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Beyond the Bedside: A Human Rights Approach to Adolescent Health

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BEYOND THE BEDSIDE: A HUMAN RIGHTS APPROACH TO ADOLESCENT HEALTH

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INTRODUCTION

In the United States, debates and dialogues on adolescent health, particularly in the political and legal arenas, frequently focus on one of two issues: abortion and medical decision making. As Martha Minow explains, adults often "invoke children to wage their own battles with one another" on issues such as abortion and teenage pregnancy.[1] Family planning and treatment decisions are important issues that merit considered attention, but there is much more to adolescent health. A number of other issues—ranging from violence to substance use to obesity—have a significant impact on the health and well-being of adolescents.

Adolescents today confront a world with increasing challenges. Health care is a necessary component of well-being, and ensuring adolescents have access to health care and a voice in medical treatment decisions consistent with their maturity is vital. However, much of the adolescent experience that implicates health status takes place beyond health care facilities. Adolescents' daily experience is filled with issues and events that have potentially significant health implications. This symposium Essay aims to shed light on the breadth of health issues confronting adolescents and explore the utility of human rights law in understanding and responding to key health issues confronting adolescents today.

Employing a human rights framework, this Essay seeks to forge a more holistic understanding of and approach to adolescent health. If the goal of law and policy on adolescent health is to ensure children's health so that they can realize their full potential and become productive members of their communities, then policy makers, child advocates, health care professionals, and other essential stakeholders must address more comprehensively the full range of issues that influence adolescent health.

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[1] Martha Minow, *Children's Rights: Where We've Been, and Where We're Going*, 68 TEMP. L. REV. 1573, 1583 (1995); *see also* MARTIN GUGGENHEIM, WHAT'S WRONG WITH CHILDREN'S RIGHTS 243–44 (2005) (suggesting that adolescent abortion cases are less about children's rights and more a disagreement among adults over unwanted teenage pregnancy).

Focusing on three such current concerns—violence, substance use, and obesity—Part I of this Essay explores the scale and impact of these issues in the lives of adolescents. In doing so, Part I reveals the consequences of a broad range of issues for adolescent health and demonstrates the need to go beyond political debates on contentious issues to achieve meaningful progress in developing law, policy, and programs that encompass all adolescent health concerns. Part II then briefly addresses the limits of a medical model and related concerns with over-relying on the health care sector to address all adolescent health issues. Access to health care is crucial, but addressing the full range of adolescent health issues will require law, policies, and programs that contemplate adolescent well-being beyond health care facilities. In Part III, this Essay discusses the value of using human rights law as a starting point for developing a comprehensive response to adolescent health issues. Human rights law can facilitate identification of the breadth of issues affecting adolescents while simultaneously providing a legal framework for developing appropriate responses to the various harms that adolescents experience.

I. CURRENT ADOLESCENT HEALTH ISSUES

Numerous issues affect adolescent health today, including: violence, motor-vehicle injuries, other unintentional injuries, mental health issues, substance use, sexual risk behavior, nutrition, and obesity.[2] This Essay selects three key health

[2] The Centers for Disease Control and Prevention includes the following health topics in the Adolescent Health section of its website: alcohol and other drugs; asthma; crisis preparedness and response; food allergies; food safety; health disparities; infectious diseases, injury, and violence; mental health; noise-induced hearing loss; nutrition, physical activity, and obesity; sexual risk behavior: HIV, STDs, teen pregnancy prevention; skin cancer; and tobacco use. *Adolescent and School Health*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/healthyyouth/healthtopics/index.htm (last updated Mar. 1, 2011); *see also Child and Adolescent Health and Development: Which Health Problems Affect Adolescents and What Can Be Done to Prevent and Respond to Them?*, WORLD HEALTH ORG., http://www.who.int/child_adolescent_health/topics/prevention_care/adolescent/dev/en/index.html (last visited Nov. 1, 2011) (listing mental health,

topics—violence, substance use, and obesity—as they are indicative of the breadth of issues that affect adolescent well-being.[3]

A. Violence

Violence is a prominent issue in the lives of millions of adolescents.[4] Adolescents are exposed to a variety of forms of

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substance abuse, violence, unintentional injuries (including motor vehicle injuries), nutrition, sexual and reproductive health, and HIV as key adolescent health issues).

[3] In examining adolescent health, one encounters a threshold challenge—much of the research on children does not adequately disaggregate data on adolescents. In many studies, adolescents are grouped either with other children in statistics on individuals under eighteen years of age, or with young adults in research on ten- to twenty-four-year-olds, or sometimes fifteen- to twenty-four- year-olds. Even with the constraints created by the lack of disaggregated data, selecting and exploring three representative issues helps foster a better understanding of the range of issues that impact adolescent well-being.

[4] I use the term "violence" as used in the landmark *U.N. Study on Violence Against Children*. The U.N. Study states that the "definition of violence is that of article 19 of the Convention [on the Rights of the Child]: 'all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.'" U.N. Secretary-General, *Rep. of the Independent Expert for the United Nations Study on Violence Against Children*, *delivered to the General Assembly*, ¶ 8, U.N. Doc. A/61/299 (Aug. 29, 2006) (by Paulo Sérgio Pinheiro) [hereinafter *U.N. Study on Violence Against Children*]. The *U.N. Study on Violence Against Children* noted that it also relied upon:

> the definition in the *World Report on Violence and Health* (2002): the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, that either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity.

Id. In other words, "violence" encompasses acts of commission (e.g., physical and emotional abuse and exploitation) and acts of omission (e.g., neglect), whether committed by a parent, caregiver, peer, or other adult in the community. *See generally* WORLD HEALTH ORG. [WHO], WORLD REPORT ON VIOLENCE AND HEALTH (Etienne G. Krug et al. eds., 2002) (Switz.), *available at* http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf (including in its definition of violence topics such as child abuse and neglect, youth violence, and sexual abuse); *Violence Prevention*,

violence, in various contexts and settings, and from multiple sources. Adolescents are victims of direct forms of violence ranging from child maltreatment, to commercial sexual exploitation, to gun violence. They also witness violence in the home and in their communities and society, which affects their psycho-social well-being and development.[5] Violence is inflicted on adolescents by both adults and peers.

In the United States, the majority of urban adolescents have witnessed or been victims of violent behavior (and more than eighty percent of U.S. children live in urban areas).[6] The costs to the adolescents themselves, their communities, and the nation are significant. Such costs include the direct costs of medical care, social services, and legal services needed to address the harm to children, as well as the indirect costs associated with long-term injury or disability, lasting psychological trauma, disruption in or premature ending to schooling, and productivity losses over the lifetime of those children adversely affected by violence.[7] The economic costs of child abuse alone in the United States are estimated at more than $100 billion annually.[8]

CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/violenceprevention/ (last updated Oct. 20, 2011) (noting that violence prevention includes addressing child maltreatment, sexual violence, youth violence, school violence, and other issues).

[5] *See* Mary Schwab-Stone et al., *No Safe Haven II: The Effects of Violence Exposure on Urban Youth*, 38 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 359, 365 (1999).

[6] *Id.*; *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS., CHILD HEALTH USA 2010 (2010), *available at* http://www.mchb.hrsa.gov/chusa10/popchar/pages/105ruc.html (reporting that in 2007, more than eighty-one percent of U.S. children lived in urban areas); Renée Boynton-Jarrett et al., *Cumulative Violence Exposure and Self-Rated Health: Longitudinal Study of Adolescents in the United States*, 122 PEDIATRICS 961, 967 (2008), *available at* http://pediatrics.aappublications.org/content/122/5/961.full ("[W]itnessing gun violence, threat of violence, feeling unsafe, repeated bullying, and criminal victimization each independently and significantly increased risk for poor [health].").

[7] *See* U.N. Comm. on the Rights of the Child, General Comment No. 13: The Right of the Child to Freedom from All Forms of Violence, ¶ 16, U.N. Doc. CRC/C/GC/13 (Apr. 18, 2011) [hereinafter CRC General Comment No. 13].

[8] *See* CHING-TUNG WANG & JOHN HOLTON, PREVENT CHILD ABUSE

Moreover, cost calculations still fail to fully capture the human suffering.

Adults—both family members and strangers—subject adolescents to various forms of violence. Overall, research suggests that one in every five children in the United States suffers some form of maltreatment.[9] Violence in the home remains a common occurrence in the United States, with recent research identifying approximately three million children who were abused or neglected by parents or guardians in the year studied.[10] The majority of these children suffered neglect, although approximately 476,600 suffered physical abuse and another 302,600 experienced emotional abuse.[11] Sexual abuse in the home remains a disturbingly common harm inflicted on children, with twenty-two percent of physically abused children having suffered sexual abuse.[12]

AM., TOTAL ESTIMATED COST OF CHILD ABUSE IN THE UNITED STATES: ECONOMIC IMPACT STUDY (2007), *available at* http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf (reporting the results of their Pew Charitable Trust funded research showing a cost of $103.8 billion for child abuse and neglect in 2007 alone); *see also* Philip J. Cook & Jens Ludwig, *The Costs of Gun Violence Against Children*, FUTURE CHILD., Summer-Autumn 2002, at 87, 97 (estimating the annual cost of gun violence against youth at $15 billion or more).

[9] CTRS. FOR DISEASE CONTROL & PREVENTION, CHILD MALTREATMENT: FACTS AT A GLANCE 2010 (2010), *available at* http://www.cdc.gov/violenceprevention/pdf/CM-DataSheet-a.pdf.

[10] U.S. DEP'T OF HEALTH & HUMAN SERVS., FOURTH NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT (NIS-4) 3–15 (2010) [hereinafter NIS-4], *available at* http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/reports/natl_incid/nis4_report_congress_full_pdf_jan2010.pdf. The NIS-4 utilizes two standards to measure child abuse and neglect. The "Harm Standard" is "relatively stringent in that it generally requires that an act or omission result in demonstrable harm in order to be classified as abuse or neglect." *Id.* at 3. The "Endangerment Standard" includes all the Harm Standard children and also includes children who were not yet harmed by maltreatment, but who experienced abuse or neglect that placed them in danger of being harmed. *Id.* Using the Endangerment standard, the NIS-4 estimate for 2005-2006 found that 2,905,800 children suffered maltreatment. *Id.* at 6. Of course, it is likely that many cases of abuse and neglect go unreported or undiagnosed, so that the actual figures might well be higher than reported data.

[11] *Id.* at 6–7.

[12] *Id.* at 7.

