

# **KIDS COUNT Indicator Brief**

## **Reducing the Teen Death Rate**

The Annie E. Casey Foundation

July 2003

*KIDS COUNT Indicator Brief*

## **Reducing the Teen Death Rate**

The rate of teen death in the U.S. remains substantially higher than in many of our peer nations, based largely on higher rates for the three most prevalent cause of death among adolescents and young adults: motor vehicle accidents, homicide, and suicide (Centers for Disease Control, 1999). To be sure, risk is heightened when teens drive, drink or use drugs, and have access to lethal weapons (Centers for Disease Control, 1999). However, merely limiting opportunities for excess or accident is not sufficient. Strategies to reduce teen mortality need to strengthen parents' and other caretaking adults' involvement with teens; fortify youth development agencies and other community organizations that serve adolescents and their parents; and seize opportunities to introduce or bolster policies that concern at-risk teens.

This *KIDS COUNT Indicator Brief* first offers broad strategies that address the underlying causes of our nation's high teen mortality rates, and then tackles the three leading causes of teen death:

- **Support the Adults Who Play Significant Roles in the Lives of Teens**
- **Strengthen the Capacity of Communities to Support Teens' Healthy Development**
- **Focus Intensively on Motor Vehicle Safety**
- **Develop Policies and Programs Aimed at Preventing Violence**
- **Address Teen Suicide by Bolstering the Capacity of Families and Communities to Recognize and Treat Teens in Emotional Distress**

### **1. 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 an important role in fostering healthy development and preventing risky behaviors (Simpson, 2001; National Council of Economic Advisors, 2000). In particular, parent involvement is a major

influence in helping teens avoid drinking and drug use, violent behavior, and the kind of mental health problems that lead to suicide attempts.

- **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. The prevalence of drinking is nearly twice as high among 15 to 16 year olds who do not feel close to a parent and who don't eat dinner with their parents. Teens aged 15 to 16 who don't eat dinner with their parents on a regular basis are twice as likely to have attempted suicide as those who do (Kann, et.al., 1998).
- **Help parents gain the skills needed to act as effective advocates and brokers for their children.** Neighborhood resources can make a difference for teens—but only if they are utilized by youngsters and their families. Research shows that children do better when parents have the kinds of managerial skills that allow them to locate and utilize programs and services (Furstenberg, 1999). Family support and parent education programs—which are often geared to parents with very young children—should be redesigned to meet the needs of all families.
- **Expand access to family mental health services geared to adolescents.** Researchers have found that generally speaking, rates of illness and death are 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 affects. Adolescents' health can be harmed by a social climate that is conflictual and angry; 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.

## 2. Strengthen the Capacity of Communities to Support Teens' Healthy Development

- **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. For example, the presence of affluent neighbors affects the likelihood that young women in their teens will give birth or drop out of school, even after family factors are taken into account. Racial integration in the neighborhood appears to improve school outcomes for African Americans students. Efforts to strengthen communities and address the isolation of segregated neighborhoods therefore hold promise for helping to reduce risk for teens (Coulton, 1996).

- **Create or expand community coalitions aimed at addressing teens' needs, following best practices.** In recent years, a great deal has been learned about the kinds of programs that can help to reduce risk for adolescents (for example, by helping them avoid unwanted pregnancies and substance abuse). For example, a KIDS COUNT working paper on teen childbearing in America's largest cities found that local efforts—particularly programs that are comprehensive and flexible and include a public education component—have helped to bring down the teen birth rate in many of the nation's cities. Success was also attributed to more employment opportunities for teens, as well as investments in youth-oriented activities such as sports and recreation, career counseling, tutoring, and leadership development (Annie E. Casey Foundation, 1999).
- **Support youth development programs.** Programs that equip youth with academic, vocational, and work readiness skills, as well as “life skills” and developmental opportunities, can help them avoid risky behaviors and make a successful transition to adult responsibilities (Brown et al., 2001). Core principles of youth development include mentoring, community service, leadership development, long-term follow-up and supports. Close relationships with caring adults, community service (especially when it is school-based), and community supports have all been associated with lowering teens' risky behaviors (Simpson, 2001).
- **Ensure 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. Children and adolescents may be exposed to work-related hazards; about 100,000 young people seek treatment in hospital emergency departments for work-related injuries each year, and the average of 70 annual deaths related to injuries suffered at work is believed

to be an underestimate. Better monitoring of young people's occupational health and safety, better training and supervision, and strict limits on teens' work hours have been recommended by the National Research Council's Forum on Adolescence (1998).

