REPORT

Improving the Odds for Adolescents

State Policies that Support Adolescent Health and Well-being

Susan Wile Schwarz | Yumiko Aratani

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National Center for Children in Poverty
Mailman School of Public Health
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The National Center for Children in Poverty (NCCP) is a leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

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For policymakers, adolescence presents an invaluable opportunity to ensure that all young people can access the high-quality services and supports they need to improve their odds of becoming successful, healthy, productive adults. This report, based on findings from NCCP's Improving the Odds for Adolescents project, highlights key findings from NCCP's database of state policy choices. This database provides a unique, comprehensive picture of policies across the states that support adolescent health and well-being. The report summarizes emerging patterns and can be used to stimulate dialogue, both within the states and nationally, about how to make more strategic, coherent investments in America's adolescents. State specific profiles are available online at: www.nccp.org/projects/ITOAdolescents_stateprofiles.html.

AUTHORS

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Executive Summary

For policymakers, adolescence presents an invaluable opportunity to ensure that all young people can access the high-quality services and supports they need to improve their odds of becoming successful, healthy, productive adults.

At an historic moment when the provisions and breadth of health care reform are under vigorous debate, it is important to take stock of how well the states are currently meeting the health and development needs of all adolescents, and particularly disadvantaged youth. This report presents information from **NCCP's Improving the Odds for Adolescents** project about state policy choices that affect the health and well-being of adolescents.[1]

Improving the Odds for Adolescents (ITOA) provides printable profiles of states' policy choices that affect the health and well-being of America's adolescents as well as select demographic trend data for each state.

Summary of Selected Key Findings

Health

For adolescents whose family income is up to 200 percent of the federal poverty line (FPL), almost every state offers public health insurance coverage through the Children's Health Insurance Program (CHIP), and about a third offer coverage through Medicaid. Variability exists among states' choices to extend coverage to different groups of vulnerable youth. Only about one-fifth of states do not terminate Medicaid enrollment for juvenile justice-involved youth.

Most states recognize the key role schools play in promoting the health and well-being of their students. However, there has been noticeably less agreement in how integrated and extensive this role should be and whether it should include health services provision. More than half of states have specific health-related curricula requirements, including physical education requirements, and about a third fund direct health services offered by school-based health centers. Health curricula in nearly two-thirds of states must cover prevention of HIV, sexually transmitted infections, and pregnancy. Yet, only one-fifth require schools to provide any services related to this prevention.

Nearly all states may allow adolescents to consent to a variety of reproductive health and family planning services, with the exception of abortion services, but very few have policies explicitly dictating who can and cannot consent to services and whether confidentiality will be maintained. Lack of clarity about the right to consent and confidentiality can cause confusion among service providers and especially among adolescents in need of care.

Mental Health

Overall support for mental health services is fairly low except around drug and alcohol-related issues. Almost three-quarters of states require that drug and alcohol prevention education is included in the health curriculum, but only one state explicitly establishes social and emotional learning standards for schools. Similarly, most states allow minors to consent to care for drug or alcohol abuse but less than half allow minors to consent to outpatient mental health care. The vast majority of states require that providers of mental health service in schools meet certain training or certification requirements, yet very few states require schools to provide mental health services to students.

Violence and Injury Prevention

States are mixed in their violence and injury prevention policies. Nearly two-thirds of states require that general violence and injury prevention education be included in the curriculum, but only a quarter require that school curricula explicitly address dating violence. All states have some form of graduated driver licensing system in place, but the individual components of these systems vary from state to state, as does the duration of the restrictions. More than half of states ban cell phone use for new

adolescent drivers, and even more ban texting while driving.[2] Less than half of states have comprehensive laws protecting adolescents from interpersonal violence, and only a few states have adequate laws protecting against cyberstalking.

Youth Development

States are also mixed in their efforts to promote youth development. Less than half of states require students to remain in school until age 18, but there is a growing movement to systematize and better track graduation rates at the state level. There is more support for providing further educational opportunities to former foster youth than for undocumented immigrant youth. All states provide some degree of funding to afterschool programs for youth, but there is little complementary effort to evaluate the quality of these programs, and even fewer states provide support for mentoring initiatives.

Summary

Looking at the overall national picture, states were weakest in supporting adolescent health and well-being in the following areas:

- health service provision in school settings and school-based health center (SBHC) coverage through Medicaid and CHIP;
- mental health services and supports in school settings;
- consent and confidentiality rights for both reproductive and mental health services;
- emerging topics, such as bullying, cyberstalking, interpersonal violence, and obesity prevention; and
- socially divisive topics, such as abortion and services and supports provided to juvenile justice-involved youth and undocumented immigrants.

Recommendations

Each of these areas presents opportunities for states to fine-tune their existing policies, evaluating their efficacy and scale of implementation, and to establish new policies that are informed by adolescent health research. Based on the latest research in the field and in consultation with a panel of adolescent health experts and state coordinators, we identified steps states can take to better support adolescents' healthy development.

- Expand public health insurance coverage to reach more youth in need of care, regardless of living situation, such as immigration status or living in state custody.
- Push schools to adopt evidence-based health promotion curricula and programs across all content areas that promote adolescent well-being.
- Mandate a coordinated school health approach, incorporating student health and mental health into the mission of schools and integrating analyses of student health, health promotion, and health services into the No Child Left Behind school improvement plans, where applicable.
- Invest in SBHCs and support the replication of other best practices shown to improve academic and health outcomes, such as high quality afterschool programs for youth.
- Explicitly extend consent and confidentiality rights to adolescents, especially around sensitive topics such as reproductive health and mental health.
- Strengthen laws to empower adolescents to protect themselves from violence and abuse, with particular attention to the most vulnerable youth, such as, but not limited to, protection order access and bullying and cyberstalking legislation.
- Encourage potentially cost-saving collaborations with the private sector to expand growth opportunities for all youth, such as, but not limited to, internships and mentoring programs.
- Invest in programs that enable adolescents, and especially vulnerable youth, to successfully transition to independent adulthood, such as, but not limited to, independent living skills training and other aftercare services, including education services, vocational training, and counseling.

Introduction

For policymakers, adolescence is an invaluable opportunity to ensure that all young people, and particularly disadvantaged youth, can access the high-quality services and supports they need to improve their odds of becoming successful, healthy, productive adults. For almost 15 years, the National Center for Children in Poverty (NCCP) has reported on state-level policy efforts to promote the well-being of young children and their families, particularly low-income children, with projects like Improving the Odds for Young Children (ITO). Improving the Odds for Adolescents (ITOA) mirrors the original ITO project, providing a comprehensive picture of the policy choices states make to promote the health and well-being of adolescents and support them as they prepare to enter adult life. Improving the Odds for Adolescents tracks policies that:

- promote healthy development – through improved access to high-quality preventive and sexual health care services for adolescents, both in schools and in dedicated health care settings, and through in-school initiatives that educate and establish physical, sexual, and nutritional behaviors that support sound health;
- promote mental health – through improved access to high-quality, confidential mental health services for adolescents in schools and in dedicated health care settings and through in-school initiatives to support social and emotional development;
- decrease violence and unintentional injury – through improved safety regulations and enforcement and through universal anti-violence initiatives and legislation; and
- promote youth development – through improved access to high quality services and opportunities that support adolescent development and improved life outcomes, both inside and outside of school settings, and through support for increased school participation and graduation rates.

Using the State Profiles

In developing a comprehensive database inventorying state policies, we sought to create a resource useful to a wide variety of stakeholders in adolescent health and well-being, including, but not limited to, policymakers and their advisors, adolescent health coordinators, service providers, advocates, educators, and the research community, as well as adolescents and their families. The policy database allows policymakers, researchers, and stakeholders to see what policies are and are not in place in a given state or across the nation. Individually, each state profile can serve as a quick resource for those who work in or implement policy, such as state adolescent health coordinators, service providers, school boards, and others. Taken as a whole, the database identifies national policy trends and gaps. We have created this inventory of policies to support informed discussion about the needs of America's youth, particularly low-income or disadvantaged youth, and encourage states and localities to develop and safeguard policies that are responsive to this group's unique needs.

In consultation with the National Network of State Adolescent Health Coordinators and a panel of experts in the field of adolescent health, we identified a number of potential ways different constituents and stakeholders can make use of the state profiles. Specifically, the state profiles can:

- enable mapping of national policy trends in support of policy replication across states;
- allow for identification of possible study samples for policy impact evaluation;
- help identify a federal role in leading policy trends;
- encourage and facilitate cross-systems collaboration and communication across state and child-serving agencies as well as internal communication within these agencies;
- support a whole child approach by presenting in one place comprehensive information necessary for adolescent health and well-being and providing a framework to show how it reaches across disciplines and agencies; and
- provide a baseline to support an intensive focus on evidence-based program implementation at the state level.

This report highlights findings from NCCP's database of state policy choices, which assembles data from multiple and varied sources to provide a unique picture of adolescent health policies across the states. While the definitions of adolescence vary, the most inclusive definition includes children who are age 10 through 18, though the lower limit is often set at age 12. And just as researchers disagree about the onset of adolescence, policies geared toward this age group vary in their scope. With regard to policies affecting school curricula and regulations, we limited ourselves to middle and high schools. In other cases, the exact age endpoints bounding the group in question varied by the data available or the particular policy in question. This report also provides discussion about the role of policy – its ability to support adolescent health and well-being and its limitations and implementation challenges – as well as the role of the database, including state profiles and online tool, in supporting more effective, evidence-based policymaking. More extensive information is available on the National Center for Children in Poverty website, including state-by-state profiles of adolescents and their families, policy choices, trends, and recent developments, as well as data tables that allow for comparison across states on each of the policy choices.

Background: The Importance of Adolescence and Key Policy Areas

The teenage years represent a critical period for the physical, mental, social, and emotional development necessary to successfully navigate the transition from childhood to adulthood. Although adolescence is generally considered a time of relatively good health, during this period, the body and brain undergo significant changes that have lifelong implications, such as achieving sexual maturity and establishing behavior patterns.[3] As adolescents transition to adulthood, factors ranging from weight status to completion of high school, among many others, have a significant impact on their health status, emotional well-being, and ability to contribute and participate meaningfully in society throughout their adult lives.

Because their brains are still developing, adolescents are particularly receptive to the positive influences of youth development strategies, social and emotional learning, and behavioral modeling.[4] But adolescents' developing brains, coupled with hormonal changes, also make them more susceptible to challenges, such as depression, and more likely to engage in risky and thrill-seeking behaviors than either younger children or adults. Because of these factors, both positive and negative, adolescence represents a period of both tremendous opportunity but also of great risk, a reality that underlines the importance of effective, innovative, research-based policy for this age group. The key policy content areas we focused on are health, mental health, violence and injury prevention, and youth development.

Reproductive health and obesity prevention are two key areas for adolescent physical health. Reproductive health traditionally encompasses the prevention of sexually transmitted infections (STIs) and pregnancy but can also include the ability to develop healthy adult romantic relationships.[5] In 2009, about one-third of sexually active high school students reported not using a condom at last intercourse.[6] Perhaps unsurprisingly, teenage pregnancy rates have increased in recent years. Chlamydia rates continue to increase and a previous decline in gonorrhea has reversed course.[7] Further, over the last three decades, overweight and obesity rates among children have risen steadily and alarmingly. In 2007, an estimated 37 percent of adolescents age 10 to 13 and 27 percent of adolescents age 14 to 17 had a body mass index (BMI) that qualified them as overweight or obese.[8] Being overweight increases the risk for a number of poor health outcomes, such as diabetes, heart disease, high blood pressure, and cancer,[9] and it is estimated that elevated BMI among children contributes an extra 14 billion dollars in health care spending each year.[10]

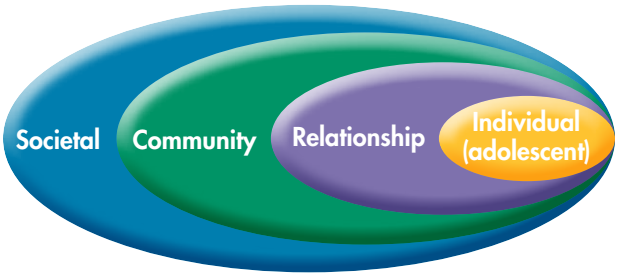
Research also shows that one-fifth of adolescents have a diagnosable mental health disorder,[11] and about half of all lifetime mental health disorders start during adolescence.[12] Rates of substance use also increase as teens get older, and up to one-quarter of adolescents engage in alcohol use.[13] Further, mental health problems are known to be associated with poor educational outcomes.[14] Those with mental health difficulties during their early teen years are more likely to be disconnected from society as young adults, that is, not employed or serving in the military and not pursuing higher education.[15]

Among children age 10 to 18, unintentional injury is the leading cause of death, with motor vehicle accidents accounting for the largest portion.[16] Interpersonal violence is another significant cause of unintentional injury. Studies vary, with findings suggesting anywhere between nine and 60 percent of adolescents have experienced some form of dating violence.[17] Victims of dating violence are not only at increased risk for injury, they are also more likely to attempt suicide and get into physical fights, among other troubling outcomes.[18]

The final area we examined does not speak directly to the physical or mental health of adolescents but rather is part of a growing body of research informed by developmental theory: Positive Youth Development. Research in developmental science increasingly demonstrates the importance not only of prevention, intervention, and treatment strategies but also of positive influences and assets-building in helping adolescents stay healthy, make positive choices, achieve their goals, and successfully cross the bridge to adulthood. Thus, these four areas – health, mental health, violence and injury prevention, and positive youth development – are highly linked to optimal outcomes for adolescents.