Even though the youngest children are the most frequent victims of family violence, nearly one-quarter of child victims are adolescents.[13] Moreover, although adolescents are less likely to be victims,[14] many individuals who were victimized at a young age continue to suffer trauma from early abuse when they reach adolescence and need assistance.[15]

Beyond the home, adolescents and younger children are at risk of violence and exploitation at the hands of other adults. Adolescents are frequent victims of violence in the community, resulting in physical injuries and sometimes death. Homicide is the second leading cause of death among adolescents and young adults.[16] Other forms of violence also affect adolescents—for

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[13] CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH & HUMAN SERVS., CHILD MALTREATMENT 2009, at 22 (2010) [hereinafter 2009 CHILD MALTREATMENT REPORT], *available at* http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf. In another study, twelve percent of girls in grades nine through twelve reported that they had been sexually abused. *See* CATHY SCHOEN ET AL., THE COMMONWEALTH FUND SURVEY OF THE HEALTH OF ADOLESCENT GIRLS 1 (1997), *available at* http://www.commonwealthfund.org/Publications/Fund-Reports/1997/Nov/The-Commonwealth-Fund-Survey-of-the-Health-of-Adolescent-Girls.aspx (select "Fund Report" hyperlink).

[14] *See* 2009 CHILD MALTREATMENT REPORT, *supra* note 13, at 22 ("In general, the rate and percentage of victimization decreased with age.").

[15] Indeed, the trauma of abuse for many child victims lasts well into adulthood. *See, e.g.*, *Reauthorization of the Child Abuse Protection and Treatment Act (CAPTA): Hearing Before the S. Subcomm. on Children & Families of the S. Comm. on Health, Educ., Labor, & Pensions*, 110th Cong. (2008) (statement of Dr. Cheryl Anne Boyce, Chief, Child Abuse and Neglect Program, National Institutes of Health), *available at* http://www.hhs.gov/asl/testify/2008/06/t20080626a.html ("Child abuse and neglect can have a profound impact on children's immediate and long-term mental and physical health."); P.E. Mullen et al., *The Long-Term Impact of the Physical, Emotional, and Sexual Abuse of Children: A Community Study*, 20 CHILD ABUSE & NEGLECT 7 (1996).

[16] *See, e.g.*, CTRS. FOR DISEASE CONTROL & PREVENTION, YOUTH VIOLENCE: FACTS AT A GLANCE 2010, at 1 (2010), *available at* http://www.cdc.gov/violenceprevention/pdf/YV-DataSheet-a.pdf. "In 2009, of a nationally-representative sample of students in grades 9-12, 3.8% reported being in a physical fight one or more times in the previous 12 months that resulted in injuries that had to be treated by a doctor or nurse." *Id*. *See generally* Linda L. Dahlberg, *Youth Violence in the United States: Major Trends, Risk Factors, and Preventive Approaches*, 14 AM. J.

example, an estimated 100,000 to 300,000 youth in the United States are at risk of commercial sexual exploitation.[17]

It is not only adults who subject adolescents to violence. Adolescents suffer harm at the hands of peers, including everything from gun violence to bullying. In recent years, peer violence among youth, including bullying, has garnered more attention from policy makers.[18] Yet bullying and other forms of violence remain significant problems. Approximately twenty percent of youth report having been bullied in school at least once in the year prior to being surveyed.[19] Other research suggests that bullying might affect closer to one-third of adolescents.[20]

PREVENTIVE MED. 259 (1998); Halim Hennes, *A Review of Violence Statistics Among Children and Adolescents in the United States*, 45 PEDIATRIC CLINICS OF N. AM. 269 (1998).

[17] *See* RICHARD ESTES & NEIL ALAN WEINER, THE COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN IN THE U.S., CANADA AND MEXICO 4 (2d prtg. 2002), *available at* http://www.sp2.upenn.edu/restes/CSEC_Files/Complete_CSEC_020220.pdf.

[18] In March 2011, the Obama Administration held a Conference on Bullying Prevention. *See* Press Release, Office of the Press Sec'y, The White House, Background on White House Conference on Bullying Prevention (Mar. 10, 2011), *available at* http://www.whitehouse.gov/the-press-office/2011/03/10/background-white-house-conference-bullying-prevention; *see also U.N. Study on Violence Against Children*, *supra* note 4; Marilyn A. Campbell, *Cyber Bullying: An Old Problem in a New Guise?*, 15 AUSTRALIAN J. GUIDANCE & COUNSELLING 68, 68 (2005) ("Historically, bullying has not been seen as a problem that needed attention, but rather has been accepted as a fundamental and normal part of childhood . . . . In the last two decades, however, this view has changed and schoolyard bullying is now seen as a serious problem that warrants attention."). *See generally* Pernille Due et al., *Bullying Victimization Among 13- to 15-Year-Old School Children: Results from Two Comparative Studies in 66 Countries and Regions*, 20 INT'L J. ADOLESCENT MED. & HEALTH 209 (2008) (reporting on the incidence of bullying in sixty-six countries).

[19] Danice K. Eaton et al., *Youth Risk Behavior Surveillance—United States 2009*, MORBIDITY & MORTALITY WKLY. REP. (SURVEILLANCE SUMMARY 5) 1, 8 (2010), *available at* http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf.

[20] SIMONE ROBERS ET AL., NAT'L CTR. FOR EDUC. STATISTICS, INDICATORS OF SCHOOL CRIME AND SAFETY: 2010, at 42–44 (2010), *available at* http://nces.ed.gov/pubs2011/2011002.pdf (detailing 2007

With advances in technology and the spread of the internet, cyberbullying and online harassment have emerged as growing problems.[21] Research findings suggest that between nine percent and thirty-five percent of children report being victimized by online harassment of some form.[22] Research on cyberbullying and online harassment is still in its early stages, though recent studies indicate that cyberbullying is on the rise and its impact on youth can be very significant.[23] Overall, adolescents aged fourteen to seventeen experience the highest rate of online harassment.[24]

Dating, which should offer caring, supportive relationships

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findings that thirty-two percent of twelve- to eighteen-year-old students reported having been bullied at school during the academic year).

[21] *See* Robert Slonje & Peter K. Smith, *Cyberbullying: Another Main Type of Bullying?*, 49 SCANDINAVIAN J. PSYCHOL. 147, 147 (2008) ("In recent years a new form of aggression or bullying has emerged, labeled 'cyberbullying' . . . .").

[22] MARCI FELDMAN HERTZ & CORINNE DAVID-FERDON, CTRS. FOR DISEASE CONTROL & PREVENTION, ELECTRONIC MEDIA AND YOUTH VIOLENCE: A CDC ISSUE BRIEF FOR EDUCATORS AND CAREGIVERS 5 (2008), *available at* http://www.cdc.gov/violenceprevention/pdf/EA-brief-a.pdf.

[23] Janis Wolak et al., *Does Online Harassment Constitute Bullying? An Exploration of Online-Only Harassment by Known Peers and Online-Only Contacts*, 41 J. ADOLESCENT HEALTH (SUPPLEMENT) S51, S52 (2007) (finding a fifty percent increase between 2000 and 2005 in the incidence of adolescents reporting that they have been victims of electronic aggression rising to the level of bullying—six to nine percent); *see* Campbell, *supra* note 18, at 70–71 ("[R]esearch has shown that verbal and psychological bullying may have more negative long-term effects . . . . In addition, in cyber bullying there is a potential for a much wider audience to be aware of the incident than in schoolyard bullying.").

[24] Cal. Sch. Bds. Ass'n, *Cyberbullying: Policy Considerations for Boards*, POLICY BRIEF, July 2010, at 2, *available at* http://www.csba.org/~/media/AFF96056D6E4454B8B5298DF29EF4D65.ashx; *see also* Data Memorandum re: Cyberbullying and Online Teens from Amanda Lenhart, Senior Research Specialist, to the Pew Internet & Am. Life Project (June 27, 2007), *available at* http://www.pewinternet.org/~/media//Files/Reports/2007/PIP%20Cyberbullying%20Memo.pdf.pdf ("Girls are more likely than boys to say that they have ever experienced cyberbullying . . . . Older girls in particular are more likely to report being bullied than any other age and gender group, with 41% of online girls ages 15 to 17 reporting these experiences.").

to youth during this formative stage of their lives, proves to be another potential source of harm for adolescents; approximately one out of every four adolescents report physical, verbal, emotional, or sexual abuse from a dating partner each year.[25] Violence and rape experienced in the dating context are significantly associated with eating disorders, other risk behaviors, psychological issues, and suicide.[26]

In short, adolescents are at risk of a host of different forms of violence from a variety of sources, in their homes, at school, and in their communities. The impact, if not addressed early, can have life-long consequences. Therefore, policies and programs aimed at ensuring adolescent health and well-being must incorporate consideration of all forms of violence against youth and develop stronger measures to prevent such violence.[27]

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[25] *See* Rita K. Noonan & Dyanna Charles, *Developing Teen Dating Violence Prevention Strategies*, 15 VIOLENCE AGAINST WOMEN 1087, 1087 (2009) ("Nearly one out of every four teens reports some form of abuse—verbal, physical, emotional, or sexual—from a dating partner each year."); *see also* Diann M. Ackard & Dianne Neumark-Sztainer, *Date Violence and Date Rape Among Adolescents: Associations with Disordered Eating Behaviors and Psychological Health*, 26 CHILD ABUSE & NEGLECT 455, 468 (2002) (finding that roughly nine percent of girls and six percent of boys report having experienced some form of date-related violence or abuse); Jay G. Silverman et al., *Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality*, 286 JAMA 572, 574 (2001) (in a survey of female high school students in Massachusetts public schools, finding that approximately one in five female students reported being physically or sexually abused by a dating partner).

[26] Ackard & Nuemark-Sztainer, *supra* note 25, at 457 ("[D]ate violence and rape was associated with increased risk of substance use (4–5 times greater than girls not abused), unhealthy weight control behaviors (3–4 times greater), sexual risk behaviors (2–8 times greater), and suicidality (7–9 times greater).").

[27] Public health professionals have recognized the importance of addressing violence as a health issue. *See, e.g.*, Linda L. Dahlberg & James A. Mercy, *History of Violence as a Public Health Problem*, 11 VIRTUAL MENTOR 167, 167 (2009), *available at* http://virtualmentor.ama-assn.org/2009/02/pdf/mhst1-0902.pdf (detailing the evolution of public health's work on violence prevention).

B. Substance Use

Substance use and abuse have a significant impact on the well-being of adolescents. Youth smoking, alcohol consumption, and drug use all have immediate and long-term health consequences.

