KIDS COUNT Indicator Brief

Reducing the Teen Death Rate

July 2009

The Annie E. Casey Foundation

KIDS COUNT Indicator Brief
Reducing the Teen Death Rate

.

Life continues to hold considerable risk for adolescents in the United States. In 2006, the teen death rate stood at 64 deaths per 100,000 teens (13,739 teens) (KIDS COUNT Data Center, 2009). Although it has declined by 4 percent since 2000, the rate of teen death in our country remains substantially higher than in many peer nations, based largely on higher rates for the three most prevalent causes of death among adolescents and young adults: motor vehicle accidents, homicide and suicide (Institute of Medicine, 2008). A range of risky behaviors contribute to teens' risk of injury and disease, including alcohol and drug use and risky sexual behaviors.

To be sure, reducing the teen death rate will require strategies that make accidents and excess less likely. Complicating the challenge is a wide gap between the realities of teens and the perceptions of adults – who grossly underestimate adolescents' risk-taking behaviors (Action for Children North Carolina, 2006). Prevention efforts must tackle the key risk factors facing adolescents, while also supporting the important adults in teens' lives and addressing the underlying causes of our nation's high teen mortality rates. This *KIDS COUNT Indicator Brief* offers broad strategies that:

- **Focus intensively on motor vehicle safety**
- **Support policies and programs aimed at preventing teen violence**
- **Address teen suicide by bolstering the capacity of families and communities to recognize and treat teens in emotional distress**
- **Support adults who play significant roles in the lives of teens**
- **Strengthen the capacity of families and communities to support teens' healthy development**
- **Strengthen understanding of the teen years**

- **Focus intensively on motor vehicle safety**
Motor vehicle crashes continue to be the leading cause of fatalities among American teens, accounting for more than one-third of the deaths among youth aged 16 to 19 (Centers for Disease Control and Prevention, 2009). This age group has a higher risk of being in a car accident than any other age group. According to the National Highway Transportation Safety Administration (NHTSA), 3,490 teenage drivers died in automobile crashes in 2006. The risk of being in a car crash is particularly high for teens during the first year in which they are eligible to drive. For teenage boys, the risk is even greater: Per mile driven, 16- to 19-year-old male drivers are four times as likely to be involved in a crash as older drivers (Centers for Disease Control and Prevention, 2009). There is good news as well. Preliminary data for 2008—when fewer overall drivers took to the roads due to economic pressures and seat belt use increased markedly in several parts of the nation—show a record drop in fatalities due to car crashes (NHTSA, 2009).

Research points to the wisdom of a comprehensive approach to teen driver safety that incorporates these key components:

Strengthen and expand graduated driver licensing (GDL) programs. Teens tend to be multi-taskers and are prone to distraction. It is difficult for many young people to tune out noisy friends or turn off cell phones. Lack of driving experience and immaturity are the main causes of their high crash rates. Parents have an important role to play in modeling and monitoring safe driving. Research shows that parental involvement in supervising and regulating teens' practice and early independent driving is critical to ensuring their safety on the road (Simons-Mortons & Ouimet, 2006). But government policy plays a role as well. Currently, 46 states and the District of Columbia have three-stage GDL systems that issue restricted licenses to their youngest drivers, reducing limits over time. None of these states, however, has yet incorporated all of the components recommended by the Insurance Institute for Highway Safety, the National Transportation Safety Board, and NHTSA. Studies indicate that most strict and comprehensive graduated driver licensing (GDL) systems are associated with substantial reductions (38 percent for fatal crashes; 40 percent for non-fatal injury crashes) for 16-year-old drivers (Baker et al., 2007).

Focus on increasing seat belt use among teens. This means modeling consistent seatbelt use, supporting public education efforts and enforcing existing seat belt laws. Teens are less likely to use seat belts than another other age group. In a national survey of seat belt use among high school students, 12 percent of males and 8 percent of females said they rarely or never wear seatbelts. Not wearing a seat belt can have severe consequences. Nearly 60 percent of the young people involved in fatal car accidents in 2006 were not wearing seat belts at the time (NHTSA, 2009). Finally, the failure to use seatbelts can be linked to alcohol use. Drivers are less likely to use seat belts when they have been drinking. In 2007, for example, 64 percent of the teen drivers who were involved in fatal car crashes and had been drinking were not wearing seat belts (NHTSA, 2009).