Conceptual Framework: The Socio-ecological Model and Adolescent Health Policy

To further categorize policies that influence adolescents and their outcomes within the key areas of health, mental health, violence and injury, and youth development, we adopted the Centers for Disease Control and Prevention's (CDC) socio-ecological model as a framework.[19] As shown in the figure below, there are four levels: individual, relationship, community, and societal.



- Individual: The first level encompasses adolescents' biological and personal-history factors. These individual factors include age, education, and family income, among others.
- Relationship: The second level involves a close social circle. This group includes those with whom an adolescent has meaningful relationships, such as peers, parents, other family members, intimate partners, neighbors, teammates, coaches, mentors, and other caring adults, all of whom influence an individual adolescent's behaviors.
- Community: The third level includes social settings in which adolescents are embedded, settings that influence their behaviors and norms, such as schools, religious institutions, and neighborhoods. School, in particular, is one of the most important community settings for adolescents since it is where they spend the majority of their waking hours. One of school's important missions is to provide a comprehensive health education curriculum that promotes health-enhancing behaviors among students.[20]
- Societal: The final level includes a wide range of societal factors that create a climate for promoting sound health and mental health, positive

development, and safe behaviors among adolescents. These factors include health, educational, and social policies as well as social and cultural norms. It also includes law and legislation.

While focusing on state policy choices that promote access or improve quality within the key content areas, we further identified four types of policies operating at the community and societal levels that influence adolescents at the individual and relationship levels: (a) health promotion, prevention, and early intervention; (b) services at schools; (c) workforce development (for teachers and staff at school); and (d) law and legislation.

Health Promotion, Prevention, and Early Intervention

The importance of health instruction in secondary education has long been recognized, and the Institute of Medicine has advised that students should receive the health-related education and services necessary for becoming healthy and productive adults.[21] Research shows that high quality, school-based health-promotion programs can be effective in influencing students' health behaviors.[22] Therefore, the health promotion curriculum at school plays a vital role in preventing or reducing the many health-risk behaviors that tend to increase during adolescence, and in promoting and encouraging healthy behaviors and choices. Healthy People 2010 and 2020 both advocate increasing the number of schools that provide comprehensive health promotion programs, at all grade levels, to prevent problems in areas including reproductive health, diet and physical activity, substance use, and unintentional injury and violence. Health-risk behaviors include unprotected sexual activities; poor dietary habits and physical inactivity; smoking, drinking, and substance use; and other behaviors that contribute to suboptimal health or mental health outcomes in the teenage years and beyond.[23] In the socio-ecological framework, the community, or in this case, the school, can provide health education and social support, both of which play an important role in influencing the behaviors of adolescents and those in their social network.[24]

Prevention and early intervention programs are another important strategy to address risks in all areas of children's lives,[25] and federal initiatives demonstrate the high priority the government has placed on child and youth well-being.[26] Medicaid is one of several federal initiatives to provide health care coverage to many low-income children. Since 1997, the Child Health Insurance Program (CHIP) has complemented Medicaid, covering low-income uninsured children who did not meet Medicaid income eligibility requirements. Under CHIP, states set premiums and cost sharing based on income level. [27] The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, the child health component of Medicaid, is the only entitlement to comprehensive and preventive child health services in the United States.[28] Periodic screening is the core of the EPSDT program, and it aims to provide the care all children and adolescents need to be healthy and to identify any conditions that require additional assessment or treatment. Accessing these health services equips families with the information they need to better support their children's health and development.[29]

Services at Schools

Because adolescents spend the majority of their daily lives in school, schools are also one of the most important ways to access, screen, and identify young people with potential health and mental health needs, to support their overall wellness, and provide needed services. Adolescents can be a difficult population to reach with health care, but school-based health centers (SBHCs) can significantly increase access to care, particularly around potentially sensitive issues such as sexuality and reproductive health, mental health, and substance use. Research shows the positive impact of school-based mental health services on a variety of emotional and behavioral problems in children.[30] According to one study, 16 million adolescents experienced symptoms requiring care, but only one-third saw a physician, and those lacking a usual source of care were more likely to not receive care. Further, the study found that inequities in care access were related more to lack of usual source of care than socioeconomic characteristics.[31]

Workforce Development

We also looked at states' initiatives in workforce development, focusing on training to teachers and service providers who work with adolescents. Providing high quality and age-appropriate programs and services is important, and the quality of teachers and providers has a significant impact on their effectiveness.[32] Health-related instruction often involves sensitive topics, so equipping teachers with specialized skills and training is crucial to supporting higher quality instruction, and where available, more effective implementation of evidence-based curricula.[33] Similarly, providers with more education and state certification are more likely to adopt evidence-based practices and provide higher quality health and mental health services.[34]

Law and Legislation

Finally, laws and legislation play a key role in influencing the behaviors of individual adolescents and those in their social circles. As adolescents' autonomy and independence grow, they increasingly make their own choices about their health or choices that impact their safety and overall well-being. Research shows that many minors have the capacity and the right to make their own decisions about their health care.[35] States' choices in prohibiting or allowing minors to consent to care have large implications for young people's health-seeking behaviors and service utilization, especially in the areas of reproductive and mental health. Consent laws are one of the most direct and tangible methods through which states can impact adolescents' ability to access care without directly increasing costs. States have the authority to determine the services and supports to which they allow minors to consent without parental permission and, in some cases, notification. However, the ability to consent without permission alone is not necessarily enough to ensure access to care. Research indicates that adolescents would forego needed care for sensitive health issues, such as reproductive health services, if parental notification or permission were required.[36] In a national study of adolescents, concern about confidentiality was the number one reason given for missing needed care.[37] And those who are most vulnerable and in need of care are the ones more likely to forgo care due to confidentiality concerns.[38] Maintaining confidentiality with adolescent patients shows respect for their developing autonomy and helps build trusting relationships between the physician and the patient.[39] Further, law and legislations promoting vehicle safety and reducing interpersonal violence play an important role in protecting adolescents from injury.[40]

As NCCP focuses on low-income and vulnerable children, we also identify policies and programs that are targeted at adolescents who are more likely to have poor health, mental health, social, and other life outcomes, such as youth in foster care and the juvenile justice system and undocumented and other immigrant youth.

Methods: Building the State Profiles

Over the last two years, NCCP conducted a wide-reaching search of available state-specific policy data, in a range of content areas identified in the literature as crucial to the healthy development of adolescents. Within each content area, we identified salient state policy variables that promote either expanded access to services and supports for adolescents or improved quality of services and supports to adolescents. These variables are classified into the aforementioned four categories: promotion, prevention, and early intervention; services in school settings; workforce development; and law and legislation. In order to be considered for inclusion, each policy variable needed to be salient for either all adolescents or for underserved or disadvantaged youth in particular, exist in binary form (for which a "yes" or "no" answer could be obtained), and derive from a reliable source for all or most of the 50 states and the District of Columbia. After completing data collection and entry, we collaborated with the National Network of State Adolescent Health Coordinators to vet the data. We sent individual state data to the adolescent health coordinator in each state for review and received valid responses from 18 states. In the section that follows, any updates to the data based on these responses are noted in the endnotes of this paper and the individual state profiles, unless otherwise indicated.

Demographic and policy data in this report come from the following sources:

Break the Cycle

Casey Family Programs

Centers for Disease Control and Prevention (CDC)

CDC's State-level School Health Policies and Practices

CDC's Web-based Injury Statistics Query and Reporting System (WISQARS)

CDC's Wide-ranging Online Data for Epidemiologic Research (WONDER)

CDC's Youth Risk Behavior Surveillance System (YRBSS)

Center for Adolescent Health and the Law

Chapin Hall

Children's Defense Fund

Current Population Survey

Data Resource Center for Child and Adolescent Health

Education Commission of the States

Family Planning Perspectives

Gay, Lesbian and Straight Education Network

Governors Highway Safety Association

Guttmacher Institute

Individual state agency key contact interviews

Individual state legislature homepages

Insurance Institute for Highway Safety

Kaiser Family Foundation

National Academy for State Health Policy

National Association of State Boards of Education

National Conference of State Legislatures

National Governors Association

National Immigration Law Center

National Resource Center for Youth Development

National Women's Law Center

Office of Juvenile Justice and Delinquency Prevention

Pepperdine University School of Law

Public Health Reports

The Raikes Foundation

U.S. Department of Health and Human Services (DHHS)

U.S. DHHS's National Child Care Information Center

Working to Halt Online Abuse

Findings

HEALTH

Promotion, Prevention, and Early Intervention Programs

Insurance Coverage: Medicaid and CHIP

The choices states make regarding eligibility for Medicaid and the Child Health Insurance Program (CHIP) are crucial mechanisms by which states can expand access to care to adolescents, and particularly to those who have often gone without coverage, groups that often coincide with those who have greater or specialized health care needs than their non-poor or non-low-income peers. State coverage choices are highly influenced by federal match rates. The federal matching rates for CHIP spending is relatively higher than that of Medicaid,[41] so some states will receive more federal money by raising the income eligibility of their CHIP program rather than Medicaid. Currently, of the 9.3 million adolescents age 12 to 17 who live in low-income families (under 200 percent FPL),19 percent are uninsured; by contrast, among children under 12 in low-income families, 15 percent are uninsured.

As a result of the CHIP expansion, signed into law by President Obama in early 2009, adolescents in households with income at or above 200 percent of the federal poverty line (FPL) have access to public health insurance (Medicaid/CHIP) in all but four states.

- **Almost all states set the income eligibility for CHIP at or above 200 percent of FPL for adolescents, and just under 30 percent extend Medicaid eligibility up to this limit.** As of 2009, 47 states had set the income eligibility for CHIP at or above 200 percent of FPL for adolescents. The only states that did not adopt this threshold were Alaska, Idaho, North Dakota, and Oklahoma. Of those 47 states, 15 set the income eligibility for Medicaid at or above 200 percent of FPL for adolescents.[42]

Extended Coverage to Vulnerable Youth

Immigrant Youth

States can also provide public health insurance to immigrant youth through a Medicaid option (for legal documented children only) and through separate state funds (for undocumented children). Some research shows that immigrant youth tend to have better health outcomes than their non-immigrant peers and are less likely to be engaged in risky behaviors, but this difference changes based on duration of stay in the United States; poor health outcomes and likelihood of risky behaviors increase the longer immigrants remain in this country.[43] On the other hand, immigrant youth may have higher risk for mental health problems, depending on the emotional and cognitive adjustment they have to make in immigrating to the United States.[44] Regardless, immigrant youth are much more likely to be uninsured, and about 30 to 45 percent of children from poor immigrant families (including both documented and undocumented) (about 1.3 million) are uninsured.[45]

- **Less than 50 percent of states extend CHIP coverage to legal resident children.** As of 2010, 22 states offered CHIP coverage to all or most legal resident children with household incomes at or above 200 percent of FPL.

Foster Youth

Each year, an estimated 25,000 young people leave foster care at age 18 or 19 with no formal connection to family or other social or financial support.[46] These already vulnerable youth can face even greater challenges in achieving self-sufficiency due to unmet health and mental health care needs. One important way that states can help increase access to health and mental health care services is by exercising the Chafee Medicaid option, part of the John H. Chafee Foster Care Independence Program (CFCIP), a federally funded, state-wide program designed to ease the transition to independent living. Through the Chafee Medicaid option, states can provide health insurance for youth exiting the foster care system up through the age of 21.

- **More than 50 percent of states exercise the option to provide Medicaid coverage for foster youth as they age out of the system.** As of 2009, 28 states used Chafee funds to provide Medicaid eligibility for foster care youth as they age out of the system and begin to live independently. Current law allows states to provide coverage up through age 21. As a provision of the Patient Protection and Affordable Care Act, states will need to extend Medicaid coverage former foster children up to age 26, starting in 2014.

Juvenile Justice-involved Youth

A survey of youth incarcerated in juvenile residential facilities found that their health needs, and particularly their mental health needs, were often higher than their non-incarcerated peers. Nearly 70 percent indicated at least one health care need, including care for illness or injury. Two-thirds had at least one mental illness, and the prevalence rate of severe mental illness was two to four times higher than the national rate. While residential facilities do provide health and mental health services to youth while they are incarcerated, services tend to be both inadequate and underutilized. Once youth are released from state custody, their ability to access health care, especially much-needed mental health services, can have a tremendous impact on outcomes. Unfortunately, the administrative burden of reenrolling in or re-qualifying for Medicaid can pose a significant barrier to care for many of these youth.[47]

- **Just over 20 percent of states safeguard Medicaid enrollment for juvenile justice-involved youth who have been committed to a residential facility.** In 2009, 11 states reported maintaining or suspending but not terminating Medicaid enrollment for youth while they are committed to a juvenile facility. A few other states may have systems in place to help adolescents reenroll in Medicaid as part of supports and assistance offered through aftercare services.