Smoking remains a substantial issue among adolescents. Despite widespread recognition of the harms caused by tobacco use, according to the 2009 National Youth Risk Behavior Survey, almost twenty percent of high-school students had smoked cigarettes at least once within the month prior to the study and over forty-six percent reported having tried cigarette smoking at some point.[28]

Alcohol consumption is also a prominent issue in the lives of adolescents.[29] The 2009 National Youth Risk Behavior Survey found that approximately three-fourths of youth have tried alcohol, and forty-two percent of high school students consumed at least one alcoholic drink in the month prior to the survey.[30] It further revealed that almost one-fourth of students had consumed five or more alcoholic drinks in a span of a couple of hours at some point during the month prior to the survey.[31] Binge drinking remains a persistent problem among high school students, with potentially serious consequences: Centers for Disease Control and Prevention (CDC) Director Thomas Frieden explains, "[b]inge drinking increases many health risks, including fatal car crashes, contracting a sexually transmitted

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[28] CTRS. FOR DISEASE CONTROL & PREVENTION, 2009 NATIONAL YOUTH RISK BEHAVIOR SURVEY OVERVIEW 2 (2009), *available at* http://www.cdc.gov/HealthyYouth/yrbs/pdf/us_overview_yrbs.pdf.

[29] *See* Nat'l Inst. on Alcohol Abuse and Alcoholism, Nat'l Insts. of Health, *Underage Drinking: Why Do Adolescents Drink, What Are the Risks, and How Can Underage Drinking Be Prevented?*, ALCOHOL ALERT, Jan. 2006, at 1, *available at* http://www.niaaa.nih.gov/Publications/AlcoholAlerts/Documents/aa68.pdf.

[30] CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 28.

[31] *Id.* at 2; *see also* Jacqueline W. Miller et al., *Binge Drinking and Associated Health Risk Behaviors Among High School Students*, 119 PEDIATRICS 76, 78 (2007) (finding 28.8% of youth engaged in binge drinking). "Binge drinking" is typically defined as the consumption of five or more alcoholic beverages within a timespan of a few hours. *Id.* at 77.

disease, dating violence and drug overdoses."[32] Moreover, research has found that "[h]armful drinking increases the risk of chronic health conditions such as liver disease, heart disease, and cancer" and that "harmful and binge drinking are associated with increased risk of suicide and adverse psychosocial consequences."[33]

Drug use is also prevalent among youth and creates potentially severe health risks.[34] Studies reveal that over twenty percent of students had used marijuana in the thirty days before the survey.[35] Although marijuana is by far the most common illicit drug used by youth, numerous students reported having tried ecstasy, cocaine, methamphetamines, hallucinogenic drugs (e.g., LSD, acid, PCP, angel dust, mescaline, or mushrooms), inhalants (including sniffing glue, breathing the contents of

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[32] Larry Hartstein, *CDC: Binge Drinking Big Problem Among High School Students*, ATLANTA J.-CONST. (Oct. 6, 2010, 9:41 AM), http://www.ajc.com/news/cdc-binge-drinking-big-663396.html; *see also* Eaton et al., *supra* note 19, at 5 (reporting 28.3% in the U.S. had ridden at least once in a vehicle driven by someone who had been drinking alcohol); Miller et al., *supra* note 31, at 79 (reporting research finding binge-drinking adolescents were "more likely to ride with a driver who had been drinking, be currently sexually active, drink or use drugs before last sexual intercourse, to have ever been or gotten someone pregnant, smoke cigarettes or cigars, use smokeless tobacco, be involved in a physical fight, experience dating violence, have forced intercourse, consider or attempt suicide, and use marijuana, cocaine, and inhalants").

[33] Carolyn A. McCarty et al., *Continuity of Binge and Harmful Drinking from Late Adolescence to Early Adulthood*, 114 PEDIATRICS 714, 718 (2004). Binge drinking has also been shown to be associated with decreased probability of graduating from high school on time, which in turn has an adverse impact on job prospects and earnings. *See* Miller et al., *supra* note 31, at 80 ("School performance . . . was inversely associated with the prevalence of binge drinking . . . . [T]he proportion of students with 'mostly A's' who reported binge drinking was 19.7%, whereas the proportion of students with 'mostly D's or F's' who reported binge drinking was 49.3%."); Francesco Renna, *The Economic Cost of Teen Drinking: Late Graduation and Lowered Earnings*, 16 HEALTH ECON. 407 (2007).

[34] On the risks associated with various drugs, see NAT'L INST. ON DRUG ABUSE, NAT'L INSTS. OF HEALTH, COMMONLY ABUSED DRUGS (2010), *available at* http://nida.nih.gov/PDF/CADChart.pdf.

[35] Eaton et al., *supra* note 19, at 14; CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 28, at 2.

aerosol spray cans, or inhaling any paints or sprays in order to get high), and steroids.[36]

Use of prescription drugs, including psychotropic drugs, also presents a growing issue for adolescents. Prescription drugs offer valuable potential health benefits: for example, psychotropic drugs can help adolescents manage a variety of mental health conditions. However, the potential for abuse is significant. Adolescents abuse prescription drugs more than any other drug, except marijuana.[37] "In 2006, more than 2.1 million teens abused prescription drugs" and adolescents comprised one-third of all new abusers of prescription drugs.[38]

Along with the risks of abuse, there are emerging concerns over the frequency with which youth are prescribed psychotropic drugs.[39] Approximately eight to ten percent of children under eighteen years old are taking prescription medication to treat mental health issues.[40] Rates of psychotropic drug use are dramatically higher among children in state custody with reports finding that, "on any given day, up to 50% or more of children in some state foster care systems and juvenile prisons receive psychotropic medications."[41] Though the use of psychotropic

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[36] Eaton et al., *supra* note 19, at 14–17; *see also* CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 28, at 2 (finding that 2.8% of students had used some form of cocaine one or more times during the thirty days before the survey, 4.1% had used methamphetamines, and 3.3% had used steroids (without a doctor's prescription) respectively one or more times during their life).

[37] OFFICE OF NAT'L DRUG CONTROL POLICY, EXEC. OFFICE OF THE PRESIDENT, PRESCRIPTION FOR DANGER: A REPORT ON THE TROUBLING TREND OF PRESCRIPTION AND OVER-THE-COUNTER DRUG ABUSE AMONG THE NATION'S TEENS 1 (2008).

[38] *Id.* at 2.

[39] *See, e.g.*, Angela O. Burton, "*They Use It Like Candy": How the Prescription of Psychotropic Drugs to State-Involved Children Violates International Law*, 35 BROOK. J. INT'L L. 453, 456 (2010); *see also* Leticia M. Diaz, *Regulating the Administration of Mood-Altering Drugs to Juveniles: Are We Legally Drugging Our Children?*, 25 SETON HALL LEGIS. J. 83 (2001) (discussing the concern over prescribing psychotropic drugs to youths and their effects on violent behavior).

[40] Burton, *supra* note 39, at 457.

[41] *Id.*

drugs can facilitate successful interventions, it also raises health and safety concerns with the various side effects of drugs and the potential for misuse.[42] For example, selective serotonin reuptake inhibitors ("SSRIs"), a class of antidepressants commonly prescribed to adolescents to treat symptoms associated with depression and anxiety disorders, have been found to increase the risk of suicidal thoughts and actions.[43] Use of other psychotropic drugs has been associated with increased risk of weight gain and diabetes.[44] For adolescents, who are still physically developing, and whose brains are still developing, the potential harms associated with proper use, as well as misuse, of prescription drugs call for more coordinated responses to minimize, if not eliminate, such harm.

Adolescence is a period of trial and error,[45] and youth typically are confronted with choices regarding tobacco, alcohol, and drugs at various points in their teen years. What might be viewed by some as youthful indiscretion or experimentation, however, can have long lasting adverse health consequences. For example, research indicates that approximately half of those

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[42] *See id*. at 457–58; *see, e.g.*, Alison Barnes, *Prevention Paradigms, Over-Diagnosis and Treatment, and Mad Men*, 12 MARQ. ELDER'S ADVISOR 1, 29–30 (2010) (criticizing the practice of prescribing powerful drugs for relatively minor ailments, using the example of the drug typically prescribed to treat toenail fungus, for which "the usual condition includes yellowed, thickened toenails[,]" noting "contraindications for this powerful drug include liver, heart, or kidney conditions, some of which may be undiagnosed in a patient seeking the treatment. Common side effects include severe stomachache, headache, and pain in the area of the liver.").

[43] Burton, *supra* note 39, at 461–62; *see also* Press Release, U.S. Food & Drug Admin., FDA Proposes New Warnings About Suicidal Thinking, Behavior in Young Adults Who Take Antidepressant Medications (May 2, 2007), *available at* http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2007/ucm108905.htm (warning covered such well-known and commonly prescribed drugs as Cymbalta, Paxil, Prozac, and Zoloft).

[44] John W. Newcomer, *Second-Generation (Atypical) Antipsychotics and Metabolic Effects: A Comprehensive Literature Review*, 19 CNS DRUGS (SUPPLEMENT 1) 1, 1 (2005).

[45] Elizabeth S. Scott & Thomas Grisso, *The Evolution of Adolescence: A Developmental Perspective on Juvenile Justice Reform*, 88 J. CRIM. L. & CRIMINOLOGY 137, 175 (1997); *see also* FRANKLIN E. ZIMRING, THE CHANGING LEGAL WORLD OF ADOLESCENCE 89–96 (1982).

individuals who take up smoking during adolescence will continue smoking for fifteen to twenty years.[46] And more than eighty percent of adult smokers begin smoking before they turn eighteen years old.[47] Similarly, binge drinking among adolescent boys is associated with a greater likelihood of harmful and binge drinking in adulthood.[48] In short, substance use and misuse have both immediate and long-term effects on the health and development of adolescents. These issues, too, must be a central consideration when developing law and policy aimed at achieving adolescent well-being.

C. Obesity

Wellness is important for adolescent development and impacts educational achievement.[49] Nutrition and related issues are central to adolescent well-being.[50] Undernutrition, iron

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[46] *Smoking Statistics*, WORLD HEALTH ORG. (May 28, 2002), http://www.wpro.who.int/media_centre/fact_sheets/fs_20020528.htm.

[47] Rene A. Arrazola et al., Office on Smoking & Health, Nat'l Ctr. for Chronic Disease Prevention & Health Promotion, Ctrs. for Disease Control & Prevention, *Cigarette Use Among High School Students–United States, 2000-2009*, 59 MORBIDITY & MORTALITY WKLY. REP., 1063, 1063 (2010), *available at* http://www.cdc.gov/mmwr/pdf/wk/mm5933.pdf.

