured widely to youth-serving professionals. She has served on many boards and advisory groups and as President of the Society for Adolescent Medicine. Her research and policy interests focus on the barriers that affect adolescents' access to comprehensive health care and on strategies for overcoming those barriers. Her expertise includes key issues related to financial access to health care for adolescents and young adults, consent and confidentiality protections, HIV/AIDS services, sexual and reproductive health care, and the rights of vulnerable populations of young people.

RICHARD E. KREIPE, MD

Richard E. Kreipe is Professor of Pediatrics and Adolescent Medicine Fellowship Director at the University of Rochester, NY; Board Certified in Adolescent Medicine. Dr. Kreipe is currently past-President of the Society for Adolescent Medicine (SAM). He co-edited the first Textbook of Adolescent Medicine, and is currently co-editing the Textbook of Adolescent Health Care to be published by the American Academy of Pediatrics. In recognition of his achievement as an interdisciplinary educator, he has received 12 faculty teaching awards, the Andrew W. Mellon Dean's Teaching Scholar Award, and was the SAM Visiting Professor in Adolescent Medicine for 2003. He was also the recipient of the American Academy of Pediatrics Section on Adolescent Health Adele D. Hofmann Award for 2003. He is the Principle Investigator at the University of Rochester in the New York State Department of Health Center of Excellence for the Assets Coming Together (ACT) for Youth public health initiative, a long-term, statewide, community-based effort to promote positive youth development. Dr. Kreipe is the Medical Director for the Western New York Comprehensive Care Center for Eating Disorders. He also serves on the New York State Governor's Children's Cabinet Advisory Board.