In addition to choices that states make regarding eligibility for CHIP and Medicaid, states can meaningfully impact health care access through choices they make about the types of services covered or excluded by public health insurance and in what settings.

- **Almost all states require CHIP coverage for contraceptives, but this figure may be changing.** As of 2006, 45 states required CHIP coverage for contraceptives. At that time, Alaska, Montana, North Dakota, Pennsylvania, Texas, and Wyoming did not require coverage for contraceptives. It was unclear whether any required coverage for abortion-related care[48]

Required Reproductive Health Education Curriculum

The health education curriculum can be an effective means to encourage preventive behaviors among adolescents. Research shows that school-based HIV and pregnancy prevention programs have a positive effect on the sexual behaviors of adolescents: they are less likely to engage in sexual activity or to have unprotected sex.[49] Research also demonstrates that classroom-based HIV prevention programs can have a longer effect on condom use than peer-based prevention programs.[50]

Unless otherwise noted, much of the school-curriculum data are drawn from the Centers for Disease Control and Prevention's (CDC) School Health Policies and Programs Study (SHPPS), conducted in 2006. A new study is expected to be completed in 2012.

- **More than 70 percent of states require that HIV prevention be included in the health education curriculum, and just about 60 percent of states require that general STI prevention be included in the health education curriculum.** Thirty-six states required HIV prevention education as part of the public school health education curriculum for middle and high schools, and 31 states had this requirement for general STI prevention education. However, these requirements do not necessarily include a stipulation that the curricula be evidence based. Further, five states – Florida, Michigan, Missouri, New Hampshire, and Oklahoma – showed a discrepancy between HIV prevention education and general STI prevention education requirements.[51]
- **Less than 60 percent of states require that pregnancy prevention education be included in the health education curriculum.** Thirty states required pregnancy prevention education as part of the public school health education curriculum for middle and high schools, though this requirement does not necessarily include a stipulation that the curriculum be evidence-based.[52]

Obesity Prevention Strategies

While obesity is a complex problem that will likely require a variety of approaches to adequately tackle, schools provide an important venue both to teach adolescents through curricula and enable them to make healthy choices by increasing access to physical activities and nutritious foods.[53] Data show that improving the quality and reach of school food programs can tangibly improve the health of children.[54] Similarly, improving the quality of food sold at or near school can also have a positive impact. Many foods sold at school are not subject to federal nutrition standards and typically contribute to poor nutritional choices.[55] School food policies that decrease access to foods high in fats and sugars, such as restricting vending machine hours or limiting the types of food that are sold, are associated with less frequent purchase of high fat and sugar items among high school students.[56] Adequate physical activity is another important component to obesity prevention that schools can promote. In addition to reducing the risk of obesity, physical activity can reduce depression symptoms and improve self-esteem.[57]

- **Nearly 60 percent of states have physical activity and fitness requirements, and just over 30 percent specify time requirements.** Thirty states required that physical activity and fitness be taught in middle and high schools, and 16 states specified time requirements for physical education. A potential discrepancy exists within the SHPPS data on how these policies were practiced on the ground; several of the 16 states that reported time requirements for physical education were not among the 30 states to report requiring physical activity and fitness taught in schools.[58]
- **More than 50 percent of states recommend that schools offer healthful beverages.** Twenty-eight states required or recommended that schools make healthful beverages available to students whenever other beverages are offered or sold.[59]
- **About 50 percent of states recommend that schools offer fruits and vegetables.** Twenty-four states required or recommended that schools make fruits or vegetables available to students whenever other food is offered or sold.[60]
- **Less than 20 percent of states took the lead on nutritional standards for school meals.** As of 2005, 10 states – Arizona, California, Illinois, Iowa, Kansas, Kentucky, Massachusetts, New Hampshire, South Carolina, Tennessee – had statutory nutritional standards for school meal programs that extended beyond federal regulations.[61]

Early Periodic Screening, Diagnosis, and Testing (EPSDT)

The American Academy of Pediatrics (AAP), the leading pediatrics professional organization in this country, provides recommendations on the minimum number of well-child checkups children should receive, in accordance with their needs, at different ages and stages of their development. In addition to the recommendations on number of visits, the AAP also encourages continuity of care of comprehensive health services and stresses the need to avoid fragmentation of care.[62]

- **Nearly 57 percent of states' EPSDT schedules meet the recommendations of AAP for children age 15 to 18.** As of 2009, 29 states had an EPSDT screening periodicity schedule that met AAP recommendations of four screenings for children age 15 to 18.
- **Almost 53 percent of states' EPSDT schedules meet AAP recommendations for children age 10 to 14.** As of 2009, 27 states had an EPSDT screening periodicity schedule that met AAP recommendations of five screenings for children age 10 to 14.

Services in School Settings

School-based Health Centers

School-based health centers (SBHCs) provide comprehensive, developmentally appropriate health services that adolescents need in a setting that most of them frequent: school. The benefits of SBHCs are many. In addition to improving access to care, especially for high-risk groups, and improving both physical and emotional outcomes, SBHCs reduce emergency room visits and associated costs. Studies also indicate that SBHCs improve academic outcomes for these students.[63]

- **About 37 percent of states fund SBHCs.** As of 2008, 19 states provided at least some funding for SBHCs.[64]
- **Thirty-three percent of all states have an SBHC office.** As of 2008, 17 states had a program office dedicated to SBHCs.[65]

- **Nearly 22 percent of states allow SBHCs to bill to Medicaid, and just under 12 percent provided CHIP plan coverage.** As of 2008, 11 states recognized SBHCs as a participating provider for Medicaid,[66] while just six states – Illinois, Louisiana, Maine, Maryland, Massachusetts, and Rhode Island – recognized SBHCs as a participating provider for CHIP.[67] Since those who benefit most from SBHCs are the most vulnerable groups, including adolescents from low-income families, public health insurance participation can play an important role in increasing positive impact.

Required Health Prevention Services

- **Almost 22 percent of states require schools to provide services for HIV, STI, and pregnancy prevention.** Eleven states required districts or schools to provide services for HIV, STI, and pregnancy prevention, though the CDC questionnaire did not specify to which grade levels these services are made available. Similarly, the kinds of prevention services were not specified, but the questionnaire did indicate that they might be provided in one-on-one or small group sessions by any school staff and specifically not as part of classroom instruction. [68]

Workforce Development

Research shows that teachers are key to the success of school-based health education, and providing appropriate training helps teachers to more effectively teach a range of sensitive health topics.[69]

- **Just over 70 percent of states require that their health education teachers have specialized training.** Thirty-six states required newly hired health education teachers in middle and high schools to have undergraduate or graduate training in health education.[70]

Law and Legislation: Reproductive Health Consent Laws

With the exception of abortion, the vast majority of states do allow adolescents to consent to a range of reproductive health services either through specific legislation explicitly granting permission to consent or by implicitly extending this right to most adolescents through mature minor statutes or other stipulations contingent on the minor's ability to give informed consent. Even if minors can provide consent, parental notification may still be allowed.

Some states have minimum age requirements or other stipulations attached to their consent laws. For those without an explicit policy, adolescents may be able to access reproductive or sexual health care services due to the constitutional right to privacy or if the health care provider site receives funding under Title X of the federal Public Health Services Act, commonly referred to as the Title X Family Planning program.

Because of the range of specifications and lack of explicit policy in many states, a simple yes or no answer was often difficult to determine, and therefore, the totals may be misleading with regard to the degree of permissiveness, nationally. In general, we considered a state to allow consent, in other words, marked a "yes," if we interpreted the language to mean that most minors might be able to consent to the service or services in question or if no explicit language prohibited. In addition, many states allow minors to consent to care if they meet certain criteria, such as being emancipated, married, parenting, or pregnant.

- **All states and the District of Columbia may allow minors to consent to prenatal care.** As of 2010, all states except Kansas explicitly or implicitly allowed minors to consent to their own prenatal care. Of those, 20 (Arizona, Connecticut, Idaho, Indiana, Iowa, Louisiana, Maine, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Vermont, West Virginia, Wisconsin, and Wyoming) lacked an explicit policy, but minors may still be able to obtain and consent to care because of constitutional privacy rights or if the site receives funding under the Title X Family Planning program. However, although minors may consent to care, in many states, the physician may be able to inform the minor's parents. The state of Washington also lacks an explicit policy, but the Washington Supreme Court held that a minor's privacy right to pregnancy care cannot be subjected to an absolute parental veto. Delaware and Hawaii applied nominal age restrictions, while Montana and Oklahoma stipulated that the adolescent must also receive counseling. Kansas only allowed minors to consent to prenatal care in cases where no parent or guardian was available.

- **All states and the District of Columbia may allow minors to consent to medical care for their own children.** All 50 states and the District of Columbia explicitly or implicitly allowed minors to consent to medical care for their own children, though New Mexico applied nominal age restrictions, and Texas required that the minor have custody of the child.
- **Almost every state allows minors to consent to HIV and STI prevention and treatment.** Fifty states allowed minors to consent to HIV and STI prevention and treatment services. A few states explicitly allowed minors to consent with regard to STIs and implicitly for HIV. Only South Carolina appeared to potentially prohibit consent to these services for many in this age group; the state lacked a specific provision, but required that minors be 16 or older in order to consent to care generally. In many states, the physician may be able to inform the minor's parents. For example, Colorado allowed the physician to inform the parents of a minor's decision to consent if the minor was younger than 16. Connecticut stipulated that the physician must work toward involving the parent or parents unless he or she feels that parental notification would prevent the minor from seeking, pursuing, or continuing treatment or if the minor specifically asked that parents not be notified. However, if the minor is under 16 and receiving treatment for HIV, parents may, in that case, be notified.
- **Ninety-two percent of states may allow minors to consent to family planning services.** In early 2010, all 47 states except Florida, Illinois, Mississippi, and Maine explicitly or implicitly allowed minors to consent to contraceptive and family planning services. Of those, 18 (Alabama, Connecticut, Kansas, Louisiana, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Pennsylvania, South Dakota, Vermont, West Virginia, and Wisconsin) lacked an explicit policy, but minors may still be able to obtain and consent to care because of constitutional privacy rights or if the site receives funding under the Title X Federal Family Planning program. Although minors may consent to care, in many states, the physician may be able to inform the minor's parents. The state of Washington also lacked an explicit policy, but the Washington Supreme Court held that a minor's privacy right to contraceptive care cannot be subjected to an absolute parental veto. Oklahoma stipulated that a state entity that receives funding under the Title X Family Planning program cannot require parental consent. Delaware and Hawaii applied nominal age restrictions. South Carolina stipulated that services provided must be necessary to maintain the well-being of the minor if under age 16. Among the four states that did not grant consent, adolescents in Florida, Illinois, and Mississippi may still be able to obtain care with a referral and/or if the physician indicates that lack of care poses a serious health hazard.[71]
- **Thirty-three percent of states may allow minors to confidentially consent to abortion.** Seventeen states explicitly or implicitly allow minors to consent to abortion, and in most cases, without parental notification or permission. Five of these states, Alaska, California, Montana, Nevada, and New Jersey – did have parental consent requirements, but the requirements have been found unconstitutional and unenforceable. In New Mexico, the parental notification law was not enforced. Maine allowed minors to consent but required that minors receive counseling on available services and alternatives. Among the 34 jurisdictions that did not allow, almost all had exceptions in place for cases of medical emergency or judicial bypass. Many others also included exceptions for cases of sexual abuse or incest. Delaware only allowed minors to consent if they are 16 or older or in cases of medical emergency or judicial bypass. West Virginia allowed certain health professionals to waive parental involvement on the basis of the minor's maturity or best interests.

MENTAL HEALTH

Unless another year is indicated, the following data are drawn from the CDC's School Health Policies and Programs Study (SHPPS), conducted in 2006.

Promotion, Prevention, and Early Intervention Programs

Studies demonstrate that effective, high quality drug and alcohol education curricula reduce drug and alcohol use among high school students.[72] Similarly, studies also show that social emotional learning reduces risky or problem behaviors and improves academic and behavioral outcomes.[73]

Required School Curriculum

- **Nearly 75 percent of all states require that drug and alcohol prevention be included in the health education curriculum.** Thirty-eight states required drug and alcohol prevention education as part of the public school health education curriculum for middle and high schools, though this requirement did not necessarily include a stipulation that the curriculum be evidence based.[74]

Early Periodic Screening, Diagnosis, and Testing

- **As discussed in the Health section, nearly 57 percent of states' EPSDT schedules meet the recommendations of the American Academy of Pediatrics (AAP) for children age 15 to 18.** As of 2009, 29 states had an EPSDT screening periodicity schedule that met AAP recommendations of four screenings for children age 15 to 18.
- **Almost 53 percent of states' EPSDT schedules meet AAP recommendations for children age 10 to 14.** As of 2009, 27 states had an EPSDT screening periodicity schedule that met AAP recommendations of five screenings for children age 10 to 14.