Strengthen programs aimed at combating alcohol and drug use. Drinking while under the influence of alcohol or drugs is a leading cause of teen motor vehicle fatalities. Mothers Against Drunk Driving (MADD), Students Against Destructive Decisions (SADD) and other community-based organizations have initiated a variety of public education campaigns to convince teens not to drive while under the influence of alcohol or drugs. There has been some progress, but not enough. Today, there is greater recognition that programs aimed at combating alcohol and drug use are most likely to succeed when they are comprehensive and rooted in communities. In particular, community coalitions that utilize multiple strategies across multiple sectors have proven to be effective in reducing teen drinking. One effective model worked with parents and physicians to change adolescents' behavior and the norms of the community at large by modeling healthy behaviors, and providing alcohol- and drug-free spaces for youth. Community-based treatment centers and follow-up services were made available to teens and families struggling with substance abuse and other emotional problems—including those with limited means and no insurance coverage (Ellis & Lenczner, 2000).

Get serious about the dangers of driving while using cellphones, and other forms of multitasking. For millions of teens, cell phones (including both conversation and texting) are a way of life. Studies indicate that American drivers consistently overestimate their ability to drive safely while using cellphones, although they worry about other drivers' ability to do so (Richtel, 2009). A study by the Harvard Center for Risk Analysis estimated that cellphone distractions cause 2,600 traffic deaths each year (Cohen & Graham, 2003). Legislators need to get serious about the dangers of cellphones, especially as manufacturers market a wider range of electronics for use in cars. As things stand, five states ban the use of hand-held cellphones while driving, and eight states ban the use of all cellphones for novice drivers (Richtel, 2009).

- **Support policies and programs aimed at preventing teen violence**

After motor vehicle accidents, homicide remains the second leading cause of death among 15- to 19-year-olds. In 2006, 2,291 teen deaths were due to homicide. American Indian and Alaskan Native teens ages 15 to 19 had the highest homicide rate (95 per 100,000 teens) followed by African American youth (85 per 100,000 teens). The teen death rate for American Indians and Alaskan Natives is nearly 50 percent higher than the national average (64 per 100,000 teens) while the rate for African American youth is more than 30 percent higher than the national average (KIDS COUNT Data Center, 2009).

Support laws that make guns more difficult for teens to acquire or use. Guns are the leading cause of fatal teen violence, and are used in 82 percent of teen homicides and more than half of teen suicides (Centers for Disease Control and Prevention, 2008). In states where fewer homes have guns, there are fewer accidental firearm deaths and fewer teen suicides. In comparison to the four states with the lowest levels of gun prevalence, the four states with the highest prevalence had twice as many teen suicides and about 10 times as many gun-related accidental deaths (National Council of Economic Advisors, 2000.) Other research indicates that in 75 percent of firearm suicides by teens and young adults, the gun came from the youth's own home or that of a close friend or family member (Contemporary Pediatrics, 2007).

Keep guns and non-students out of schools. This is a common-sense approach to preventing shootings. Many states and communities have targeted high-risk schools and installed metal detectors, photo ID procedures, and locker checks to reduce the threat of firearm violence. Prevention efforts aimed at reducing school violence overall can also help to keep guns and non-students off school property. Non-students pose threats, in part, by recruiting school-age youngsters for gang activity. One in four high school students surveyed in 2005 reported gang activity at their schools (Centers for Disease Control and Prevention, 2008).

Teach violence prevention and conflict resolution. While violence prevention and conflict resolution training in schools and community organizations previously focused on high school and middle school students, they are now introduced at a much younger age. Today, students as young as preschoolers are exposed to lessons on solving

problems and resolving disputes nonviolently, recognizing warning signs for violence in their peers, and providing support to friends in distress. Studies show that the key to the effectiveness of these programs is to start early (Broughton, 2008). In addition, many educators are more alert to bullying behaviors that can lead to violence. Research shows that children and youth also benefit from learning how to reconcile after aggressive interactions (Tremblay, 2006). Using a public health approach, some promising programs also attempt to concentrate their efforts on children and families where a history of violent behavior has been observed.