[48] Carolyn A. McCarty et al., *Continuity of Binge and Harmful Drinking from Late Adolescence to Early Adulthood*, 114 PEDIATRICS 714, 716–17 (2004).

[49] *See* ACTION FOR HEALTHY KIDS, THE LEARNING CONNECTION: THE VALUE OF IMPROVING NUTRITION AND PHYSICAL ACTIVITY IN OUR SCHOOLS 5 (2004), *available at* http://www.actionforhealthykids.org/resources/files/learning-connection.pdf ("Many studies show a direct link between nutritional intake and academic performance, as well as between physical activity and academic achievement."); Ctrs. for Disease Control & Prevention, *Guidelines for School Health Programs to Promote Lifelong Healthy Eating*, 45 MORBIDITY & MORTALITY WKLY. REP. (RECOMMENDATIONS & REP. 9) 1, 1 (1996), *available at* http://www.cdc.gov/mmwr/pdf/rr/rr4509.pdf ("Healthy eating patterns in childhood and adolescence promote optimal childhood health, growth, and intellectual development; prevent immediate health problems, such as iron deficiency anemia, obesity, eating disorders, and dental caries; and may prevent long-term health problems, such as coronary heart disease, cancer, and stroke.").

[50] *See, e.g.*, J. Michael Murphy et al., *The Relationship of School*

deficiency anemia, overweight and obesity, unsafe weight-loss methods, eating disorders, and dental caries each affect significant numbers of adolescents, resulting in adverse health consequences.[51] Poor health, in turn, interferes with learning and results in students missing school, falling behind their peers, and being unable to realize their full potential.[52] Each of the above nutrition-related issues merits attention. However, for illustrative purposes, this section focuses on one issue which has become a much more significant problem in recent years—overweight and obesity. Although a variety of factors influence whether an individual becomes overweight or obese—including level of physical activity and genetic factors—poor eating habits and nutrition are significant variables.[53]

The incidence of childhood obesity has more than tripled since 1980.[54] Over eighteen percent of U.S. adolescents are obese and many others are overweight.[55] Today, adolescents and younger children who are obese are developing "chronic health conditions previously seen only among adults" including high blood pressure, Type 2 diabetes, hyperlipidemia, asthma, obstructive sleep apnea, joint disease and musculoskeletal pain, gastrointestinal problems, and liver and gallbladder problems.[56]

Breakfast to Psychosocial and Academic Functioning, 152 ARCHIVES PEDIATRICS & ADOLESCENT MED. 899, 905 (1998) (finding that better nutrition at breakfast is associated with "better performance on a variety of measures of academic and psychosocial functioning in children").

[51] *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 49, at 2–5.

[52] *See id*.

[53] *See, e.g.*, James O. Hill & Frederick L. Trowbridge, *Childhood Obesity: Future Directions and Research Priorities*, 101 PEDIATRICS 570, 571 (1998) (noting obesity is influenced by eating habits, level of physical activity, environmental factors, genetics, and other variables).

[54] *Childhood Obesity*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://aspe.hhs.gov/health/reports/child_obesity/#_ftnref11 (last visited Nov. 1, 2011).

[55] *Childhood Obesity*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/HealthyYouth/obesity/ (last modified Sept. 15, 2011).

[56] Kiyoshi Yamaki et al., *Prevalence of Obesity-Related Chronic Health Conditions in Overweight Adolescents with Disabilities*, 32 RES. DEVELOPMENTAL DISABILITIES 280, 280–81 (2011).

Overweight and obese children also experience psychological and emotional health issues, including depression, associated with their health status.[57] Over the long term, obesity is associated with increased mortality and decreased life expectancy.[58] Recent studies have found that life expectancy in obese individuals can be eight to ten years shorter than that of individuals who are not overweight.[59]

Obesity and overweight strike certain communities particularly hard, with racial and ethnic disparities persisting in obesity prevalence rates.[60] Obesity rates are "significantly higher

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[57] *Id.* at 281.

[58] Prospective Studies Collaboration, *Body-Mass Index and Cause-Specific Mortality in 900,000 Adults: Collaborative Analyses of 57 Prospective Studies*, 373 LANCET 1083, 1083 (2009) (showing an eight- to ten-year reduction in life expectancy for very obese individuals but also a two- to four-year reduction in life expectancy for moderately obese individuals); J.M. Friedman, *Obesity in the New Millennium*, 404 NATURE 632, 633 (2000) ("[O]besity is associated with a significant increase in morbidity and mortality."); S. Jay Olshansky et al., *A Potential Decline in Life Expectancy in the United States in the 21st Century*, 352 NEW ENG. J. MED. 1138, 1143 (2005) ("Unless effective population-level interventions to reduce obesity are developed, the steady rise in life expectancy observed in the modern era may soon come to an end and the youth of today may, on average, live less healthy and possibly even shorter lives than their parents."). *But see* Robert Lalasz, *Will Rising Childhood Obesity Decrease U.S. Life Expectancy?*, POPULATION REFERENCE BUREAU (May 2005), http://www.prb.org/Articles/2005/WillRisingChildhoodObesityDecreaseUSLifeExpectancy.aspx (reporting challenges to the conclusions reached by Olshansky et al.).

[59] Prospective Studies Collaboration, *supra* note 58, at 1083 (study including almost 900,000 individuals). These results do not assess the impact of the more recent phenomenon of childhood obesity and the long-term effects of onset of obesity at a much younger age. *See* Gary Whitlock et al., *Body-Mass Index and Mortality—Authors' Reply*, 374 LANCET 114 (2009) ("The [900,000] participants were recruited in an era when people only rarely became obese before adulthood, so the report does not assess the effects of being obese ever since adolescence or childhood."); *see also* Olshansky et al., *supra* note 58, at 1141 ("[W]ith obesity occurring at younger ages, the children and young adults of today will carry and express obesity-related risks for more of their lifetime than previous generations have done . . . .").

[60] CYNTHIA OGDEN & MARGARET CARROLL, CTRS. FOR DISEASE CONTROL & PREVENTION, PREVALENCE OF OBESITY AMONG CHILDREN AND

among Mexican-American adolescent boys (26.8%) than among non-Hispanic white adolescent boys (16.7%)."[61] Similarly, non-Hispanic black adolescent girls are significantly more likely to be obese than non-Hispanic white adolescent girls (29.2% compared to 14.5%).[62]

Overall, the costs to society of overweight and obesity are staggering. It is estimated that the annual national medical cost of obesity (among adults and children) could be as high as $147 billion.[63] Given the morbidity and mortality risks associated with obesity and overweight—e.g., obesity is associated with an approximately 112,000 deaths annually in the United States—and the economic costs of obesity and overweight, policy makers must prioritize these issues when addressing adolescent well-being.[64]

D. Other Issues

In addition to the above three issues, a host of other health concerns confront adolescents. Motor vehicle accidents are the leading cause of death among adolescents, and according to the

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ADOLESCENTS: UNITED STATES, TRENDS 1963–1965 THROUGH 2007–2008, at 1–2 (2010), *available at* http://www.cdc.gov/nchs/data/hestat/obesity_child_07_08/obesity_child_07_08.pdf.

[61] *Id.* at 2 (figures from 2007-2008).

[62] *Id.* at 2 (figures from 2007-2008).

[63] Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates*, 28 HEALTH AFF. w822, w828 (2009) (amount calculated in 2008 dollars).

[64] *See* Katherine M. Flegal et al., *Excess Deaths Associated With Underweight, Overweight, and Obesity*, 293 JAMA 1861, 1863–64 (2005) (reporting that obesity is associated with approximately 112,000 deaths annually in the United States). Its economic cost is estimated to exceed $147 billion annually (calculated in 2008 dollars). Finkelstein et al., *supra* note 63, at w828. The Obama Administration has taken several important steps to raise the profile of this issue. First Lady Michelle Obama has made childhood obesity a priority. *See, e.g.*, *About Let's Move*, LET'S MOVE, http://www.letsmove.gov/about (last visited Nov. 1, 2011). *See generally* WHITE HOUSE TASK FORCE ON CHILDHOOD OBESITY, REPORT TO THE PRESIDENT, SOLVING THE PROBLEM OF CHILDHOOD OBESITY WITHIN A GENERATION (2010), *available at* http://www.letsmove.gov/sites/letsmove.gov/files/TaskForce_on_Childhood_Obesity_May2010_FullReport.pdf.

CDC, "[i]n 2009, about 3,000 teens in the United States aged 15–19 were killed and more than 350,000 were treated in emergency departments for injuries suffered in motor-vehicle crashes."[65] Sexually-transmitted infections (STIs) present a health risk for sexually active youth.[66] Nutritional issues other than obesity, such as food insecurity,[67] are also a factor for many children in low income families.[68] Approximately fourteen million children (or roughly nineteen percent of all children) in the United States experience food insecurity at some point during the year,[69] which adversely effects their well-being,

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[65] *Teen Drivers: Fact Sheet*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/MotorVehicleSafety/Teen_Drivers/teendrivers_factsheet.html (last updated Oct. 18, 2010).

[66] *2009 Sexually Transmitted Disease Surveillance: STDs in Adolescents and Young Adults*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/std/stats09/adol.htm (last updated Nov. 22, 2010) ("Estimates suggest that even though young people aged 15-24 years represent only 25% of the sexually experienced population, they acquire nearly half of all new STDs."). For example, in 2009, adolescent girls (aged fifteen to nineteen) had the highest rates of gonorrhea of any age-specific group in the United States. CTRS. FOR DISEASE CONTROL & PREVENTION, SEXUALLY TRANSMITTED DISEASE SURVEILLANCE 2009, at 18 (2010), *available at* http://www.cdc.gov/std/stats09/surv2009-Complete.pdf.

[67] Margaret Andrews & Mark Nord, U.S.D.A. Econ. Research Serv., *Food Insecurity Up in Recessionary Times*, AMBER WAVES, Dec. 2009, at 33, *available at* http://www.ers.usda.gov/AmberWaves/december09/PDF/FoodInsecurity.pdf (defining food insecurity as "inadequate or unsure access to enough food for active, healthy living"); Life Sciences Research Office, Report, *Core Indicators of Nutritional State for Difficult-to-Sample Populations*, 102 J. NUTRITION 1559, 1598 (1990) (defining food insecurity as having "limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways").

[68] MARK NORD ET AL., U.S. DEP'T OF AGRIC., HOUSEHOLD FOOD SECURITY IN THE UNITED STATES, 2009, at 7 (2010), *available at* http://www.ers.usda.gov/Publications/err108/err108.pdf.