Social Emotional Learning

- **One state has legislation or state-level board of education policy establishing and applying social emotional learning (SEL) standards in schools.** As of 2010, only Illinois had legislation or state-level board of education policy that explicitly established and applied SEL standards in schools. Data for this variable were unavailable for many states. Among states that did not have such legislation in place, several of them have made efforts toward including SEL principles in school curricula. Notably, Massachusetts has since approved a bill that will include guidelines for the implementation of SEL curricula no later than June 30, 2011. In California, the Mental Health Services Act funds expanded mental health services for both adults and children, but it did not include an explicit SEL focus. New York's Children's Mental Health Act developed guidelines on SEL implementation in secondary school education programs, but implementation remains voluntary. Similarly, Wisconsin's Standards of the Heart initiative aimed to encourage SEL in schools, but the standards were not mandated. Legislation is currently in the works that may be relevant. In Indiana, SEL is embedded, to some extent, in the state education system, but it is not explicitly required. In the past, the Indiana State Assembly had made efforts toward a Children's Social, Emotional, and Behavior Health Plan, but the status or results of these efforts are unclear, suggesting that the initiative has been dropped for the time being. In Ohio, SEL initiatives do exist at the school-district level, but the state does not presently have statewide SEL-specific standards. In Rhode Island, SEL concepts had been embedded into Healthy Schools! Healthy Kids!, a three-year program that has since been discontinued due to lack of funding.[75]

Services in School Settings

Improving access to and uptake of a range of high quality mental health services in community-based settings, such as in schools, are key to improving both short- and long-range outcomes for adolescents.[76] Research shows that adolescents with mental health problems prefer to receive services that are youth-oriented and in school-based settings.[77]

- **Nearly 30 percent of states require schools to provide suicide prevention services.** Fifteen states required districts or schools to provide suicide prevention services.[78] Suicide is the third leading cause of death among adolescents and affects young people of all different backgrounds, though some groups have higher rates than others.[79]
- **More than 20 percent of states require schools to provide crisis intervention for students.** Eleven states required districts or schools to provide crisis intervention for personal problems.[80]
- **Almost 12 percent of states require schools to provide counseling for emotional problems.** Seven states (District of Columbia, Hawaii, Maryland, Nevada, New Jersey, Oklahoma, and Oregon) required districts or schools to provide counseling for emotional behaviors or disorders.

Workforce Development

States can support high-quality mental health services by establishing certification requirements and other specific criteria regarding the necessary

level of training for in-school mental health service providers, those who are often the "first responders" in recognizing and helping students in need. Research shows that clinicians with a higher level of education and/or national certification have a more favorable attitude toward high-quality or evidence-based services.[81]

Certification Requirements

- **Almost 95 percent of states have specific certification requirements for school counselors.** All 48 states except Kansas and Louisiana required newly hired school counselors to be certified by a state agency or board. Information was unavailable for Texas.[82]
- **Almost 95 percent of states have specific certification requirements for school psychologists.** All 48 states except Kansas and Vermont required newly hired school psychologists to be certified by a state agency or board. Information was unavailable for Texas.
- **About 90 percent of states have specific certification requirements for school social workers.** All 46 states except Arizona, Kansas, Missouri, and West Virginia required newly hired school social workers to be certified by a state agency or board. Information was unavailable for Texas.[83]

Training Requirements

- **Nearly 61 percent of states provided emotional and mental health training to health education teachers.** Thirty-one states provided funding or staff development on emotional and mental health to health education teachers.[84]

Law and Legislation: Mental Health Consent Laws

As with services related to reproductive health, adolescents seeking mental health services often want to discuss topics they prefer to keep confidential, such as peer relationships, smoking, and alcohol use.[85] The success of mental health services is often dependent upon trust between clinician and patient. Confidentiality and privacy can be significant factors in establishing such trust.[86] Many states do allow adolescents to consent to certain mental health services, either explicitly or implicitly, but most that explicitly allow consent attach specific stipulations such as minimum age requirements, limitations on the kinds of services provided or duration of care, or consent granted contingent on the minor's ability to give informed consent.

Because of the range of specifications or lack of explicit policy, a simple yes or no answer was often difficult to determine and largely open to interpretation. In general, we considered a state to allow consent, in other words, marked a "yes," if we interpreted the language to mean that most minors would be able to consent to the service or services in question. Many states allow minors to consent to care if they meet certain criteria, such as being emancipated, married, parenting, or pregnant. In the absence of additional permissive language, these states were marked as "no" because these exceptions do not apply to the majority of youth seeking care.

- **About 90 percent of states allow minors to consent to care for drug or alcohol abuse.** As of 2010, 46 states allowed minors to consent to care for drug or alcohol abuse, though most states had nominal age requirements. Of the five jurisdictions that did not explicitly allow, additional data were unavailable for two: Utah and Wyoming. Alaska had no explicit policy, but minors can consent to general medical care in cases of medical emergency or when parent or guardian cannot be contacted or is unwilling to either grant or withhold consent. New York only allowed minors to consent to this care in cases where requiring parental consent would have a detrimental effect on treatment or if consent were denied and the physician finds treatment is necessary and in the best interest of the child.[87]
- **Just under 50 percent of all states may allow minors to consent to outpatient mental health care.** As of 2010, 24 states may have allowed minors to consent to outpatient mental health care, to some extent. Most states did have some manner of explicit policy allowing consent in specific circumstances. The distinctions between "yes" or "no" designations were based on whether we interpreted the language as inclusive and expanding ability to consent without parental involvement or largely limiting except to a few specific groups. Please see footnotes in the 50-state data table for greater detail.

VIOLENCE AND INJURY

Promotion, Prevention, and Early Intervention Programs

Research shows that effective school-based violence prevention programs improve knowledge, attitudes, and strategies for dealing with violence among adolescents.[88]

- **Just under 60 percent of states require instruction in violence and injury prevention.** As of 2006, 30 states required that middle and high schools teach violence and injury prevention. While it is a promising start that more than half of states required curricula that include violence and injury prevention as a matter of state policy, and the states often set minimum standards, none explicitly requires the curriculum be evidence-based.
- **Almost 24 percent of states are taking the opportunity to address dating violence as part of their school curricula, and a few others are taking steps in this direction.** As of 2010, 12 states – Florida, Georgia, Indiana, Louisiana, Maryland, Nebraska, New Jersey, Ohio, Rhode Island, Texas, Virginia, and Washington – required school curricula to address dating violence, though it was unclear whether Washington's program had ever been implemented or if any of the states stipulated evidence-based curricula. Among the jurisdictions that did not have such a requirement, some states have taken steps in this direction, such as issuing recommendations in support of anti-dating violence education. The California legislature has expressed its intent that schools receiving funds as part of the Carl Washington School Safety and Violence Prevention Act provide age-appropriate instruction in domestic and dating violence prevention, but this program is not state-wide. Tennessee law urged the department of education to develop a curriculum that addresses teen dating violence, but it is unclear whether such a curriculum has ever been developed or implemented.

Workforce Development

In violence prevention programs, interactive techniques such as group work, cooperative learning, or role playing can better engage students than non-interactive techniques, and training is crucial to developing and implementing these and other effective techniques.[89] Thus, training teachers on the most effective violence and injury prevention strategies is vital to promoting student safety both in and out of school.

- **Just over 75 percent of states support teacher training on violence and injury prevention and safety.** As of 2006, 39 states funded or offered staff development on violence and injury prevention and safety to their health education teachers.[90]

Law and Legislation: Vehicle Safety

Licensing

Numerous studies have found that graduated driver's licensing (GDL) is an effective, evidence-based, and developmentally appropriate strategy that significantly reduces motor vehicle injuries and fatalities.[91] However, not all GDL programs are equal in their effectiveness, depending upon the individual components. As a guideline, we tracked policies based on the recommendations of the Insurance Institute for Highway Safety.

- **All states have some form of GDL system.**[92]
- **Almost all states require a learner's holding period of at least six months.** As of 2010, 49 states required a learner's permit or learner's license holding period of at least six months for new adolescent drivers. Only New Hampshire and Wyoming did not require this holding period. In Connecticut and South Dakota, new adolescent drivers could reduce the holding period if they completed driver education. According to several studies, a mandatory holding period is one of the most important elements in reducing traffic injuries and fatalities, with crash risk being particularly high during the first six months of driving.[93]
- **Nearly 85 percent of states limit new adolescent drivers to one or two underage passengers.** As of 2010, 43 states restricted underage passengers to one or two for new adolescent drivers, though some states allowed exceptions for family members or dependents. Data suggest that increasing the number of passengers in a vehicle can significantly increase crash risk among adolescent drivers.[94]
- **Nearly 85 percent of states required at least 30 hours of driving practice.** As of 2010, 43 states required practice driving certification of at least 30 hours for new adolescent drivers. Providing

new adolescent drivers the opportunity to practice and gain supervised experience on the road is the basis of the GDL system.[95]

- **About 20 percent of all states impose a driver curfew of 10 pm or earlier.** As of 2010, 10 states imposed a night driving restriction at 10 pm or earlier for new adolescent drivers. Among the states that did not have an across-the-board restriction, Illinois, Indiana, and Mississippi did have night driving restrictions but allowed later hours on the weekends. Driving at night is associated with higher crash rates among all drivers, but the risk for adolescent drivers is even greater.[96]
- **About 16 percent of states make drivers wait until age 16 before allowing them behind the wheel.** As of 2010, eight states – Connecticut, Delaware, Kentucky, Massachusetts, New Jersey, New York, Pennsylvania, and Rhode Island, and the District of Columbia – required learner's entry age of 16 or older.[97]
- **Although every state has some form of GDL system in place, very few of them maintain these restrictions until the age of majority.** As of 2010, six states implemented graduated licensing restrictions until the age of 18. In New York, the restrictions can be dropped at 17 if the driver completes driver education. However, even among the 45 jurisdictions that did not maintain all their GDL restrictions until 18, seven maintained their night driving restriction and three maintained the underage passenger restriction.[98]

Cell Phone Use While Driving

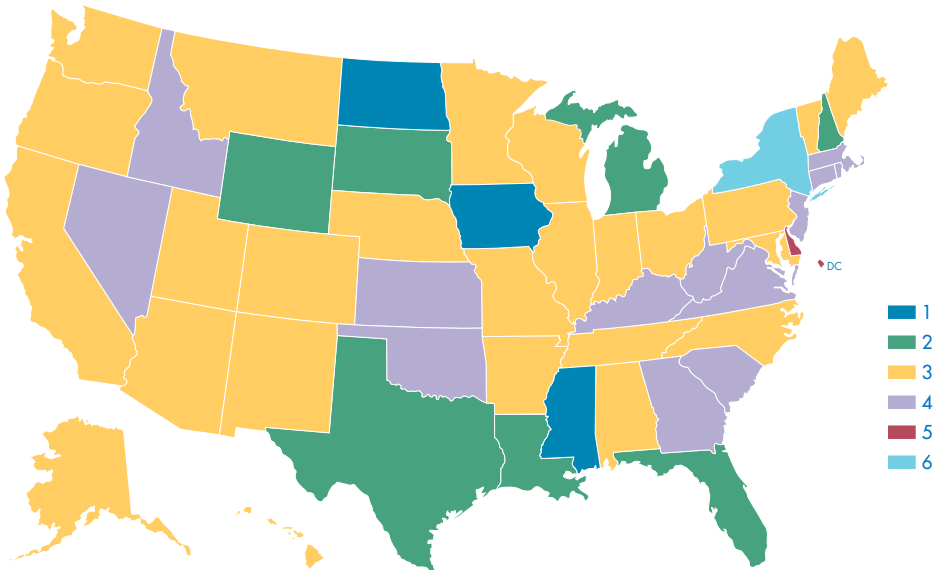
Legislation regarding cell phone use while driving is gaining momentum, particularly legislation focusing on teenagers. States can enhance the impact of this type of legislation by increasing enforcement efforts, though this may be difficult when the ban only applies to certain age groups. States can also improve impact by educating the public so more people are aware of laws regulating cell phone use while driving.[99]

- **More than half of states ban all cell phone use for new adolescent drivers, and even more ban texting while driving.** As of 2010, 29 states banned all cell phone use for new adolescent drivers, and 38 banned texting while driving for new adolescent drivers.

Law and Legislation: Interpersonal Violence

In addition to the continued epidemic of dating violence, recent high profile cases of bullying and electronic harassment leading to violence and, in some cases, death have highlighted the need for states to respond quickly through legislation that establishes clear guidelines on the rights and responsibilities of schools to protect the physical safety and well-being of students and the rights of individuals, particularly those most vulnerable, to protect themselves.