Educate adults who parent or work with teens about the risk factors for violent behavior, and expand mental health services for troubled teens. Public health researchers have identified risk factors for teens who may be more inclined toward violent behavior, including a history of early aggression; exposure to violence at home and in the neighborhood; failure in school; a family history of drug and/or alcohol abuse; a heightened sense of alienation; and association with peers who are prone to violent behavior (Centers for Disease Control and Prevention, 2008). Effective prevention efforts address violent behavior, but also provide teens with strategies for coping with emotional problems, family issues, and community-based stressors.

- **Address teen suicide by bolstering the capacity of families and communities to recognize and treat teens in emotional distress**

As of 2006 suicide was the third leading cause of death for teens between the ages of 15 and 19. In 2006, 1,555 teens 15 to19 committed suicide—a rate of 7 out of 100,000. This rate has dropped by 9 percent since 1999 (KIDS COUNT Data Center, 2009).[1] American Indians/Alaskan Natives had the highest rate at 19.7 per 100,000 which was almost 5 times that of African Americans teens who had the lowest suicide rate (4.2 per 100,000) followed by white teens age 15 to19 (7.8 per 100,000) (KIDS COUNT Data Center, 2009). Male teens ages 15 to 19 were approximately four times as likely as their female counterpart to commit suicide (11.6 vs. 2.8 per 100,000).

In 2007, 14.5 percent of high school students reported that they had seriously considered suicide during the past year and 6.9 percent had made at least one suicide attempt (Centers for Disease Control and Prevention, 2008). Suicide rates rise in the teen years for a variety of reasons. Teens considering suicide often face problems at home that are out of their control or seem overwhelming, such as economic crisis, divorce, alcoholism, domestic violence, or sexual abuse. As the incidence of depression rises, so does the teen suicide rate. A family history of depression or suicide also increases a teen's risk for self-destructive behaviors.

Provide support systems for teens and families. Teens with an adequate support network of friends, family, religious affiliation, peer groups, or extracurricular activities have ways to deal with their everyday frustrations. A support network is especially crucial for teens who have suffered physical or sexual abuse and those who have very poor relationships with their parents (Simpson, 2001). If a troubled teenager feels that he

---

[1] The coding of mortality data changed significantly in 1999 from ICD-9 to ICD-10. Data from before 1998 cannot be compared with data from 1999 onward.

or she cannot confide in parents, a more neutral person—a counselor, mentor, grandparent, member of the clergy, school advisor, or family doctor—should be enlisted to provide support. For parents and other family members, a support network can also make a difference. While research indicates that about half of the psychiatric illnesses experienced by adults, including depression, anxiety and substance abuse, start by the time a child is 14, parents are not always aware of the severity of their children's emotional challenges. Most teens do not communicate their intention to commit suicide to parents, family members or even friends. In fact, 90 percent of the time, parents are unaware of their teens' suicide attempts (Friedman, 2006).

Alleviate pressures experienced by gay teens. Gay teens are at especially high risk of suicide. Studies show that lesbian, gay, bisexual, and transgender youth are approximately four times more likely to attempt suicide than heterosexual youth (Massachusetts Department of Education, 2006). In addition, a 2008 study of white and Latino gay, lesbian and bisexual young adults found that those from rejecting families are eight times more likely to attempt suicide and six times more likely to suffer from significant depression than their heterosexual peers (Ryan et al., 2009). Those who must cope alone with the social stigma against homosexuality or who are rejected or subjected to violence at home may develop feelings of inadequacy or worthlessness that contribute to suicide attempts. Support for gay and bisexual youth from skilled, sensitive and knowledgeable health care and mental health providers and schools, social service agency and suicide prevention program staff is essential to ensuring healthy outcomes throughout the life span.

Increase public awareness of the signs of teen depression. Adults who spend time with teens need to be aware of those behaviors and remarks that may be signs of depression or otherwise indicate a risk of suicide, including suicide threats (direct and indirect); withdrawal from friends and family; an extreme inability to concentrate; loss of interest in favorite activities; changes in eating and/or sleeping patterns; dramatic changes in personality and/or appearance; expressions of hopelessness, excessive guilt or shame; self-destructive behaviors (reckless driving, drug abuse, promiscuity); preoccupation with death; and bequeathal of cherished possessions (Mental Health America, 2009; Simpson, 2001).