[69] JOHN COOK, FEEDING AMERICA, CHILD FOOD INSECURITY IN THE UNITED STATES: 2006-2008, at 4 (2010), *available at* http://feedingamerica.org/hunger-in-america/hunger-studies/~/media/Files/research/state-child-hunger-2010.ashx?.pdf; *see also* Katherine Alaimo et al., *Food Insufficiency and American School-Aged Children's Cognitive, Academic, and Psychosocial Development*, 108 PEDIATRICS 44, 44 (2001) (reporting over fourteen million

development, educational achievement, and ultimately their future.[70] When we step back from the current contentious debates over abortion or whether a child is mature enough to make significant medical treatment decisions, we see that numerous other issues threaten the health and well-being of adolescents. An effective approach to adolescent health must address all of these problems and the underlying structural issues that contribute to these health risks.[71]

II. THE LIMITS OF THE MEDICAL MODEL

By adopting a holistic understanding of adolescent health and well-being, it becomes readily apparent that the medical or health care model has important limitations. Medical care is essential. Bedside care cannot be replaced. However, public health issues and other community-based health issues have a dramatic impact on adolescent well-being, often in subtle ways that the medical system does not reach until after harm has occurred. An adolescent may be a victim of violence in the home, suffering physical abuse and emotional and psychological trauma, yet never seek or access medical care to address these

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children in the United States experience food insecurity).

[70] *See* Katherine Alaimo et al., *supra* note 69, at 46 (finding food-insufficient children are more than twice as likely than food-sufficient children to repeat a grade and to miss more school days, and they are also more likely to have psychosocial issues). *See generally* ACTION FOR HEALTHY KIDS, *supra* note 49, at 5 ("Many studies show a direct link between nutritional intake and academic performance, as well as between physical activity and academic achievement."); DAVID SEITH & ELIZABETH ISAKSON, NAT'L CTR. FOR CHILDREN IN POVERTY, WHO ARE AMERICA'S POOR CHILDREN? EXAMINING HEALTH DISPARITIES AMONG CHILDREN IN THE UNITED STATES 9 (2011), *available at* http://www.nccp.org/publications/pdf/text_995.pdf ("One of the clearest indicators of health interfering with education is health-related absenteeism.").

[71] *See, e.g.*, Boynton-Jarrett et al., *supra* note 6, at 968 ("[I]nterventions aimed at promoting adolescent health and well-being cannot focus on behavior modification alone. Broader social policy changes aimed at reducing violence exposure in childhood and adolescence, including promoting safer schools and communities, may have greater effects on health trajectories during adolescence and young adulthood.").

harms.[72] Similarly, bullying might leave no physical marks but can lead to emotional and psychological trauma and push youth into depression.[73] As discussed in Part I, the short- and long-term impact on youth can be significant.

Medical care is not designed to address all of these harms, at least not without the assistance of other early intervention strategies that facilitate identification of youth in need of care and connect them with appropriate health care services. Even then, hospitals and other medical facilities are not set up to address the structural issues underlying violence against adolescents or the environmental factors influencing overweight and obesity. As Carole Warshaw explains, "The medical model, in fact, can only 'medicalize,' reduce things to categories it can handle and control."[74] Medical treatment is essential, but the

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[72] *See generally* Amy B. Silverman et al., *The Long-Term Sequelae of Child and Adolescent Abuse: A Longitudinal Community Study*, 20 CHILD ABUSE & NEGLECT 709, 709 (1996) (finding that child abuse leads to increased likelihood of "more depressive symptomatology, anxiety, psychiatric disorders, emotional-behavioral problems, suicidal ideation, and suicide attempts" during early adulthood); Kristen W. Springer et al., *Long-term Physical and Mental Health Consequences of Childhood Physical Abuse: Results from a Large Population-Based Sample of Men and Women*, 31 CHILD ABUSE & NEGLECT 517, 518 (2007) ("[I]n a population-based cohort of middle-aged men and women, childhood physical abuse predicted worse mental and physical health decades after the abuse."); Martin H. Teicher, *Wounds That Time Won't Heal: The Neurobiology of Child Abuse*, CEREBRUM: DANA F. ON BRAIN SCI. (Oct. 1, 2000), http://www.dana.org/news/cerebrum/detail.aspx?id=3378 ("[E]arly maltreatment, even exclusively psychological abuse, has enduring negative effects on brain development.").

[73] *See* Silverman et al., *supra* note 72. In some instances, the results have been tragic. *See, e.g.*, Erik Eckholm & Katie Zezima, *6 Teenagers Are Charged After Classmate's Suicide*, N.Y. TIMES, Mar. 30, 2010, at A14 (detailing the suicide of a 15-year-old girl and 11-year-old boy who had been subjected to persistent bullying and harassment); *see also* Young-Shin Kim & Bennett Leventhal, *Bullying and Suicide. A Review*, 20 INT'L J. ADOLESCENT MED. & HEALTH 133, 151 (2008) ("Not only does bullying interfere with normal developmental and educational processes but also places adolescents at an unnecessary and additional risk for suicidal thoughts and actions. It seems clear that these adolescents are at increased risk for suicidal behaviors/ideations and deserve our particular care and attention.").

[74] Carole Warshaw, *Limitations of the Medical Model in the Care of*

"structural constraints" of busy emergency rooms and medical facilities limit the opportunities to identify and address the root causes of an adolescent's illness or injury.[75]

By highlighting the limits of medical facilities' capacity to address adolescent health issues, I do not intend this Essay to be a critique of the medical model. After all, a hospital or other medical facility is not designed to address the systemic community issues that adversely affect adolescent health. Foremost, the problem lies not with health care professionals, but rather with policy makers and others who assume that the health care system is the only sector relevant to adolescent health. The reality is that policies, programs, and funding decisions on housing, education, the environment, urban and regional development, transportation, and employment all implicate adolescent health.[76] When policy makers contemplate action in each of these arenas, they must assess adolescent health needs and the potential impact of new policies and programs on the health status of adolescents.

Recognizing the limitations of the medical model and the need for a more holistic approach to adolescent health issues can aid policy makers and child advocates in other areas that implicate adolescent and child well-being. The limitations of the medical model are not unique to medicine or health care; for

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Battered Women, 3 GENDER & SOC'Y 506, 515 (1989).

[75] *Id.* at 507 (discussing a study that examined medical records of battered women in the early 1990s, which found that "structural constraints of a busy urban emergency room in a training institution led not only to nondetection and nonintervention but, more important, to a lack of receptiveness and response by health care providers to the issues that a battered woman struggles with").

[76] *See* TONY ITON ET AL., CTR. FOR HEALTH IMPROVEMENT, TARGETING ROOT CAUSES TO ADDRESS INEQUITIES AND IMPROVE HEALTH: IMPLICATIONS FOR HEALTH REFORM 2 (2009), *available at* http://www.chipolicy.org/pdf/6166.HealthInequities2009.pdf. For a detailed examination of the social determinants of health and policy implications, see COMM'N ON SOC. DETERMINANTS OF HEALTH, WHO, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH—FINAL REPORT (2008), *available at* http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf. *See generally* Michael Marmot, *Social Determinants of Health Inequalities*, 365 LANCET 1099 (2005).

example, the legal system, which also typically focuses on individual cases, has similar constraints. As Annette Appell has written, "legalistic approaches do little to address broader systemic problems that create risks for children, such as racism, poverty, poor schools, and limited economic opportunity."[77] Similarly, the health care system does little to address these and other root causes of violence, substance use, obesity, and other health risks.[78] Through a holistic assessment of adolescent health issues, it becomes clear that every sector of society has a role to play in supporting and ensuring adolescent well-being. If policy makers are to address health-related issues that all youth face, they need to confront adolescent health in a more comprehensive and integrated manner and, importantly, earlier in the process.[79]

III. RETHINKING OUR APPROACH—A HUMAN RIGHTS FRAMEWORK

The breadth of challenges to adolescent health and the natural limits of a medical model demonstrate the need for a more comprehensive response. This section examines international human rights law with a view to explicating its utility in creating a comprehensive framework that addresses the full range of issues affecting adolescent health. As discussed below, there is much to be gained from adopting a rights-based approach to adolescent health. To begin, a human rights

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[77] Annette Ruth Appell, *Representing Children Representing What?: Critical Reflections on Lawyering for Children*, 39 COLUM. HUM. RTS. L. REV. 573, 620 (2008).

[78] *See* TONY ITON ET AL., *supra* note 76, at 2.

[79] Over the past few decades, the medical field itself has increasingly discussed the importance of prevention and early intervention, and more recently policy makers have focused on prevention as a vehicle for reducing health care expenditures. *See* Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 661 (2008); Lawrence G. Smith & Megan Anderson, *New Directions in American Health Care*, 39 HOFSTRA L. REV. 23, 31 (2011) ("Another possible strategy for reducing health care costs is to sharpen the focus on preventing diseases and promoting wellness, rather than managing disease after people get sick. Prevention and health promotion may cost less in the long run . . . .").

framework can be used as a checklist to help identify ways and settings in which adolescents' well-being is at risk.[80] It then can be used to provide the template for a response to those health risks.[81] Fundamentally, a human rights approach has the added advantage of being based on a legal mandate, as opposed to a reliance on goodwill, charity, or ethical precepts.[82] As such, it provides further value by creating obligations on the part of the state to address the various issues that implicate adolescent health.[83] This section starts by reviewing the core health rights

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[80] *See, e.g.*, Comm'n on Human Rights, Commentary on the Norms on the Responsibility of Transnational Corporations and Other Business Enterprises with Regard to Human Rights, U.N. Doc. E/CN.4/Sub.2/2003/38/Rev.2 (Aug. 26, 2003) (providing a human rights checklist for businesses). What I am proposing here is that by reviewing each right that a child/adolescent has (e.g., those enshrined in the Convention on the Rights of the Child) and considering how each such right arises in the adolescents' lives and the impact of each right, or denial of such right, on adolescent health, human rights treaties can help to identify present risks to adolescent well-being.

[81] Once the health risks have been identified using a human rights framework, the health-related issues the state must address and its specific obligations under human rights law vis-à-vis each of these issues become readily apparent.