Map 1: **Number of graduated drivers licensing elements required, by state**



Consensus on how to address cyberstalking and other forms of electronic harassment is slow in coming, but states are beginning to respond. Effectively dealing with cyberstalking poses particular new challenges to lawmakers and the legal system. Many states have responded by adding language about "electronic communications" onto existing statutes designed to deal with offline stalking, and others have enacted dedicated laws to address this relatively new threat, with varying degrees of success. See box for more information.

Unless another year is indicated, the following information is drawn from Break the Cycle's 2010 State Law Report Cards, for which data were collected in 2009**.** One of the leading national organizations combating dating violence among adolescents, Break the Cycle graded states on each of the 11 indicators against ideal policy criteria based on the recommendation of legal professionals in this field as well as the available literature. States that met the criterion received 10 points for that indicator and those with the most adverse policy received zero points. The final raw score was a weighted average of the scores for the 11 indicators, with the weights assigned according to the relative importance of the indicator. States who earned eight points or more received an A. Scores of at least seven points but less than eight points received a B, and so on.

- **About 43 percent of states' domestic violence protection laws for adolescents received a grade of B or higher from Break the Cycle.** Specifically, seven states received a grade of A, and 15 states received a grade of B. The grading system assesses each state's responsiveness to the unique needs of this age group and the state's laws' impact on adolescents seeking protection from abusive relationships.
- **Almost all states have laws that could extend protection to same-sex couples.** Forty-six states had protection laws that could or did include same-sex couples. The five states that excluded same-sex couples, either explicitly or by stated intent, were Idaho, Louisiana, Montana, North Carolina, and South Carolina. While Idaho's civil domestic violence law does not explicitly exclude same-sex couples as written, when the law was adopted, the legislature stated that it was intended for opposite-sex couples only.

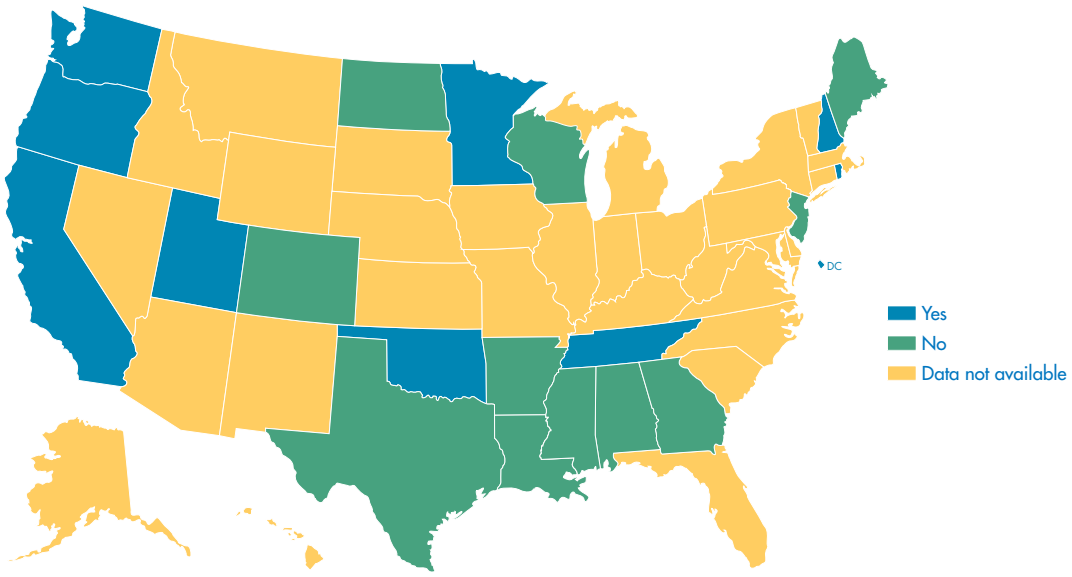
Cyberstalking

According to Naomi Goodno, an expert on cyberstalking at Pepperdine University School of Law, statutes that shift the focus from the perpetrator's behavior (as with many stalking statutes) and onto its effect on the victim are the most effective in prosecuting cyberstalkers and protecting victims. As with other crimes, laws regulating stalking and cyberstalking must include a malicious intent requirement as well as require the act itself. Specifically, a stalker or cyberstalker must intentionally engage in particular conduct with the intention to cause harm. However, defining such conduct is where laws governing stalking often fall short in protecting against the relatively new crime of cyberstalking.

As Goodno explains, effective cyberstalking statutes must encompass conduct that would cause a "reasonable person" to fear physical harm or suffer severe emotional distress (the "reasonable person" standard), not just actual or implied threats with the apparent ability to carry them out ("credible threats"), as is the case with many stalking statutes. Statutes that contain credible threat or physical proximity requirements only – those that focus on the perpetrator's actions – are inadequate in effectively addressing the range of electronic harassment. Cyberstalking may not contain a "threat" itself, that is, an actual communication directly delivered from stalker to victim, and can originate from any location, often unknown to the victim. Instead, statutes should include a "reasonable person" standard, focusing on the victim and whether his or her fears or distress are reasonable because of the cyberstalker's conduct. Another gap in many states' efforts to deal with cyberstalking by amending existing stalking legislation is the failure to address third party harassment, in which the cyberstalker dupes third parties to harass his victim for him, which similarly does not meet the "credible threat" standard. A few states have recognized the inadequacy of merely amending existing stalking statutes to effectively address the issue and have since enacted new statutes that address cyberstalking in particular.[103]

- **Eighty-four percent of states allow victims of domestic violence who are dating their abuser to apply for a civil domestic violence protection or restraining order.** The eight states that did not allow victims to apply for protection orders against a dating partner were Alabama, Georgia, Kentucky, Ohio, South Carolina, South Dakota, Utah, and Virginia.
- **Almost 30 percent of states allow petitions for protection orders against minors.** Fifteen states explicitly allowed petitions for protection orders against a minor abuser, but the vast majority of states did not specify whether or not they allowed such petitions. Five states – Maryland, Missouri, Nevada, New Jersey, and Oregon – explicitly prohibited protection orders against minors. However, Maryland did allow Juvenile Peace Orders to be issued against minors, which would then be heard in Juvenile Court.[100]
- **About 25 percent of states have laws in place that specifically protect students from bullying based on sexual orientation.** As of 2010, 13 states had laws in place to protect students from bullying and harassment on the basis of sexual orientation and gender identity or expression.[101] Many other states had legislation addressing bullying more generally among school-age children in the form of no-tolerance policies, reporting requirements, curriculum requirements, or a combination of punitive and preventive approaches.
- **Nearly 20 percent of all states allow minors to petition for protection orders.** Ten states explicitly allowed minors to petition for protection orders, though some have minimum age requirements, and 11 states explicitly prohibited it. The vast majority of states did not specify one way or another.[102]
- **Three states are leading the way with statutes that explicitly and comprehensively address cyberstalking.** As of 2006,[104] three states – Ohio, Rhode Island, and Washington – had stalking statutes that explicitly and comprehensively addressed cyberstalking, including use of the "reasonable person" standard and prohibiting third party harassment. An additional four states had statutes that did begin to address the issue, but the laws as written were not comprehensive enough to provide adequate protection. Specifically, Illinois, Louisiana, Mississippi, and North Carolina had enacted dedicated cyberstalking statutes that dealt with some but not all important aspects of cyberstalking. Illinois' legislation fell short in its failure to address third party harassment, while Louisiana, North Carolina, and Mississippi included requirements that the harassing electronic communication be sent directly to the victim. Many states have since enacted laws that address some aspects of cyberstalking but treat this behavior as a harassment misdemeanor rather than a felony, unless certain conditions are met. For example, Missouri law includes certain written, electronic, or telephonic communications and could include third party harassment but does not qualify as a felony unless the perpetrator is over 21 years old and the victim under 18 years old.

Map 2: **States that allow minors to petition for order of protection**



YOUTH DEVELOPMENT

Adolescents tend to be relatively malleable, that is, they are receptive to new ideas and influences, both positive and negative, and targeted investments in their development can have huge payoffs for their health and wellbeing. For example, high quality afterschool programming tailored toward this age group can improve academic performance and reduce risk-taking behaviors and opportunities. According to Richard M. Lerner, from Tufts University's Institute for Applied Research in Youth Development, successful positive youth development programs have three major characteristics: they promote caring youth-adult relationships, they emphasize the development of life skills, and they promote youth participation in every aspect of the program.[105] Although, for the most part, statewide initiatives that encompass all of these characteristics do not exist, we looked at state efforts that support the development of youth as assets, many of which demonstrate one or some of the characteristics identified by Lerner.

Programs and Initiatives in School to Promote Educational Attainment and Achievement

Research shows that educational attainment is strongly associated with health, with regard to both health behaviors and health status. High school completion is a useful measure of educational attainment, in particular because its positive impact on health is well studied.[106] Policies that effectively increase educational attainment, such as those that improve high school graduation rates, could have a large positive effect on population health.[107]

In our society, earning a high school diploma represents a minimum point of entry into jobs that pay adequate wages. Yet, many states still adhere to century-old guidelines only mandating school attendance through age 14 or 16, vestiges of an era when high school completion was not a necessity for financial survival.[108] Research shows that raising the compulsory age of school attendance can keep many adolescents in school who otherwise would have dropped out.[109] Raising the age of compulsory school attendance is one important tool states can use to improve graduation rates, which in turn can improve the health and well-being of both the individual and his or her present and future offspring.[110]

- **All states fund afterschool programs to some extent,[111] but these initiatives are not necessarily state-wide, and few states are monitoring the quality of programming provided.** In 2010, all 51 jurisdictions reported that they fund afterschool programs, but only 11 reported that they funded evaluation initiatives for these programs.[112] Research demonstrates that high quality afterschool programs contribute to positive social and educational outcomes among adolescents and reduce risky behaviors, crime, criminal victimization, alcohol and substance use, teen pregnancy, and other poor outcomes.[113]
- **By the end of the year, well more than 50 percent of states will be using a common formula to calculate high school graduation rates.** As of 2010, 26 states used the Compact Rate formula to measure graduation rates, and 21 additional states indicated that they intend to begin using the formula in 2011 or 2012. The Compact Rate formula divides the number of on-time graduates in a given year by the number of first-time ninth graders four years earlier, adjusting for transfers in and out of the system. It was designed by the National Governors Association's Center for Best Practices to provide a consistent and more accurate method for states to track their graduation rates, with the ultimate goal of improving student outcomes.
- **About 40 percent of states require their students to stay in school through age 18.** As of 2010, 21 states set the minimum compulsory completion age of high school at 18 or older.
- **Few states are supporting mentoring opportunities for their students.** As of 2010, 10 states reported that they funded mentoring initiatives for middle or high school-age students. Well-designed mentoring initiatives and afterschool programs fulfill all three of the characteristics Lerner identified as key to successful youth development programs. Research indicates that when students believe that adults in their lives care about their overall well-being, they are less likely to engage in risky behaviors and more likely to succeed academically.[114]

Post-secondary Education Opportunities for Vulnerable Groups

Foster Youth

Former foster youth experience significantly worse outcomes than their peers.[115] Research shows that many young people leaving foster care face numerous challenges as they transition to independent living, including unemployment and involvement in the court system, among others, that can adversely affect their life outcomes.[116] Emancipated foster youth disproportionately experience periods of homelessness and poverty. In 2001, Congress established the Chafee Educational and Training Voucher (ETV) program as part of the Chafee Foster Care Independence Program. Continuing their education past high school is one of the most valuable ways that former foster youth can secure a stable future for themselves and their families. The ETV program provides vouchers of up to $5,000 per year to young adults leaving foster care who wish to pursue higher education. Before the ETV program began, some states provided and continue to provide tuition waivers to allow foster youth or former foster youth to attend publicly funded higher education institutions by waiving some or all of the tuition and fees for students who met certain criteria.

- **Nearly 85 percent of states are utilizing federal funding to help foster youth obtain post-secondary education.** As of 2010, 43 states provided ETV or tuition waivers for foster youth seeking post-secondary education.[117]

Undocumented Immigrants

In 2009, there were an estimated 10.8 to 11.1 million undocumented immigrants living in the United States, with about nine percent (just under one million) between the ages of 10 and 19.[118,119] While this number is down from a peak in 2007, the overall number of illegal immigrants increased about 27 percent between 2000 and 2009. Providing access to post-secondary education for this segment of the American population not only benefits the individual, but the country as a whole stands to gain through their increased contributions to the workforce and increased taxable earnings as well as lower crime and poverty rates.

- **About 20 percent of states are working to ensure the affordability of educational opportunities for undocumented immigrants.** As of 2008, 10 states allowed undocumented immigrants to receive in-state tuition.[120] An equal number, specifically, Alaska, Arizona, Colorado, Iowa, Michigan, Mississippi, North Carolina, Texas, Utah and Virginia, have considered legislation that would ban undocumented immigrants from receiving in-state tuition.[121]

Programs and Initiatives to Promote Successful Transition to Young Adulthood

Job Opportunities for Adolescents

Helping those students not pursuing post-secondary degrees to acquire vocational training or transition into stable employment is an important investment toward securing their financial independence in young adulthood and beyond. Forming partnerships with the private sector and incentivizing greater community involvement is a relatively low-cost strategy to develop job skills, encourage relationships with caring adults, and improve outcomes for all adolescents.