- **Support the adults who play significant roles in the lives of teens**

As their children enter the teen years, many parents feel that their influence diminishes. However, research consistently shows that parents remain a powerful influence on teens, and can play a critical role in fostering healthy development and preventing risky behaviors (Ackard et al., 2006). In particular, parent involvement and parent-child connectedness are major influences in helping teens avoid drinking and drug use, unhealthy weight-control behaviors, violence, and the kind of mental health problems that lead to suicide attempts.

Help parents gain the skills needed to act as effective advocates for their children.
Neighborhood resources can make a difference for teens—but only if they are utilized by young people and their families. Research shows that children do better when parents

have the skills required to locate and access programs and services (Furstenberg, 2001). Family support and parent education programs—which are often geared to parents with very young children—must be designed to meet the needs of all families.

Expand access to family mental health services geared to families with adolescents. A wide body of research from multiple fields has found that rates of illness and death tend to be higher for people who are socially isolated. Warm relationships with parents, family members and friends are important protective factors for teens, as for people of other ages. But being part of a family (or other social network) can also have adverse effects. Adolescents' mental health can be compromised by many factors related to their family social climate, such as the ongoing presence of conflict and anger, parent-child relationships that lack warmth and emotional support, and parenting styles that are overly controlling and dominating. Over the long term, these conditions can increase teens' emotional reactivity to conflict and undermine their ability to manage stress (Singer & Ryff, 2001). Expanding access to family mental health services is therefore a key to reducing risk.

Base labor policies and employment practices on the premise that teens, like younger children, need time with their parents. Young people are most likely to avoid dangerous or destructive behaviors when they are close to their parents and spend time with them, for example by eating dinner together. Studies show that the prevalence of drinking is nearly twice as high among 15- to 16-year-olds who do not feel close to a parent and do not eat dinner together. Moreover, teens aged 15 to 16 who do not eat dinner with their parents on a regular basis are twice as likely to attempt suicide as those who do (Kann, et al., 1998). Still other research shows that teens—particularly girls— who regularly eat meals with their families have lower rates of drug use, depression and low self-esteem (Larson et al., 2006).

- **Strengthen the capacity of families and communities to support teens' healthy development**

The transition from childhood to adulthood is a period of major physical, biological, social and psychological changes. It is a time that offers opportunities on many fronts to encourage healthy development, but it is also during the teen years that many of the medical and psychological problems of adulthood take root. Consequently, the teen years are among the most critical points in the life cycle for ensuring access to prevention, early intervention and treatment services.

Recognize the impact of neighborhood effects on teens' behaviors. While families are the most important influence on children and youth, neighborhood effects can also make a difference. Research shows that the lives of adolescents are clearly influenced by the communities in which they live, particularly in terms of their participation in high-risk behaviors, such as drug use and sexual activities, their access to medical and mental health services, and the quality of their connections both within and outside their neighborhoods (Boardman & Saint Onge, 2005; Wilkenfeld et al., 2008). In addition, many studies have found that living in racially diverse neighborhoods has a positive effect on school outcomes for African American youth (Kurlaender & Yun, 2005).

Efforts to strengthen communities and address the isolation of segregated neighborhoods therefore hold promise for helping to support teens' healthy development.

Create or expand community coalitions aimed at addressing teens' needs, following best practices. In recent decades, a great deal has been learned about the kinds of program that can help to reduce risk for adolescents, particularly in the areas of preventing unwanted pregnancies and substance abuse. For example, a 2008 review of best practices in youth substance-abuse reduction found that while school-based programs alone do not have a significant impact on adolescents' use of substances, positive outcomes are more likely when school-based programs are used in combination with school-community partnerships and community-based approaches (Cheon, 2008).

Support youth development programs. Research consistently finds that effective youth development programs can help adolescents avoid risky behaviors and make successful transitions to adulthood (Brown et al., 2001). Effective programs equip young people with skills and knowledge in key areas—including educational achievement and cognitive development, health and safety, social and emotional wellbeing, and self-sufficiency—through activities such as mentoring, community service, leadership development, and long-term follow-up and supports. Successful youth development programs are those that allow young people to feel safe, engage them as partners, encourage the development of social skills and positive relationships with caring adults, set high expectations for growth and behavior, and operate in the context of the larger community (Urban, 2008).