[82] Richard Reading et al., *Promotion of Children's Rights and Prevention of Child Maltreatment*, 373 LANCET 332, 332 (2009) ("The greatest strength of an approach based on the UNCRC is that it provides a legal instrument for implementing policy, accountability, and social justice, all of which enhance public-health responses."). Although one of the important aspects of international human rights law is that it creates a legal mandate, challenges persist with respect to the enforcement of international law. *See, e.g.*, Pemmaraju Sreenivasa Rao, *Multiple International Judicial Forums: A Reflection of the Growing Strength of International Law or Its Fragmentation?*, 25 MICH. J. INT'L L. 929, 931 (2004) (noting the absence of enforcement mechanisms accompanying much of international law); Prosper Weil, *Towards Relative Normativity in International Law?*, 77 AM. J. INT'L L. 413, 414 (1983) (explaining that international law has numerous "structural weaknesses," including "the inadequacy of its sanction mechanisms").

[83] Although the United States is typically an active participant in the drafting of international human rights treaties, it has traditionally resisted international human rights law obligations by moving slowly toward ratification of international human rights treaties. For example, it took the United States forty years to become a party to the Convention on the

provisions under international law. Following that, this section looks to other provisions of international human rights law for a response to some of the health impacts discussed in Part I.

A. The Core Right to Health Provisions

International human rights law includes numerous sources that address adolescent health issues.[84] In exploring international human rights law for guidance on adolescent health issues, the natural starting point is international law's provisions on health rights. Examining international law's right to health provisions, one finds some of the key considerations relevant to the provision of health care, which overlaps with the medical model.

Prevention and Punishment of the Crime of Genocide, Dec. 9, 1948, 78 U.N.T.S. 277. *See Convention on the Prevention and Punishment of the Crime of Genocide—Status of Ratifications*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-1&chapter=4&lang=en (last visited Nov. 1, 2011). In addition, when the United States has ratified international human rights treaties, it frequently has sought to limit their domestic legal effect. *See* Lori Fisler Damrosch, *The Role of the United States Senate Concerning "Self-Executing" and "Non-Self-Executing" Treaties*, 67 CHI.-KENT. L. REV. 515, 517-18 (1991). Even if the U.S. government seeks to limit a treaty's domestic effect by declaring it non-self-executing, the United States is still obligated under international law to adopt domestic implementing legislation that gives effect to the treaty. For children's advocates, the legal mandate of international human rights law, even if constrained, can be a valuable tool in pursuing legislative and judicial remedies for adolescents. Indeed, U.S. courts have looked to international human rights law in numerous cases. *See, e.g.*, Roper v. Simmons, 543 U.S. 551, 575–78 (2006) (citing international law prohibiting the imposition of the death penalty on child offenders); The Paquetta Habana, 175 U.S. 677, 700 (1900) ("International law is part of our law, and must be ascertained and administered by the courts of justice of appropriate jurisdiction."); *see also* THE OPPORTUNITY AGENDA, HUMAN RIGHTS IN STATE COURTS 2011 (2011), *available at* https://opportunityagenda.org/files/field_file/2011.08.25%20Human%20Rights%20in%20State%20Courts%202011%20FINAL.pdf. On the enforcement of human rights in the United States generally, see BRINGING HUMAN RIGHTS HOME: A HISTORY OF HUMAN RIGHTS IN THE UNITED STATES (Cynthia Soohoo et al. eds., 2009).

[84] *See generally* HEALTH AND HUMAN RIGHTS: BASIC INTERNATIONAL DOCUMENTS (Stephen P. Marks ed., 2004) (including excerpts of various international instruments covering a broad range of health and human rights issues).

Under international human rights law, an adolescent's right to health mandates that each state party to the relevant treaties: (1) recognize each individual's right to the "highest attainable standard of health"; (2) ensure each adolescent's right to access health care services and treatment; and (3) adopt measures to address particular issues relevant to children's health.[85]

First, by employing the right to the "highest attainable standard of health"[86] formulation, international human rights law acknowledges two important variables—differences among individuals and countries.[87] It accounts for the fact that biological differences among individuals mean that not all individuals are able to enjoy the same level of health.[88] It also acknowledges the differences in available resources among states; poorer nations cannot afford to provide the health care services to its population that wealthy countries can afford, and mandating the same

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[85] Convention on the Rights of the Child, art. 24, G.A. Res. 44/25, U.N. Doc. A/RES/44/25 (Nov. 20, 1989) [hereinafter CRC]; *see also* International Covenant on Economic, Social and Cultural Rights, art. 12(1), G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (Dec. 16, 1966) (recognizing every individual's right to "highest standard of physical and mental health") [hereinafter ICESCR]. *See generally* Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101, 114–15 (2005) ("[T]he individual right to health has been interpreted to embrace, as part of its minimum core content, basic provisions of emergency health care necessary to save lives, including the treatment of prevalent diseases, the provision of essential drugs, and safeguards against serious environmental health threats.").

[86] *See* CRC, *supra* note 85, art. 24(1) (recognizing the child's right to "the highest attainable standard of health"); *see also* ICESCR, *supra* note 85, art. 12(1) (recognizing every individual's right to the "highest standard of physical and mental health").

[87] *See, e.g.*, U.N. Comm. on Econ., Social & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, ¶ 9, U.N. Doc. E/C.12/2000/4 (July 4, 2000) [hereinafter General Comment No. 14] (stating that ICESCR's right to health "takes into account both the individual's biological and socio-economic preconditions and the State's available resources").

[88] *See, e.g.*, ASBJORN EIDE & WENCHE BARTH EIDE, ARTICLE 24: THE RIGHT TO HEALTH 1 (2006) ("[T]he highest attainable standard of health tak[es] into account the genetic and other biological predispositions of the individual child and the risks that children are exposed to . . . .").

outcomes from both is impractical.[89] International human rights law recognizes that developing countries have more limited resources and utilizes flexible language to make health rights meaningful in all countries by requiring states parties to ensure health rights "to the maximum extent of their available resources."[90] Second, the

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[89] For example, compare Canada with Chad: Canada's per capita GDP is US$33,375 and its per capita health care expenditure is US$3,173, whereas Chad's GDP per capita is only an estimated US$1,427 and its per capita health care expenditure is US$42. *See* U.N. DEV. PROGRAMME (UNDP), HUMAN DEVELOPMENT REPORT 2007/2008, at 229, 232, 247, 250 (2007), *available at* http://hdr.undp.org/en/media/HDR_20072008_EN_Complete.pdf.

[90] CRC, *supra* note 85, art. 4. If the CRC's drafters had adopted a more stringent, inflexible standard, some developing countries likely would have refused to ratify the CRC. Article 4 addresses developing countries' concerns, by allowing "[w]ith regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation." *Id*.

Given the current opposition to recognizing health rights in the United States, it is ironic that during the drafting of the CRC, the United States proposed removing the "available resources" language, only to be opposed by delegations from a number of developing countries. This opposition led to the compromise position in which economic, social, and cultural rights were addressed in a separate sentence and allowances were made for available resources with respect to these rights. *See* U.N. Comm'n on Human Rights, *Question of a Convention on the Rights of the Child: Report of the Working Group on a Draft Convention on the Rights of the Child*, at 30–31, U.N. Doc. E/CN.4/1989/48 (Mar. 2, 1989), *reprinted in* THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD: A GUIDE TO THE "TRAVAUX PRÉPARATOIRES" 115, 155 (Sharon Detrick ed., 1992).

The resource qualifiers of the second sentence do not eliminate developing countries' obligations with respect to economic, social, and cultural rights. They still are obligated to work toward full implementation of the CRC. The CRC requires that they do as much as possible with the resources they have, look to the international community to access additional resources, and build capacity so that they will have greater resources for ensuring children's rights in the future. *See* Int'l Comm'n of Jurists et al., Maastricht Guidelines on Violations of Economic, Social and Cultural Rights ¶ 8 (1997) [hereinafter Maastricht Guidelines] ("The State cannot use the 'progressive realization' provisions in article 2 of the [ICESCR] as a pretext for non-compliance."). *See generally* Philip Alston & Gerard Quinn, *The Nature and Scope of States Parties' Obligations Under the International Covenant on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q. 156,

adolescent's right to health obligates states to strive to ensure children have access to treatment and facilities for care.[91] A central component of this obligation is ensuring access for all adolescents without discrimination of any kind.[92] Finally, international human rights law requires states to address specific health issues particularly relevant to children, including infant and child mortality and the provision of primary health care services.[93]

These provisions alone provide a broad mandate for countries to ensure the well-being of adolescents and other children.[94] The "right to the highest attainable standard of health" certainly could be read to include an obligation to

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160 (1987) (discussing the justiciability of economic, social, and cultural rights, "[n]otwithstanding the tendency among some commentators to dismiss the legal significance of the [International Covenant on Economic, Social and Cultural Rights], it is a treaty that gives rise to formal obligations on the part of ratifying or acceding states"); Michael J. Dennis & David P. Stewart, *Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health*?, 98 AM. J. INT'L L. 462, 514 (2004) ("This is not to say that economic, social, and cultural rights are not human rights, or that they are devoid of content . . . . Clearly they *are* rights, and they *are* binding on states that have ratified the ICESCR. We agree that states parties *do* have legal obligations under the Covenant . . . .").

[91] *See, e.g.*, CRC, *supra* note 85, art. 24(1) (recognizing children's right "to facilities for the treatment of illness and rehabilitation of health" and establishing states parties' obligations to "strive to ensure that no child is deprived of his or her right of access to such health care services"); ICESCR, *supra* note 85, art. 12(2)(d). The CRC's mandate that countries "strive to ensure" that every child has access to health care recognizes that low income nations will progressively realize rights over time. *See* sources cited *supra* note 90.

[92] Both the CRC and the ICESCR include non-discrimination provisions that mandate that states assure to each individual the rights contained in that convention or covenant without discrimination of any kind. *See* CRC, *supra* note 85, art. 2; ICESCR, *supra* note 85, art. 2(2).

[93] CRC, *supra* note 85, art. 24(2).

[94] *See* UNICEF INNOCENTI RESEARCH CENTRE, LAW REFORM AND IMPLEMENTATION OF THE CONVENTION ON THE RIGHTS OF THE CHILD 39–42 (2008), *available at* http://www.unicef-irc.org/publications/pdf/law_reform_crc_imp.pdf (detailing legislation adopted in a number of countries to comply with CRC Article 24's mandate that states parties recognize the child's right to the highest attainable standard of health).

prevent violence against adolescents, protect adolescents from the health risks of substance use and abuse, and address adolescent obesity.[95] As the Committee on Economic, Social, and Cultural Rights—the U.N. body that oversees implementation of and compliance with the International Covenant on Economic, Social and Cultural Rights—has stated, "The right to health is closely related to and dependent upon the realization of other human rights . . . including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement."[96]

B. The Human Rights Law Response to Adolescent Health Issues

Beyond international law's specific provisions on the right to health and its emphasis on the right to the "highest attainable standard of health" and access to care, international human rights law also offers, and mandates, much more that is relevant to adolescent health and well-being. Specifically, it addresses many of the other issues affecting adolescent health, including various forms of maltreatment and exploitation; drugs, alcohol, and smoking; and nutritional issues, including obesity.