- **Nearly all states' career and technical education (CTE) offices partner with the private sector to provide internship programs for teenagers.** As of 2010, 48 states indicated that they had a CTE office that partnered with communities to offer internship programs to middle or high school students. The only states that did not have a CTE office that formed community partnerships on internship programs were New Mexico, North Dakota, and Tennessee. Forty states funded CTE offices within the state departments of education, and at least 10 states housed their CTE offices elsewhere. It was unclear whether New Mexico had a CTE office at all.

Vulnerable Adolescents

Juvenile-justice Involved Youth

Youth involved in the juvenile justice system are at high risk for poor outcomes, such as disconnectedness in young adulthood and repeated re-incarceration. Many of these youth have unmet mental health and substance abuse needs before, during, and after their stays in state custody.[122] States can improve

the chances of success for these youth – financially, socially, and emotionally – by providing comprehensive aftercare services as they leave state custody. Additional support, training, and counseling can help this group of youth already at high risk get their lives back on track.

- **About 61 percent of states provide support services to help youth exiting the juvenile justice system successfully reintegrate into society.** In 2010, 31 states reported that they provided aftercare services to ease the transition from the juvenile justice system, including education, life skills training, vocational training, and counseling services. Data were unavailable for nine states.[123]

Foster Youth

Engaging the private sector to work with youth to develop vocational and life skills is particularly important for foster youth, who often lack family or other support systems to help them transition from state custody to independent living.

- **About 25 percent of states collaborate across sectors to encourage job opportunities for former foster youth.** In 2010, 12 states reported that they collaborated with the private sector to help expand job opportunities for youth aging out of foster care. Eight states specifically indicated that they did not do so: Arizona, Idaho, Indiana, Kansas, Minnesota, North Carolina, Pennsylvania, and Tennessee. Responses were unavailable for the majority of states.[124]

The 2008 Fostering Connections Act makes significantly more funds available to states to retain state guardianship for youth up to age 21, and as a result, more states are choosing to exercise this option every year. Retaining state guardianship allows foster youth to maintain health care coverage and other important benefits while they prepare for independent living and significantly improves the odds of success for this vulnerable group. Recent health care reform legislation requires that all states maintain Medicaid coverage for eligible youth aging out of foster care, starting in 2014. In addition, states could explore ways to provide additional supports even to those foster youth who have struggled academically and are not pursuing further education or are having difficulty finding employment, as these youth are most in need of support.

- **About 73 percent of states are utilizing available federal funding to support foster youth as they age out of the system, but they tend to do so conditionally.** As of 2009, 37 states allowed foster youth aging out of the system to voluntarily retain state guardianship until age 21. The majority of states that did allow foster youth to remain attached certain conditions, such as requiring that the youth be enrolled in school or gainfully employed.[125]

Law and Legislation: Youth Engagement

Adolescence is a time when children become passionate about ideas and ideals, and these passions can be channeled toward constructive involvement.[126] Research shows that programs that challenge and positively engage youth and promote greater community involvement are associated with improved developmental assets, fewer risky behaviors, and higher levels of thriving.[127] More specifically, the concept of youth voice, that is, giving young people a role in decision-making as partners whose input is valued, guided by caring and supportive adults, contributes to a heightened sense of civic belonging, empowerment, and competence.[128] Youth involvement in government not only gives young people a stake in the legislative process, an opportunity to highlight issues important to them, and valuable leadership training, but the youth voice also offers a much-needed resource for policymakers designing legislation targeting adolescents.

Eighty percent of states are engaging youth and giving them a voice in the legislative process. As of 2009, 41 states had legislative youth advisory councils or commissions that gave high school students a voice in approving legislation involving youth.[129]

Conclusion and Policy Recommendations

Promoting Adolescent Health and Well-being through Access and Coverage Improvements

We found discrepancies in the choices states made about public health insurance coverage for adolescents. Most states offered CHIP coverage for adolescents whose family income was up to 200 percent of the federal poverty line (FPL), but far fewer extended Medicaid coverage to comparable limits. In conjunction with public health insurance coverage, slightly more than half of the states encouraged prevention and early intervention in adolescents by requiring the AAP-recommended number of EPSDT visits for this age group. Variability also exists among states' choices about extending coverage to different groups of vulnerable youth. Following the lead of the federal government, states are doing a better job covering youth exiting the foster care system than youth exiting the juvenile justice system. In total, no state fulfilled all seven of the public health insurance access variables discussed here, but Maryland and Rhode Island fulfilled six.

Promoting Adolescent Health and Well-being in Educational Settings

A modest majority of states required health education curricula across core topic areas we examined – reproductive health, drug and alcohol use, and violence and unintended injury – and a comparable number required instruction in physical activity and fitness. Two states, Rhode Island and Washington, fulfilled all eight variables related to school curricula.

When the Center for Disease Control and Prevention's (CDC) Division of Adolescent and School Health surveyed states on nutritional standards in 2006, around half required that healthful food and beverages be offered to students, and few instituted school meal nutritional standards that exceeded the standards set forth by the federal government. Since 2006, these numbers have increased, and decision-makers at the local, state, and federal level have begun to fine-tune their obesity prevention strategies. Most recently, at the end of last year, President Obama signed the Healthy, Hunger-free Kids Act of 2010, significantly expanding funding for school-nutrition programs, improving access to and the quality of food served, and implementing other incentives to help states reduce child obesity rates.

With the exception of emerging health topics, such as dating violence and social emotional learning, most states have recognized the key role schools play in promoting the health and well-being of their students. However, there has been noticeably less agreement in how integrated and extensive this role should be. While most states required curricula on HIV, sexually transmitted infections, and pregnancy prevention education, only one-fifth offered the necessary health services for such prevention. Likewise, less than one-third of states required suicide prevention services, and even fewer still required middle and high schools to provide crisis intervention services or counseling for emotional problems. There has been significant movement on the state level to integrate health into the mission of schools since the CDC collected these data in 2006, but support for school-based health centers, whose wide-ranging benefits are well-documented, remains limited. Even fewer states have implemented financing mechanisms that would extend access to school-based health centers where they do exist to low-income youth with public health insurance. Only Maryland fulfilled all eight of the variables related to health and mental health service provision in school settings.

Although states may not agree on allocating funding for or requiring the provision of school-based health services in addition to health education curricula, the overwhelming majority have taken the comparatively inexpensive steps to ensure that those adults responsible for teaching about health or providing direct services to students receive specialized training and, in the case of providers, state certification. Nonetheless, states may not be providing teacher training comprehensively or evenly across

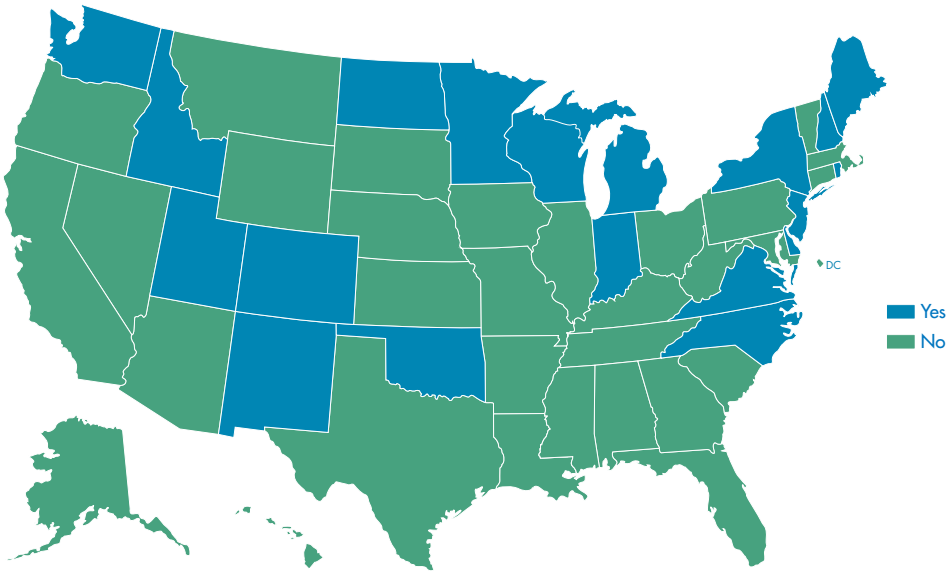
Table 1: **Health topic curricula requirements, by state**

STATE	Drug/alcohol prevention	HIV prevention	STI prevention	Pregnancy prevention	Physical activity/ fitness	Physical education time	Violence and injury/safety	Dating violence	Total
ALABAMA	x	x	x	x	x	x	x		7
ALASKA									0
ARIZONA									0
ARKANSAS					x		x		2
CALIFORNIA	x					x			2
COLORADO									0
CONNECTICUT	x	x	x	x	x				5
DELAWARE	x	x	x	x	x		x		6
DISTRICT OF COLUMBIA	x	x	x	x	x	x	x		7
FLORIDA	x	x		x				x	4
GEORGIA	x	x	x	x	x		x	x	7
HAWAII						x			1
IDAHO	x	x	x	x	x		x		6
ILLINOIS	x	x	x	x	x	x	x		7
INDIANA	x	x	x		x	x	x	x	7
IOWA	x	x	x						3
KANSAS									0
KENTUCKY	x	x	x	x	x		x		6
LOUISIANA	x						x	x	3
MAINE	x						x		2
MARYLAND	x	x	x	x	x		x	x	7
MASSACHUSETTS	x	x	x	x	x		x		6
MICHIGAN	x	x			x		x		4
MINNESOTA		x	x	x					3
MISSISSIPPI				x					1
MISSOURI	x	x				x			3
MONTANA	x	x	x		x	x	x		6
NEBRASKA	x				x			x	3
NEVADA	x	x	x	x	x	x	x		7
NEW HAMPSHIRE	x	x			x				3
NEW JERSEY	x	x	x	x		x	x	x	7
NEW MEXICO	x	x	x	x	x		x		6
NEW YORK	x	x	x	x	x		x		6
NORTH CAROLINA	x	x	x	x	x		x		6
NORTH DAKOTA						x			1
OHIO								x	1
OKLAHOMA	x	x							2
OREGON	x	x	x	x			x		5
PENNSYLVANIA	x	x	x	x	x		x		6
RHODE ISLAND	x	x	x	x	x	x	x	x	8
SOUTH CAROLINA	x	x	x	x	x				5
SOUTH DAKOTA							x		1
TENNESSEE	x	x	x	x	x		x		6
TEXAS	x	x	x	x	x		x	x	7
UTAH	x	x	x	x	x	x	x		7
VERMONT	x	x	x	x	x		x		6
VIRGINiA	x	x	x	x	x		x	x	7
WASHINGTON	x	x	x	x	x	x	x	x	8
WEST VIRGINiA	x	x	x	x	x	x	x		7
WISCONSIN		x	x	x		x			4
WYOMING									0

Table 2: **Services in school settings, by state**

STATE	Fund SBHCs	SBHCs bill to Medicaid	SBHCs bill to CHIP	SBHC program office	HIV, STD, pregnancy prevention	Counseling	Crisis intervention	Suicide prevention	Total
ALABAMA					x			x	2
ALASKA									0
ARIZONA									0
ARKANSAS									0
CALIFORNIA									0
COLORADO	x	x		x	x		x	x	6
CONNECTICUT	x	x		x					3
DELAWARE	x	x		x					3
DISTRICT OF COLUMBIA						x		x	2
FLORIDA	x				x				2
GEORGIA					x			x	2
HAWAII					x	x	x	x	4
IDAHO								x	1
ILLINOIS	x	x	x	x	x			x	6
INDIANA							x		1
IOWA								x	1
KANSAS	x			x					2
KENTUCKY									0
LOUISIANA	x	x	x	x				x	5
MAINE	x	x	x	x					4
MARYLAND	x	x	x	x	x	x	x	x	8
MASSACHUSETTS	x	x	x	x					4
MICHIGAN	x			x					2
MINNESOTA									0
MISSISSIPPI					x		x	x	3
MISSOURI									0
MONTANA									0
NEBRASKA									0
NEVADA					x	x	x	x	4
NEW HAMPSHIRE									0
NEW JERSEY	x			x		x			3
NEW MEXICO	x	x		x			x		4
NEW YORK	x	x		x					3
NORTH CAROLINA	x			x					2
NORTH DAKOTA									0
OHIO									0
OKLAHOMA						x			1
OREGON	x			x	x	x	x	x	5
PENNSYLVANIA							x		1
RHODE ISLAND	x	x	x	x					4
SOUTH CAROLINA									0
SOUTH DAKOTA									0
TENNESSEE					x			x	2
TEXAS	x								1
UTAH									0
VERMONT									0
VIRGINA									0
WASHINGTON									0
WEST VIRGINA	x			x			x		3
WISCONSIN							x	x	2
WYOMING									0

Map 3: **States fulfilling all six workforce development variables**



the main content areas of health, mental health, and unintentional injury and violence. In sum, 19 states fulfilled all six variables related to workforce development, meaning those states offered teacher training in the area of health, mental health and violence and injury prevention and certification requirements for in-school service providers.