Promote safe work opportunities for teens. Researchers say that at least 40 percent of teens work at some time during the year, either while in school or during the summer or both. Working can have positive and negative consequences for adolescents. It may enhance responsibility, independence, and self-esteem. However, high-intensity work (more than 20 hours per week) is associated with unhealthy and problem behaviors, including substance abuse. Many working teens are exposed to multiple work-related hazards and use dangerous machinery and equipment despite federal prohibitions (Runyan, 2006). About 70,000 young people seek treatment in hospital emergency departments for work-related injuries each year, and the average of 70 teen deaths annually from injuries suffered at work is believed to be an underestimate. The National Institute for Occupational Safety and Health (NIOSH) recommends that employers, schools, parents and teens work together to create healthy environments for young workers that include adequate training and supervision of young workers, the implementation of on-site injury-prevention programs, and knowledge of child labor laws and restrictions (NIOSH, 2003).

Ensure that adolescent health services, settings and providers are equipped to work effectively with teens. Health services have an important role to play in promoting teen health and preventing disease and behavioral/mental health problems. However, many of the health settings that serve teenagers are not designed to do so effectively. For example, research indicates that more than one third of teens with behavioral problems requiring medical or psychological intervention are not receiving mental health services

(The National Academies, 2008). In addition, public and private health services for teens tend to be highly fragmented, poorly equipped to handle the full spectrum of teens' needs—which include health promotion, prevention and behavioral health services—and are staffed by providers who have not been trained to interact effectively with this age group. According to research conducted by The National Academies, effective strategies for strengthening adolescent health services should include a primary health care system for adolescents that works in partnership with community services; a focus on prevention; providers trained and licensed to work with adolescents; and ensuring teen's rights to access and receive confidential medical services (The National Academies, 2008).

- **Strengthen understanding of the teen years**

In recent years, researchers emphasize that the complex developmental shifts that take place in the teen years can best be understood with an interdisciplinary approach (Dahl, 2004). Bringing together insights from neuroscience, developmental psychology, social policy, and other fields can provide insight into risk and resiliency in adolescence, and can inform the design of effective early intervention and prevention strategies.

Strengthen understanding of resilience in adolescence, especially among high-risk youth. For many years, researchers have sought to understand why some teens manage to stay healthy and avoid high-risk behaviors in circumstances where many of their peers do not. They have examined not only risk factors, but also protective factors, taking into account many kinds of influences--genetic, biological, and environmental. Increasingly, this resilience framework has been used to develop preventive strategies, including family-strengthening approaches. A deeper understanding of resilience in adolescence may lead to more effective interventions (Kumpfer & Summerhays, 2006).

Increase understanding of how risk and protective factors cluster and interact.
Researchers report that both risk factors and protective factors tend to cluster in the teen years. A better understanding of how these factors interact could lead to more effective health-promoting efforts, including interventions that address multiple health risk behaviors in an integrated way (Mistry et al., 2009). Studies that consider multiple variables can also improve interventions for adolescents in special circumstances, such as homeless youth (Kidd & Shahar, 2008).

Focus, in particular, on youth with disabilities. In recent decades, schools across the U.S. have made strides in addressing the educational needs of youth with disabilities. Less has been done to assess or address other challenges reported for this population, including feelings of social isolation and higher levels of risk-taking behaviors (Altshuler, Mackelpring & Baker, 2008).

Shed light on gender differences in adolescent risk and protective factors.
Researchers know that girls are more likely than boys to experience depression as they enter the teen years, but they do not yet have a comprehensive understanding of this gender difference.

Adolescence is one of the most important and challenging transitions in the life cycle. It is a period of rapid growth and change, a time of increasing independence and growing self-knowledge. Most teens make their way through these important years with relative success. Some thrive despite daunting threats to their health and safety, such as poverty, illness, access to lethal weapons, drugs, physical and sexual abuse, and an absence of positive role models. Others meet problems that undermine their physical and emotional health, and do not survive the teen years. Helping adolescents avoid risk requires multifaceted efforts that target not only specific hazards, but also the broader forces that jeopardize their wellbeing.