As discussed in Part I, various forms of violence and exploitation plague the lives of millions of children. The U.N. Convention on the Rights of the Child (CRC) addresses numerous aspects of this problem. Article 19 of the CRC mandates that states parties:

> [T]ake all appropriate legislative, administrative, social and educational measures to protect the child from all

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[95] General Comment No. 14, *supra* note 87, ¶ 4 (reporting that the drafting history and express language of the ICESCR's Article 12 make clear that "the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment").

[96] *See, e.g.*, *id.* ¶ 3.

> forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.[97]

As the Committee on the Rights of the Child—the U.N. body that oversees implementation of and compliance with the CRC—has noted, Article 19 leaves "no leeway" in terms of each state party's obligation to prohibit all forms of violence against children.[98] Moreover, all *appropriate* measures "cannot be interpreted to mean acceptance of some forms of violence" but in fact means that all sectors of government can contribute effectively to addressing the problem.[99] Equally important, this obligation requires more of a state than simply adopting legislation prohibiting child abuse or violence against children. States parties are also required to take appropriate administrative, social, and educational measures,[100] and the Committee on the Rights of the Child has produced a set of recommended steps that can help enable families, communities, and professionals to combat violence against children.[101]

In addition, the CRC also mandates that states parties protect children from all forms of exploitation, including child labor and sexual exploitation,[102] thereby providing a framework for

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[97] CRC, *supra* note 85, art. 19.

[98] CRC General Comment No. 13, *supra* note 7, ¶ 37.

[99] *Id.* ¶ 39; *see also supra* note 76 and accompanying text (discussing the various sectors of society that affect adolescent health and the social determinants of health).

[100] CRC, *supra* note 85, art. 4 ("States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention.").

[101] CRC General Comment No. 13, *supra* note 7, ¶¶ 38–47 (such measures include "identification and prevention of factors and circumstances which hinder vulnerable groups' access to services and full enjoyment of their rights[;]" poverty reduction strategies; appropriate public health, safety, housing, education, and employment policies; improved access to health, social welfare, and justice services; reduced demand for and access to alcohol, illegal drugs, and weapons; and other steps aimed at ensuring adolescent well-being).

[102] CRC, *supra* note 85, arts. 34–36.

addressing violence and exploitation suffered at the hands of adults outside the home. Other international human rights law imposes similar obligations on states to prevent exploitation of children.[103] Finally, a human rights framework is also relevant to adolescent peer violence issues.[104] It helps expose bullying and related activities as not merely "rites of passage" for adolescents but rather "'exercise[s] of power to deny others their humanity' and caus[e] harm."[105] International human rights law can provide the foundation for developing a response to peer violence.[106]

International human rights law also addresses the adolescent

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[103] *See, e.g.*, Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the U.N. Convention Against Transnational Organized Crime, G.A. Res. 25, Annex II, U.N. GAOR, 55th Sess., Supp. No. 49, U.N. Doc. A/45/49 (Vol. I), at 60 (2001); Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, G.A. Res. 54/263, Annex II, U.N. GAOR, 54 Sess., Supp. No. 49, U.N. Doc. A/54/49 (Vol. III), at 6 (2000); Int'l Labour Org. Convention Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labor, ILO Doc. C182 (June 17, 1999), *available at* http://www.ilo.org/ilolex/cgi-lex/convde.pl?C182.

[104] *See* Michael B. Greene, *Bullying in Schools: A Plea for Measure of Human Rights*, 62 J. SOC. ISSUES 63, 71–74 (2006); *see also* HUMAN RIGHTS COMM'N, SCHOOL VIOLENCE, BULLYING AND ABUSE: A HUMAN RIGHTS ANALYSIS (2009), *available at* http://www.hrc.co.nz/hrc_new/hrc/cms/files/documents/02-Apr-2009_12-23-18_Human_Rights_School_Violence_V4.pdf. Similarly, there is also precedent for responding to peer dating violence as a human rights violation. *See generally* GEETA RAMASESHAN, INTERNATIONAL WOMEN'S RIGHTS ACTION WATCH ASIA PACIFIC, ADDRESSING RAPE AS A HUMAN RIGHTS VIOLATION: THE ROLE OF INTERNATIONAL HUMAN RIGHTS NORMS 11 (2007), *available at* http://www.iwraw-ap.org/aboutus/pdf/OPS10_Final_Publication_Version_Dec_18.pdf ("[S]tates are still responsible for efforts to eliminate and mitigate violations by private persons as part of their international obligations.").

[105] Greene, *supra* note 104, at 72 (quoting Stuart Henry, *What Is School Violence?*, ANNALS AM. ACAD. POL. & SOC. SCI., Jan. 2000, at 16, 21).

[106] *Id.* at 71 ("From a human rights perspective, then, not only can all forms of bullying be understood as human rights violations, but it is also clearly incumbent upon schools to provide social programs that remedy such infractions and the underlying norms and structures that facilitate the violations. As such, a human rights perspective can serve to mobilize schools and local communities to address all forms of bullying.").

health issues associated with substance use and abuse.[107] For example, "[t]obacco control law and policy flows from the right to life and is built upon several layers of other rights including the rights to equality, health, education, a clean environment, and information."[108] Policy makers can continue to use these rights as the basis for strengthening law and policy aimed at reducing the harmful effects of tobacco use. Also, the CRC has recognized the potential harms caused by drugs, by mandating that states parties:

> [T]ake all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.[109]

In fact, the Committee on the Rights of the Child has been active in highlighting children's vulnerability to substance use and abuse, whether it is related to tobacco, alcohol, or other drugs.[110]

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[107] *See, e.g.*, Allison Smith Estelle, *International Response to Drug Abuse Among Young People: Assessing the Integration of Human Rights Obligations*, (Francois-Xavier Bagnoud Center for Health and Human Rights Working Papers, 2000), *available at* http://www.harvardfxbcenter.org/resources/working-papers/FXBC_WP9--Estelle.pdf.

[108] Rangita de Silva de Alwis & Richard Daynard, *Reconceptualizing Human Rights to Challenge Tobacco*, 17 MICH. ST. J. INT'L L. 291, 372 (2008-2009).

[109] CRC, *supra* note 85, art. 33.

[110] *See* RACHEL HODGKIN & PETER NEWELL, UNICEF, IMPLEMENTATION HANDBOOK FOR THE CONVENTION ON THE RIGHTS OF THE CHILD 498–01 (2002). For example, in its Concluding Observations to Poland's report, it noted children's vulnerability to a range of harms including drug abuse and alcoholism. *Id.* at 498 (citing Comm. on the Rights of the Child, Consideration of Reports Submitted Under Article 44 of the Convention—Concluding Observations: Poland, ¶ 20, U.N. Doc. CRC/C/15/Add.31 (Jan. 15, 1995)). In the Committee's Concluding Observations to Slovakia, it "encourage[d] the State Party to provide children with accurate and objective information about substance abuse, including tobacco use." *Id.* at 501 (quoting Comm. on the Rights of the Child, Consideration of Reports

Finally, with respect to nutritional issues, although international human rights law historically has concentrated more on malnutrition and related issues[111] rather than obesity, its language is applicable to obesity issues.[112] First, Article 27 of the CRC requires that states recognize each child's right to an adequate standard of living and "take appropriate measures to assist parents and others responsible for the child to implement this right and . . . in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing."[113] Given that globally the number of overweight and obese individuals now outnumbers the number of people who are hungry and malnourished,[114] the requirement to implement nutritional programs must include programs that help

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Submitted Under Article 44 of the Convention—Concluding Observations: Slovakia, ¶ 42, U.N. Doc. CRC/C/15/Add.140 (Oct. 23, 2000)); *see also* Comm. on the Rights of the Child, Consideration of Reports Submitted by States Parties Under Article 44 of the Convention—Concluding Observations: Denmark, ¶ 52, U.N. Doc. CRC/C/DNK/CO/4, (Apr. 7, 2011) (expressing concern over "the potential abuse of psycho-stimulant drugs by children").

[111] *See* CRC, *supra* note 85, art. 24(2)(c) (explicitly mandating that states act to reduce malnutrition but not explicitly mentioning obesity, as it emerged as a problem more recently); EIDE & EIDE, *supra* note 88, at 27–28 ("At the time of the drafting of CRC, including Article 24, 'malnutrition' was considered to be synonymous with 'undernutrition' . . . . Today, however, one faces increasingly more complex situations which require more diversified responses . . . [as] [t]he prevalence of obesity, diabetes (Type 2) and cardiovascular diseases figure increasingly higher on the disease statistics . . . ."); Naomi Priest et al., *A Human Rights Approach to Childhood Obesity Prevention*, *in* PREVENTING CHILDHOOD OBESITY: EVIDENCE, POLICY & PRACTICE 40, 42 (Elizabeth Waters et al. eds., 2010) ("Historically, this right to adequate food has largely been interpreted and applied in the context of freedom from hunger and under-nutrition, the right to food in emergencies and to issues of food access and food security.").

[112] Priest et al., *supra* note 111, at 42 ("It is now argued that a ['']right to food['] approach . . . should require States to respect and protect consumers and to promote good nutrition, including protecting the poor and vulnerable from unsafe food and inadequate diets and helping to address obesity.").

[113] CRC, *supra* note 85, art. 27.

[114] *See* Nick Squires, *Overweight People Now Outnumber the Hungry*, TELEGRAPH (Aug. 15, 2006, 12:01 AM), http://www.telegraph.co.uk/news/uknews/1526403/Overweight-people-now-outnumber-the-hungry.html.

prevent and treat overweight and obesity.[115] In Article 24, the CRC requires states parties to "ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition . . . ."[116] Obesity may be a newer challenge in the human rights arena (and for the world), but nutritional issues are ones that international human rights law has been addressing for years.[117] These provisions provide the mandate for a framework of law, policy, and programming that ensures good nutrition and provides parents and children with necessary information to prevent obesity. More broadly, international human rights law provides impetus to address the social determinants of health and other structural issues, such as the built environment (e.g., lack of access to supermarkets with healthy food options or green spaces for exercise), that foster conditions conducive to obesity and other unhealthy outcomes.[118]

Running through all of these issues is one of the foundational principles of children's rights law—the child's right to participate in decisions that affect his or her life. Article 12 of the CRC reads: "States Parties shall assure to the child who is

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[115] *See* Priest et al., *supra* note 111, at 42.