Promoting Adolescent Health and Well-being through Positive Youth Development

States are mixed in their efforts to promote positive youth development. Fewer than half of states required students to remain in school until age 18, but there is a growing movement at the state level to systematize and better track graduation rates. All states provided some degree of funding to afterschool programs tailored to adolescents, but there was little complementary effort to evaluate the quality of these programs, and even fewer states provided support for mentoring initiatives. More states should fund and encourage the replication of validated mentoring initiatives and afterschool programs, the development of new programs, and the continued evaluation into the effectiveness of both new and existing programs.

As with health insurance coverage, there was more support for providing further educational opportunities to former foster youth than to immigrants, in this case, undocumented. The overwhelming majority of states were taking advantage of available federal funding to help foster youth seek post-secondary education, and nearly 75 percent of states supported foster youth by allowing them to retain state guardianship through the age of 21, thus easing their transition to independent living. States' promising support for foster youth may be due in part to the federal government's leadership on these issues. A lesser 60 percent of states provided transition supports to youth leaving state custody by way of the juvenile justice system.

Promoting Adolescent Health and Well-being through Law and Legislation

A quick glance at the minor consent law data can give an overly inclusive impression that does not necessarily match reality. In the vast majority of states, *it is possible* that adolescents can consent to the reproductive and sexual health services we tracked, with the exception of abortion. However, for most variables, as many as 40 percent of states did not explicitly specify whether minors could consent, leaving the decision at the discretion of service providers. Because of federal funding

Table 3: **Required graduated licensing system components, by state**

STATE	Learner's entry at 16+	Six+ month learner's holding period	Practice driving 30+ hours	Night driving restricted at 9 or 10 pm	Underage passenger limit at 1 or 2	Restrictions last until age 18	Total
ALABAMA		x	x		x		3
ALASKA		x	x		x		3
ARIZONA		x	x		x		3
ARKANSAS		x			x	x	3
CALIFORNIA		x	x		x		3
COLORADO		x	x		x		3
CONNECTICUT	x	x	x		x		4
DELAWARE	x	x	x	x	x		5
DISTRICT OF COLUMBIA	x	x	x		x	x	5
FLORIDA		x	x				2
GEORGIA		x	x		x	x	4
HAWAII		x	x		x		3
IDAHO		x	x	x	x		4
ILLINOIS		x	x		x		3
INDIANA		x	x		x		3
IOWA		x					1
KANSAS		x	x	x	x		4
KENTUCKY	x	x	x		x		4
LOUISIANA		x	x				2
MAINE		x	x		x		3
MARYLAND		x	x		x		3
MASSACHUSETTS	x	x	x		x		4
MICHIGAN		x	x				2
MINNESOTA		x	x		x		3
MISSISSIPPI		x					1
MISSOURI		x	x		x		3
MONTANA		x	x		x		3
NEBRASKA		x	x		x		3
NEVADA		x	x	x	x		4
NEW HAMPSHIRE			x		x		2
NEW JERSEY	x	x			x	x	4
NEW MEXICO		x	x		x		3
NEW YORK	x	x	x	x	x	x	6
NORTH CAROLINA		x		x	x		3
NORTH DAKOTA		x					1
OHIO		x	x		x		3
OKLAHOMA		x	x	x	x		4
OREGON		x	x		x		3
PENNSYLVANIA	x	x	x				3
RHODE ISLAND	x	x	x		x		4
SOUTH CAROLINA		x	x	x	x		4
SOUTH DAKOTA		x		x			2
TENNESSEE		x	x		x		3
TEXAS		x			x		2
UTAH		x	x		x		3
VERMONT		x	x		x		3
VIRGINA		x	x		x	x	4
WASHINGTON		x	x		x		3
WEST VIRGINA		x	x	x	x		4
WISCONSIN		x	x		x		3
WYOMING			x		x		2

stipulations and the constitutional right to privacy, many providers could well interpret the lack of state-level direction as fundamentally permissive. We could not account for how the lack of clarity around consent laws was actually practiced on the ground, so in these cases, states with no explicit policy appeared to permit consent.

However, permitting consent did not always translate into confidentiality, another important aspect of adolescent care, and a preference toward confidentiality did not always translate into absolute confidentiality. Many states that appeared to protect confidentiality would allow providers to notify parents in certain circumstances, based on the provider's judgment. Wherever possible, we noted which states may allow physicians to notify parents. Because of the difficulty disentangling all of these issues, we did not include a unique confidentiality policy variable. Further, individual case-specific stipulations in the legal language often clouded the answer.

With regard to mental health services, most states allowed minors to consent to care for alcohol or substance use problems, but less than half allowed minors to consent to outpatient mental health services. Again, case-specific stipulations often clouded the answer. Ultimately, states' lack of clarity with regard to many of the consent laws and confidentiality rights could well pose barriers to adolescents' seeking or receiving care, particularly around sensitive issues.

Violence and injury legislation exists in different stages across the nation. Overall, there was clear national consensus concerning the efficacy of graduated driver licensing (GDL) systems in reducing motor vehicle accidents. Although only three states fulfilled all of the selected variables related to motor vehicle safety, every state had some form of GDL system in place. There was less agreement about which individual components of GDL are necessary to include. Interpersonal violence laws, particularly around sensitive or emerging issues – such as filing protection orders for or against minors, bullying protection for sexual minority youth, and cyberstalking – appear to be in their naissance. Few states met the standards we stipulated for adequate protection laws. Only Washington fulfilled all eight of the variables related to interpersonal violence, but there is evidence that state-level attention and support for this type of legislation is on the rise.

Recommendations

Looking at the overall national picture, states were weakest in supporting adolescent health and well-being in the following areas:

- health services provision in school settings and SBHC coverage through Medicaid and CHIP;
- mental health services and supports in school settings;
- consent and confidentiality rights for both reproductive and mental health services;
- emerging topics, such as bullying, cyberstalking, interpersonal violence, and obesity prevention; and
- socially divisive topics, such as abortion and services and supports provided to juvenile justice-involved youth and undocumented immigrants.

Each of these areas presents opportunities for states to fine-tune their existing policies, evaluating their efficacy and scale of implementation, and to establish new policies that are informed by adolescent health research. Based on the latest research in the field and in consultation with a panel of adolescent health experts and state coordinators, we identified steps states can take to better support adolescents' healthy development.

- Expand public health insurance coverage to reach more youth in need of care, regardless of living situation, such as immigration status or living in state custody.
- Push schools to adopt evidence-based health promotion curricula and programs across all content areas that promote adolescent well-being.
- Mandate a coordinated school health approach, incorporating student health and mental health into the mission of schools and integrating analyses of student health, health promotion, and health services into the No Child Left Behind school improvement plans, where applicable.
- Invest in SBHCs and support the replication of other best practices shown to improve academic and health outcomes, such as high quality after-school programs for youth.
- Explicitly extend consent and confidentiality rights to adolescents, especially around sensitive topics such as reproductive health and mental health.

- Strengthen laws to empower adolescents to protect themselves from violence and abuse, with particular attention to the most vulnerable youth, such as, but not limited to, protection order access and bullying and cyberstalking legislation.
- Encourage potentially cost-saving collaborations with the private sector to expand growth opportunities for all youth, such as, but not limited to, internships and mentoring programs.
- Invest in programs that enable adolescents, and especially vulnerable youth, to successfully transition to independent adulthood, such as, but not limited to, independent living skills training and other aftercare services, including education services, vocational training, and counseling.

Challenges and Limitations

The adolescent state profiles were modeled after the Improving the Odds for Young Children profiles, which follow an access and quality dichotomy. The existing format for both conceptualizing and presenting the state policies necessitated that we limit our scope to policies that directly address the improvement of access or improvement of quality of services and supports to adolescents. To this end, any promising state policy or initiative geared toward improving the lives of adolescents was necessarily excluded if the policy could not fit into the access and quality rubric.

Second and perhaps more significantly, we were only able to include variables for which there exist comparable policies in all or most of the states and for which there was a relatively recent and reliable data source. The policy variables included here were only as precise and meaningful as the sources available. We used the most recent reliable data source we could find, but in many cases, the source was already several years old. The fluidity of the policy context dictates that we are constantly trying to capture a moving target, so to some extent, the data listed here were immediately outdated. Similarly, many salient policies we would have liked to highlight were ultimately excluded due to their relative uniqueness or otherwise incomparable nature; the unavailability of reliable published data for any, most, or all of the states; or the difficulty of locating an individual at the state level who could provide an answer. For example, we dropped a number of variables pertaining to services covered by public health insurance, services provided to youth transitioning from state custody, and required mental health training for teachers due to lack of data or lack of consistent knowledge at the state agency level.

The template's structure did not allow for nuance, which placed limits on the validity of the tool itself, to some extent. The binary nature of the checklist format necessitated a simple "yes" or "no" answer. However, for some of the policy variables, particularly those concerning consent laws, the yes or no was perhaps less meaningful than the details in the legal language itself – the "yes, but"/"no, but" cases. Wherever possible and applicable, we attached endnotes to provide further detail where the more complete answer may have been too complex to be conveyed with a simple yes or no.

Similarly, the yes/no format meant that we were unable to highlight states where policies may have addressed the basic spirit or intent of the issue but did not explicitly meet the standards we used, based on the specific wording of the variable. The way the data are presented, all states that did not meet the specified threshold appeared the same, whether the state had a policy that came close or the state did not have any similar policy on the books. Likewise, the format and scope of the profiles allowed great breadth in terms of type of policies included but prevented deeper analysis, such as assessment of any variation in how and to what degree given policies are implemented, enforced, or funded, all of which could contribute to a richer and more accurate picture of the policy landscape in practice.

Future Directions

The creation of the state profiles is a beginning. Future research can aim to enhance precision, depth, and scope of understanding. Establishing a baseline inventory of policies lends itself to regular scans for newer and more accurate sources, policy changes, and other relevant developments.

Future work could include identifying and collecting data that allow for greater precision in evaluating state efforts to integrate health directly into the mission of schools. For example, with regard to school-based efforts to prevent obesity, future work could take a closer look at school

food nutritional standards and practices; training requirements for school nutrition directors; and physical education standards, time requirements, and curricula. In addition, future iterations of the state profiles can expand existing content areas such as tobacco-related policies or protections for sexual minority youth, and add new content areas, such as policies that address environmental health concerns or policies aimed at extending high quality health and mental health services to homeless and runaway youth or others not connected to any formal system. In sum, using the existing profiles as a starting point, future research can add detail and enhance the level of precision on each of the variables, mitigating or even directly addressing many of the limitations of the current iteration, and ultimately improving all stakeholders' ability to support the health and well-being of America's adolescents.

Endnotes

1. For the purposes of this paper, we considered the District of Columbia to be a "state," and calculated totals based on a denominator of 51 states.

2. States vary, but much of the legislation banning texting while driving exclusively targets adolescent drivers, despite evidence showing that texting while driving significantly increases crash risk for all drivers.

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49. Fisher, J., Fisher, W. A., Bryan, A. D., & Misovich, S. J. (2002). Information-motivation-behavioral skills model-based HIV risk behavior change intervention for inner-city high school youth. *Health Psychology, 21,* 177-186.

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51. Among the states that did not have such a requirement, Colorado and Maine indicated that this policy was in place as of Oct. 2010.

52. Among the states that did not have such a requirement, Colorado and Maine indicated that this policy was in place as of Oct. 2010.

53. Schwarz, S. W., & Peterson, J. (2010). *Adolescent obesity in the United States: Facts for policymakers*. New York: National Center for Children in Poverty, Columbia University.

54. *White House Task Force on Childhood Obesity. (2010). Report to the President: Solving the problem of childhood obesity within a generation.* Washington, DC: Executive Office of the President of the United States. Retrieved from http://www.letsmove.gov/white-house-task-force-childhood-obesity-report-president.

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57. Tremblay, M. S., Inman, J. W., & Willms, J. D. (2000). The relationship between physical activity, self-esteem, and academic achievement in 12-year-old children. *Pediatric Exercise Science, 12,* 312-323.

58. Among the states that did not require physical education and fitness, Louisiana, Oregon, and Maine indicated that they did have such a requirement, as of Oct. 2010. Also at that time, among the states that did not have specified time requirements, six states – Louisiana, Ohio, Oklahoma, Oregon, Texas, and Virginia – indicated that they did have such requirements.

59. Among the states that did not, Colorado, Indiana, Minnesota, Ohio, Oklahoma, Rhode Island, and Virginia indicated that this policy is in place as of Oct. 2010. Among the states that did, North Dakota indicated that this policy was not in place, as of Dec. 2010.

60. Among the states that did not require or recommend, Colorado, Indiana, Minnesota, Oklahoma, and Rhode Island indicated that this requirement was in place as of Oct. 2010. Among the states that did, North Dakota and Oregon indicated that this requirement was no longer in place, as of Dec. and Oct. 2010, respectively.