References

Ackard, D., Newmark-Sztainer, D. et al. 2006. Parent-child connectedness and behavioral and emotional health among adolescents. *American Journal of Preventive Medicine* 30(1):59-66.

Action for Children North Carolina. 2006. *Sex, drugs and rock n' roll: What teens do, what parents assume and what parents can do*. Accessed at http://www.kidscount.org/kcnetwork/issues/documents/ncteenriskreport.pdf.

Altshuler, S.J., Mackelprang, R.W. & Baker, R.L. 2008. Youth with disabilities: A standardized self-portrait of how they are faring. *Journal of Social Work in Disability & Rehabilitation* 7(1):1-18.

Baker S.P., Chen, L., Li, G. 2007. *Nationwide review of graduated driver licensing*. AAA Foundation for Traffic Safety.

Boardman, J.D. & Saint Onge, J.M. 2005. Neighborhoods and adolescent development. *Children, Youth and Environments* 15(1):138-64. Accessed at www.colorado.edu/journals/cye.

Broughton, A. 2008. Experts on youth violence: Intervene early or pay dearly later. Accessed at cnn.com.

Brown, D., DeJesus, E., Maxwell, S. & Schiraldi, V. 2001. *Barriers to and promising approaches to workforce and youth development for young offenders.* Annie E. Casey Foundation.

Centers for Disease Control and Prevention. 2009. *Teen drivers: Fact sheet*. Accessed at www.cdc.gov/MotorVehicleSafety/Teen_Drivers/teendrivers_factsheet.html.

Centers for Disease Control and Prevention. 2008. *Youth violence: Facts at a glance.* Accessed at www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf.

Centers for Disease Control and Prevention. 2008. *Youth violence prevention: Risk factors for the perpetration of youth violence*. Accessed at www.cdc.gov/ncipc/dvp/YVP/YVP-risk-p-factors.htm.

Centers for Disease Control and Prevention. 2007. Suicide trends among youth and young adults ages 10-24 years—United States, 1990-2004. *Morbidity and Mortality Weekly Report* 56(35);905-08.

Centers for Disease Control and Prevention. 2008. *Suicide: Facts at a glance.* Summer 2008. Accessed at www.cdc.gov/ncipc/dvp/suicide/suicide_data_sheet.pdf.

Cheon, J.W. 2008. Best practices in community-based prevention for youth substance reduction: Towards strengths-based positive development policy. *Journal of Community Psychology* 36(6):761-79.

Cohen, J.T. & Graham, D.H. 2003. *A revised economic analysis of restrictions on the use of cell phones while driving*. Risk Analysis 23: 5-17.

Contemporary Pediatrics. 2007. *To reduce teen suicide toll, remove guns*. Accessed at http://contemporarypediatrics.modernmedicine.com/contpeds/2007+AAP+Dateline/To-Reduce-Teen-Suicide-Toll-Remove-Guns/ArticleStandard/Article/detail/468775.

Dahl, R.E. 2004. Adolescent brain development: A period of vulnerabilities and opportunities. Keynote address. *Annual of the New York Academy of Sciences* 1021:1-22.

Ellis, T.M. & Lenczner, S.J. 2000. *Lessons for the field: Community anti-drug coalitions as catalysts for change.* A report to the Annie E. Casey Foundation, Community Anti-drug Coalitions of America.

Friedman, R.A. 2006. Uncovering an epidemic—Screening for mental illness in teens. *The New England Journal of Medicine* 355(26).

Furstenberg, F. 2001. Managing to make it: Afterthoughts. *Journal of Family Issues* 22: 150-162.

Kann, L., Kinchen, S.A, Williams, B.I. et al. 1998. *Youth risk behavior surveillance, 1997.* Atlanta, GA: Centers for Disease Control and Prevention.

Kidd, S, & Shahar, G. 2008.Resilience in homeless youth: The key role of self-esteem. *American Journal of Orthopsychiatry* 78(2):163-72.

Kumpfer, K.L. & Summerhays, J.F. 2006. Prevention approaches to enhance resilience among high-risk youth. *Annual of the New York Academy of Sciences* 1094:141-63.

Kurlaender, M. & Yun, J.T. 2005. Fifty years after Brown: New evidence of the impact of school racial composition on student outcomes. *International Journal of Educational Policy, Research, and Practice: Reconceptualizing Childhood Studies* 6(1):51-78.