[116] CRC, *supra* note 85, art. 24(2)(e).

[117] *See, e.g.*, CRC, *supra* note 85, art 24(2)(c)–(e); ICESCR, *supra* note 85, art. 12; Universal Declaration of Human Rights, art. 25(1), G.A. Res. 217A (III), U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948) ("Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food . . . .").

[118] Michele Ver Ploeg, *Food Environment, Food Store Access, Consumer Behavior, and Diet*, CHOICES, 3d Quarter, 2010, http://www.choices magazine.org/magazine/article.php?article=137 (last visited Nov. 1, 2011) ("Environmental factors can also impact body weight and dietary health. Such factors can include access to stores and restaurants, parks and recreation facilities, sidewalks, and the availability of public transportation, and social environmental factors like crime, neighborhood cohesion, and the social and cultural norms around food.").

Other nutrition issues, including food insecurity, can also benefit from a human rights based response. *See, e.g.*, Mariana Chilton & Donald Rose, *A Rights-Based Approach to Food Insecurity in the United States*, 99 AM. J. PUB. HEALTH 1203, 1203 (2009) ("A human rights framework repositions our understanding of food insecurity to acknowledge and actively address its social and economic determinants.").

capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."[119] Youth participation in decisions affecting their lives is contemplated already to some extent in the context of adolescent health issues. Health care professionals and child advocates typically understand youth participation primarily as consisting of providing mature minors a voice in treatment decisions.[120] The goal in terms of child participation in health issues, therefore, has been to persuade doctors and nurses to ask adolescents what they want and to encourage medical professionals to give due consideration to adolescents' opinions and concerns. Guidelines of medical associations now emphasize the importance of physicians listening to their young patients and respecting their views.[121] That goal, while important, fails to capture a vital larger point: input is needed from adolescents at every stage of contemplating and responding to adolescent health issues. A holistic rights-based framework for adolescent health would ensure that youth have a voice at every stage in the process: (1) design, (2) implementation, and (3) monitoring and evaluation of law, policies, and programs aimed at addressing adolescent health issues.[122] In turn, involving youth at each stage can help foster better strategies for ensuring their well-being.

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[119] CRC, *supra* note 85, art. 12.

[120] Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L.J. 1265, 1308–17 (2000) (discussing the "mature minor" doctrine which permits mature adolescents to direct their medical treatment); *see also* Jennifer Rosato, Essay, *What Are the Implications of* Roper*'s Dilemma for Adolescent Health Law?*, 20 J.L. & POL'Y 167 (2011) (arguing that some minors should be able to make some health care decisions).

[121] Mary Donnelly & Ursula Kilkelly, *Child-Friendly Healthcare: Delivering on the Rights to Be Heard*, 19 MED. L. REV. 27, 28 (2011) (citing medical association guidelines from the U.K. and Ireland).

[122] This echoes "mainstreaming" principles used to address gender-based discrimination. In another article, I explore the value of "mainstreaming" children's rights. *See* Jonathan Todres, *Mainstreaming Children's Rights in Post-Disaster Settings*, 25 EMORY INT'L L. REV. (forthcoming 2011).

For example, on violence issues, adolescents have much to contribute. As a UNICEF Innocenti Report explains,

> [Children] are 'experts' on the factors that make children vulnerable, their reasons for leaving home, and their special needs regarding prevention, assistance and protection. Children and young people have an important role to play in helping to identify areas for intervention, design relevant solutions and act as strategic informants of research.[123]

Adolescents are witness to, and often understand well, the dynamics of bullying and other forms of peer violence. Youth also offer important insights when it comes to violence perpetrated by adults. Child trafficking provides an important example. In one study of child trafficking victims in Southeastern Europe, the youth reported that "schools did little to provide relevant information to protect them from trafficking."[124] The study also found that many children could identify a "changing point"—an event or crisis which left them more vulnerable to exploitation.[125] "The types of changes that appear to have had the greatest impact include a change of residence or of family composition, or in the child's own interaction and relationship with friends and peers."[126] These insights provide valuable information that can help shape policies and programs which can reduce the vulnerability of adolescents to various forms of violence and exploitation.

By facilitating the involvement of youth at all stages of the development and implementation of programs aimed at adolescent well-being, policy makers can ensure that they do not miss the important insights and ideas that adolescents have.[127]

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[123] Mike Dottridge, Young People's Voices on Child Trafficking: Experiences from South Eastern Europe, at vi (UNICEF Innocenti Working Papers, Paper No. IWP-2008-05, 2008), *available at* http://www.unicef-irc.org/publications/pdf/iwp_2008_05.pdf.

[124] *Id.* at 13.

[125] *Id.* at 16–17.

[126] *Id.* at 16.

[127] For one example of the value of youth input, see Jill Van den Brule, *In Post-Earthquake Haiti, Children's Voices Are Integrated into Reconstruction Effort*, UNICEF, (June 21, 2010), http://www.

More broadly, it is essential to remember that individual rights are "indivisible and interrelated."[128] One cannot successfully ensure adolescents' health rights without successfully ensuring their right to education, their right to live free from discrimination, their right to freedom from violence, and other related rights.[129] Vertical relationships among rights must also be accounted for; ensuring the economic and social rights of women and of parents generally can help foster conditions conducive to the realization of adolescents' rights.[130] Addressing rights in a holistic manner will strengthen our

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educationandtransition.org/resources/in-post-earthquake-haiti-childrens-voices-are-integrated-into-reconstruction-effort/ (quoting UNICEF Child Protection Specialist Virginia Perez Antolin as reporting that "[c]hildren's suggestions have proven to be effective, and some of these proposals are already being put into practice").

[128] U.N. Comm. on the Rights of the Child, General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, ¶ 5, U.N. Doc. CRC/GC/2003/4 (July 1, 2003); *see* World Conference on Human Rights, June 14-25, 1993, *Vienna Declaration and Programme of Action*, ¶ 5, U.N. Doc. A/CONF.157/23 (July 12, 1993) ("All human rights are universal, indivisible and interdependent and interrelated."); Maastricht Guidelines *supra* note 90, ¶ 4; ; *see also* Gillian MacNaughton & Diane F. Frey, *Decent Work for All: A Holistic Human Rights Approach*, 26 AM. U. INT'L L. REV. 441, 457 (2011) ("Human rights are interdependent in two senses, reflecting (1) the relationships between rights, and (2) the relationships between persons."); Jonathan Todres, *Rights Relationships and the Experience of Children Orphaned by AIDS*, 41 U.C. DAVIS L. REV. 417, 463 (2007) (discussing how the interrelated nature of rights is particularly relevant to the experience of vulnerable and marginalized populations and how "understanding the interrelated nature of rights at the specific level is a vital step in ensuring the efficacy of the human rights regime").

[129] As the U.N. Committee on Economic, Social, and Cultural Rights has acknowledged, "The adoption of a human rights-based approach . . . will greatly facilitate implementation of the right to health." General Comment No. 14, *supra* note 87, ¶ 64. Equally important, a human rights-based approach will help ensure that law, policy, and programs reach all issues that impact health.

[130] EIDE & EIDE, *supra* note 88, at 4. In addition, support for and realization of adolescents' rights can advance the rights of adult members of the family and community. *See* MacNaughton & Frey, *supra* note 128, at 459–60.

capacity to ensure the well-being of adolescents and enable them to realize their full potential.

CONCLUSION

Although the U.S. government typically proceeds slowly when contemplating undertaking international human rights law obligations,[131] the great majority of Americans are supportive of human rights.[132] For example, seventy-two percent of Americans believe strongly that health care should be a right, and eighty-two percent believe strongly that equal access to quality public education is a right.[133] Eighty-one percent of Americans believe lack of quality education for children in poor communities is a violation of the right to education.[134] Indeed, human rights are deeply rooted in our history.[135] Therefore, a human rights

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[131] *See supra* note 83 (explaining that it took the United States forty years to agree to become a party to the Genocide Convention). Today, the United States is one of only two countries in the world that is not a party to the CRC (the other is Somalia). *Convention on the Rights of the Child—Status of Ratifications*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en (last visited Nov. 1, 2011) (showing 193 states parties to the CRC, with the United States and Somalia being the only two holdouts).

[132] BELDEN, RUSSONELLO & STEWART, THE OPPORTUNITY AGENDA, HUMAN RIGHTS IN THE UNITED STATES: FINDINGS FROM A NATIONAL SURVEY 3 (2007), *available at* http://opportunityagenda.org/pdfs/HUMAN%20RIGHTS%20REPORT.PDF ("Americans strongly believe in the concept of human rights and agree that 'every person has basic rights regardless of whether their government recognizes those rights or not.'").

[133] *Id.* at 3–4.

[134] *Id.* at 5.

[135] *See, e.g.*, Larry Cox, *A Movement for Human Rights in the United States: Reasons for Hope*, 40 COLUM. HUM. RTS. L. REV. 135, 138 (2008) ("[Human Rights] are as at home here, if not more so, as they are in any other country. The core idea of human as opposed to constitutional rights, that these are inalienable rights that belong to every human being and are inseparable from human dignity and freedom, is at the heart of our Declaration of Independence."); *see also* Cynthia Soohoo & Jordan Goldberg, *The Full Realization of Our Rights: The Right to Health in State Constitutions*, 60 CASE W. RES. L. REV. 997, 1033 (2010) ("[M]any state constitutions include a broader array of individual rights [than the U.S.

approach to adolescent health would be consistent with U.S. values and traditions and with most Americans' views on how we should treat the youngest members of our society.

In the United States today, adolescent health issues are many and complex. Tackling any one of them is not an easy undertaking. Addressing all of them together will be even more difficult. The magnitude of the challenge, however, should not paralyze us as adults. Moreover, we cannot allow one or two politically contentious issues to impede progress in other areas affecting adolescent well-being. Today, too many adolescents suffer harm and experience health issues that prohibit them from realizing their full potential. We can, and must, do better. As Nelson Mandela has stated, "There can be no keener revelation of a society's soul than the way in which it treats its children."[136] Using a human rights framework, policy makers and child advocates, working in partnership with families and communities, can develop a comprehensive response to the full range of issues affecting adolescent health and provide all children with the opportunity to develop to their fullest potential.

Constitution], including socio-economic rights provisions.").

[136] Nelson Mandela, Speech at the Launch of the Nelson Mandela Children's Fund (May 8, 1995), *in* NELSON MANDELA, IN HIS OWN WORDS 421 (2003).