61. Among those states that did not have such standards, Indiana, Minnesota, Rhode Island, Texas, and Virginia indicated that these standards were in place as of Oct. 2010.

62. American Academy of Pediatrics. (2008). Recommendations for Preventive Pediatric Health Care (Periodicity Schedule). Retrieved March 2011, from http://practice.aap.org/content.aspx?aid=1599.

63. Walker, S. C., Kerns, S. E. U., Lyon, A. R., Bruns, E. J., & Cosgrove, T. J. (2010). Impact of school-based health center use on academic outcomes. *Journal of Adolescent Health*, 46, 251-257.

64. Rhode Island later indicated that its SBHCs were funded through community service grants as opposed to specific dedicated funding.

65. Among the states that did not have such an office, Texas indicated that it did, as of Oct. 2010. Among the states that did, Maine indicated that it did not, as of Oct. 2010.

66. Among the states that did not recognize SBHCs as a participating provider for Medicaid, Michigan, Minnesota, and Utah indicated that they did, as of Oct. 2010. Among the states that did, Colorado indicated that there are no codes specifically designed for SBHCs, but that the physicians who work there may bill under their codes, also as of Oct. 2010.

67. Among the states that did not recognize SBHCs as a participating provider for CHIP, Minnesota indicated that they did, as of Oct. 2010.

68. Among the states that did require services, Colorado and Oregon indicated that this policy was not in place, as of Oct. 2010.

69. Ahmed, N., Flisher, A. J., Mathews, C., Jansen, S., Mukoma, W., & Schaalma, H. (2006). Process evaluation of the teacher training for an AIDS prevention programme. *Health Education Research, 21,* 621-632.

70. Among the states that did not have such a requirement, Oregon indicated that this requirement was in place as of Oct. 2010.

71. Among the states that did not allow minors to consent, Maine indicated that they may, as of Oct. 2010. Among the states that did allow consent, Indiana, Rhode Island, and Utah indicated that minors may not consent, as of Oct. 2010.

72. Thomas, R. E. & Perera, R. (2006). School-based programmes for preventing smoking. *Cochrane Database of Systematic Reviews, 3*. Retrieved from http://www2.cochrane.org/reviews/en/ab001293.html.

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73. Greenberg, M. T., Weissberg, R. P., O'Brien, M. U., Zins, J. E., Fredericks, L., Resnik, H., & Elias, M. J. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist, 58,* 466-474.

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74. Among the states that did not have such a requirement, Colorado indicated that this policy was in place as of Oct. 2010. Among the states that did have such a requirement, Oklahoma indicated that this policy was not in place as of Oct. 2010.

75. Among the states that did not have such a policy or for which no data were available, Colorado, Michigan, and Virginia indicated that they did have such a policy in place, as of Oct. 2010.

76. Glied, S., & Cuellar, A. E. (2003). Trends and issues in child and adolescent mental health. *Health Affairs, 22,* 39-50.

77. Cooper, J., Aratani, Y., Masi, R., Banghart, P., Dababnah, S., Douglas-Hall, A., & Stagman, S. (2010). *Unclaimed children revisited: California case study*. New York: National Center for Children in Poverty, Columbia University.

78. Among the states that did not have a requirement, Rhode Island and Virginia indicated that they did, as of Oct. 2010. Among the states that did have a requirement, Colorado and Oregon indicated that this policy was not in place, as of Oct. 2010.

79. Mortality Reports Database. (2011). Web-based Injury Statistics Query and Reporting System (WISQARS), Centers for Disease Control and Prevention. Retrieved Mar. 2011, from http://www.cdc.gov/ncipc/wisqars.

National Adolescent Health Information Center. (2006). *Fact sheet on suicide: Adolescents & young adults*. San Francisco, CA: University of California, San Francisco. Retrieved Mar. 2009, from http://www.nahic.ucsf.edu/downloads/Suicide.pdf.

80. Among the states that did not have a requirement, Rhode Island and Virginia indicated that they did, as of Oct. 2010. Among the states that did have a requirement, Colorado and Oregon indicated that this requirement was not in place, as of Oct. 2010.

81. Kubiak, S. P., & Arfken, C. L. (2008). Comparing credentialing requirements of substance abuse treatment staff by funding source. *Journal of Substance Abuse Treatment, 35,* 93-98.

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82. In Oct. 2010, Louisiana indicated that it also had such requirements.

83. Among the 46 states that did have a requirement, Oklahoma indicated that this requirement was not in place, as of Oct. 2010.

84. Among the states that did not provide funding or staff development, Texas indicated that it did, as of Oct. 2010. Among the states that did provide funding or staff development, Oklahoma, Oregon, and Rhode Island indicated that they did not, as of Oct. 2010.

85. Koocher, G. P. (2008). Ethical challenges in mental health services to children and families. *Journal of Clinical Psychology*, *64,* 601-612.

86. Harbour, A. (2004). Understanding children and young people's rights to confidentiality. *Child and Adolescent Mental Health, 9,* 187-190.

87. In Oct. 2010, Rhode Island indicated that it did allow minors to consent.

88. Macgowan, M. J. (1997). An evaluation of a dating violence prevention program for middle school students. *Violence and Victims, 12,* 223-235.

89.Botvin, G., Griffin, K., & Nichols, T. (2006). Preventing youth violence and delinquency through a universal school-based prevention approach. *Prevention Science*, 7, 403-408.

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90. Among the states that did fund or offer staff development, Oklahoma and North Dakota indicated that they no longer do so, as of Oct. and Dec. 2010 respectively.

91. Chen, L., Baker, S. P., & Li, G. (2006). Graduated driver licensing programs and fatal crashes of 16-year-old drivers: A national evaluation. *Pediatrics, 118,* 56-62.

Shope, J. T., & Molnar, L. J. (2003). Graduated driver licensing in the United States: Evaluation results from the early Programs. *Journal of Safety Research, 34,* 63-69.

92. In Oct. 2010, North Dakota indicated that no graduated licensing system was in place, but it does require a holding period of at least six months for learner's licenses or permits.

93. Chen, L., Baker, S. P., & Li, G. (2006). Graduated driver licensing programs and fatal crashes of 16-year-old drivers: A national evaluation. *Pediatrics, 118,* 56-62.

Morrisey, M. A., Grabowski, D. C., Dee, T. S., & Campbell, C. (2006). The strength of graduated drivers license programs and fatalities among teen drivers and passengers. *Accident Analysis and Prevention, 38,* 135-141.

94. Chen, L., Baker, S. P., Braver, E. R., & Li, G. (2000). Carrying passengers as a risk factor for crashes fatal to 16- and 17-year-old drivers. *Journal of the American Medical Association, 283,* 1578-1582.

95. Morrisey, M. A., Grabowski, D. C., Dee, T. S., & Campbell, C. (2006). The strength of graduated drivers license programs and fatalities among teen drivers and passengers. *Accident Analysis and Prevention, 38,* 135-141.

96. Williams, A. F., & Preusser, D. F. (1997). Night driving restrictions for youthful drivers: A literature review and commentary. *Journal of Public Health Policy, 18,* 334-345.

97. Among the states that did not, Oklahoma indicated that they did set minimum age of 16, as of Oct. 2010. If the driver was enrolled in or had completed driver education, the minimum was 15½.

98. Among the states that did not maintain graduated driver licensing restrictions until age 18, Rhode Island indicated that it now did, as of Oct. 2010.

99. Foss, R. D., Goodwin, A. H., McCartt, A. T., & Hellinga, L. A. (2009). Short-term effects of a teenage driver cell phone restriction. *Accident Analysis and Prevention, 41,* 419-424.

100. Among the states that did not allow protection orders against minors, South Carolina and North Dakota indicated that they did allow, as of Oct. and Dec. 2010, respectively.

101. Among the states that did not have such legislation, Louisiana, Oklahoma, and Rhode Island indicated that they did, as of Oct. 2010. Among the states that did have such legislation, Colorado and Minnesota indicated that legislation that explicitly addresses sexual orientation or gender identity is not in place, as of Oct. 2010.

102. In Oct. 2010, Colorado indicated that it also allowed minors to petition. In Dec., 2010, North Dakota indicated that it also allowed minors to petition, with a parent or guardian.

103. Goodno, N. H. (2006). Cyberstalking, a new crime: Evaluating the effectiveness of current state and federal laws. Berkeley Electronic Press Legal Series, Paper 1689. Retrieved Jun. 2010, from http://Law.bepress.com/cgi/viewcontent.cgi?article=7936&context=expresso.

104. A 2011 scan of state laws suggests that Florida, Illinois, Louisiana, Maine, Minnesota, Nevada, New Mexico, Utah, and Wyoming may now have adequate statutes in place.

105. Beatty, A., & Chalk, R. (2007). *A study of interactions: Emerging issues in the science of adolescence (p. 30)*. National Research Council and Institute of Medicine. Washington, DC: The National Academies Press.

106. Freudenberg, N., & Ruglis, J. (2007). Reframing school dropout as a public health issue. *Preventing Chronic Disease: Public Health Research, Practice, and Policy, 4*(4), A107.

107. Cutler, D. M., & Lleras-Muney, A. (2006). Education and health: Evaluating theories and evidence (NBER Working Paper W12352). Cambridge, MA: National Bureau of Economic Research.

108. Bridgeland, J. M., DiIulio, J. J., Jr., & Streeter, R. (2007). *Raising the compulsory school attendance age: The case for reform*. Washington DC: Civic Enterprises.

109. Angrist, J. D., & Krueger, A. B. (1991). Does compulsory school attendance affect schooling and earnings?

The Quarterly Journal of Economics, CVI (4), 979-1014. Retrieved Feb. 2011, from www.jstor.org/stable/pdfplus/2937954.pdf?acceptTC=true.

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Zill, N. (1996). Parental schooling & children's health. *Public Health Report, 111,* 34-43.

111. While we made every effort to limit data collected to afterschool programs specifically for adolescents, the possibility exists that certain state sources may have conflated afterschool programs for different age groups in their responses.

112. In Oct. 2010, Oregon indicated that it did not provide funding for afterschool programs or evaluation.

113. Durlak, J. A., & Weissberg, R. P. (2007). *The impact of after-school programs that promote personal and social skills.* Chicago, IL: Collaborative for Academic, Social, and Emotional Learning.

114. Blum, R. W., & Libbey, H. (Eds.). (2004). School connectedness – Strengthening health and education outcomes for teenagers. *Journal of School Health, 74,* 229-299.

115. Courtney, M., & Heuring, D. H. (2005). The transition to adulthood for youth "aging out" of the foster care system. In D. W. Osgood, E. M. Foster, C. Flanagan & G. R. Ruth (Eds.), *On your own without a net: The transition to adulthood for vulnerable populations* (pp. 27-67). Chicago: University of Chicago Press.

116. Osgood, D. W., Foster, E. M., & Courtney, M. E. (2010). Vulnerable populations and the transition to adulthood. *The Future of Children, 20*(1), 209-229.

117. Among the states that did not provide waivers, Ohio and Rhode Island indicated that they did, as of Oct. 2010. Among the states that did provide waivers, South Carolina indicated that they did not, as of Oct. 2010.

118. Hoefer, M., Rytina, N., & Baker, B. C. (2010). Estimates of the unauthorized immigrant population residing in the

United States: Jan. 2009. *Population Estimates*. Department of Homeland Security. Retrieved Mar. 2011, from http://www.dhs.gov/xlibrary/assets/statistics/publications/ois_ill_pe_2009.pdf.

119. Pew Hispanic Center. (2011). *Unauthorized Immigrants in the U. S*. Retrieved Mar. 2011, from http://pewhispanic.org/unauthorized-immigration.

120. In Oct. 2010, Oklahoma reported that it did not allow undocumented immigrants to receive in-state tuition.

121. Zalesky, Ashley. (2008). In-state tuition for undocumented immigrants. Denver: Education Commission of the States. Retrieved Aug. 2010, from http://www.ecs.org/clearinghouse/75/53/7553.pdf.

122. Gottesman, D., & Schwarz, S. W. In Press. *Juvenile justice in the United States: Facts for policymakers*. New York: National Center for Children in Poverty, Columbia University.

123. In Oct. 2010, Rhode Island indicated that it also provided aftercare services.

124. In Oct. 2010, Oklahoma also indicated that it did not.

125. In Oct. 2010, Ohio indicated that it did not allow youth to stay through age 21.

126. Beatty, A., & Chalk, R. (2007). *A study of interactions: Emerging issues in the science of adolescence.* National Research Council and Institute of Medicine. Washington, DC: The National Academies Press.

127. Scales, P. C., Benson, P. L., & Mannes, M. (2006). The contribution to adolescent well-being made by non-family adults: An examination of developmental assets as contexts and processes. *Journal of Community Psychology, 34,* 401-413.

128. Mitra, D. L. (2004). The significance of students: Can increasing "student voice" in schools lead to gains in youth development? *Teachers College Record, 106,* 651-688.

129. Among the states that did not have such a council, Oklahoma indicated that it did, as of Oct. 2010. Among the states that did have a council, South Carolina indicated that it did not, as of Oct. 2010.

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