Larson, R.W., Branscomb, K.R., Wiley, A.R.. *Forms and functions of family mealtimes: Multidisciplinary perspectives*. New Directions for Child and Adolescent Development 2006:111:1-15.

Institute of Medicine of the National Academies. 2008. *Adolescent health services: Missing opportunities.*

Massachusetts Department of Education. 2007. *Massachusetts Youth Risk Behavior Survey* 2006.

Mental Health America. 2009. *Factsheet: Young people and suicide: Teen suicide.* Accessed at www.nmha.org/go/information/get-info/suicide/young-people-and-suicide-teen-suicide.

Mistry, R., McCarthy, W.J., Yancey, A.K., Lu, Y. & Patel, M. 2009. Resilience and patterns of health risk behaviors in California adolescents. *Preventive Medicine* 48(3):291-7.

National Center for Health Statistics. 2008. *Health, United States, 2008 with special feature on the health of young adults*. Accessed at www.cdc.gov/nchs/hus.htm.

National Council of Economic Advisors. 2000. *Teens and their parents in the 21st century: An examination of trends in teen behavior and the role of parental involvement.*

National Highway Traffic Safety Administration. 2009. *Young drivers. Traffic safety facts: 2007 data.*

National Highway Traffic Safety Administration. 2009. *Early estimate of motor vehicle traffic fatalities in 2008.* Traffic Safety Facts Research Note.

National Highway Traffic Safety Administration. 2008. *Graduated driver licensing system.* Traffic Safety Facts, January 2008.

National Institute for Occupational Safety and Health. 2003. *NIOSH Alert: Preventing deaths, injuries and illnesses of young workers*. Publication No. 2003-128. Accessed at www.cdc.gov/niosh/docs/2003-128/2003-128.htm.

Richtel, M. 2009. Dismissing the risks of a deadly habit. *The New York Times* July 19, p. 1.

Runyan, C.W., Schulman, M., Dal Santo, J., Bowling, M., Agans, R. 2007. Work-related hazards and workplace safety of US adolescents employed in the retail and service sectors. *Pediatrics* 119(3):526-34.

Ryan, C., Huebner, D., Diaz, R.M., Sanchez, J. 2009. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics* 123(1):346-52.

Simons-Morton, B. & Ouimet, M.C. 2006. Young drivers: Parent involvement in novice driving: A review of the literature. *Injury Prevention 2006* 12(Supplement 1):i30-i37.

Simpson, A.R. 2001. *Raising teens: A synthesis of research and a foundation for action.* Project on the parenting of adolescents. Center for Health Communication. Harvard School of Public Health.

Singer, B.H. & Ryff, C.D., eds. 2001. *New horizons in health: An integrative approach.* National Academy Press.

The National Academies. 2008. *Adolescent health services: Missing opportunities.* Report Brief, Accessed at www.bocyf.org/ahc_brief.pdf.

Tremblay, R.E. 2006. Prevention of youth violence: Why not start at the beginning? *Journal of Abnormal Child Psychology* 34:481-87.

Urban, J.B. 2008. Components and characteristics of youth development programs: The voices of youth-serving policy makers, practitioners, researchers, and adolescents. *Applied Developmental Science* 12(3):128-39.

Wilkenfeld. M.A., Moore. K.A. & Lippman, L. 2008. Neighborhood support and children's connectedness. Annie E. Casey Foundation Child Trends Fact Sheet #2008-05. Accessed at www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={6F770206-8571-4A4B-B6DA-FFA1449FD3CA}

Online resources

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org

American Foundation for Suicide Prevention
http://www.afsp.org

Forum on Adolescence (National Academy of Sciences)
http://www.bocyf.org/Forum_on_Adolescence.html

MADD (Mothers Against Drunk Driving)
www.madd.org

National Alliance for Safe Schools
www.safeschools.org

National Safety Council
http://teendriver.nsc.org/

National Youth Violence Prevention Resource Center
www.safeyouth.org

SA\VE - Suicide Awareness \ Voices of Education
http://www.save.org

Students Against Destructive Decisions (founded as Students Against Drunk Driving)
www.sadd.org