### **3. Focus Intensively on Motor Vehicle Safety**

Immaturity and lack of driving experience are the main causes of teenagers' high crash rates (National Center for Injury Prevention and Control, 1999), although drinking and failing to use seat belts are significant contributing factors. Compared to older drivers, teenagers as a group are more willing to take risks and less likely to use seat belts. Teenagers are also more likely than older drivers to underestimate the dangers in hazardous situations, and are less able to cope with dangers when they arise. Alcohol is another major factor in teen traffic fatalities. In 1997, one in five young drivers involved in fatal crashes had been drinking (NHTSA, 1999).

- **Support broad, multi-faceted substance abuse prevention programs.** Close to a third of high-school seniors are binge drinking, according to recent research (Simpson, 2001). Drinking and driving is often a fatal combination for teenagers. Mothers Against Drunk Driving (MADD), Students Against Drunk Driving (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 illegal drugs. There has been some progress, but the death rates remain high, and some vehicular safety experts recommend a zero-tolerance blood-alcohol limit for teen drivers as an effective means to reduce deaths (National Center for Injury Prevention and Control, 1999). Today, there is greater recognition that programs aimed at combating alcohol and drug abuse best 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. An effective model worked with parents and physicians to change both adolescent behavior and the norms of the community at large, model healthy behaviors, and provide alcohol- and drug-free spaces for youth. Community-based treatment centers and follow-up services were made available to teens and families who are struggling with substance abuse and other emotional problems—including those with limited means and no insurance coverage (Ellis & Lenczner, 2000).

- **Introduce graduated licensing.** Accidents may be prevented when beginning drivers learn to drive in a step-by-step learning/licensing method that links their experience and skills to progressing toward full driving privileges. In this way, new drivers accumulate behind-the-wheel experience in low-risk settings. A number of states now issue graduated licenses for teen drivers and are gathering data on rates of accident reduction. The concept has been recommended by the Insurance Institute for Highway Safety and the National Transportation Safety Board.
- **Strengthen enforcement of seat belt laws.** Most teens killed in automotive accidents were not wearing seat belts (National Center for Injury Prevention and Control, 1999). Seat belt use laws and their strict enforcement can prevent some of those deaths.

## 5. Support Policies and Practices Designed to Reduce Teen Violence

After motor vehicle accidents, homicide remains the second-leading cause of death for teens. It is the number one cause of death for African-American and Hispanic youth ages 15 to 24 (National Center for Injury Prevention and Control, 1999).

- **Support laws that make guns more difficult for teens to acquire or use.** Guns are the leading cause of fatal teen violence – used in 85 percent of teen homicides and 63 percent of teen suicides. 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 ten times as many gun-related accidental deaths (National Council of Economic Advisors, 2000).
- **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 keep weapons out of schools. Of course, reducing the number of firearms does not address the behavioral causes of teen homicides, but it can prevent deaths and injuries.

- **Teach violence prevention and conflict resolution.** Previously focused on high-school and middle-school students, conflict resolution training in schools and community organizations now introduces students as young as pre-school age to lessons about how to solve problems non-violently, how to communicate better and how to resolve disputes. 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 (Aber, et. al., 1999). Many educators are also more alert to bullying behaviors that can lead to violence.
- **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 (Brenner, 1999). Prevention efforts must seek not only to address violent behavior and cut off access to guns, but also to give teens other ways to cope with emotional problems, family issues, or community-based stress.

##### **5. Support Family and Community Resources for Recognizing and Treating Teens in Emotional Distress**

Suicide is the third leading cause of death for young people between the ages of 15 and 24, and the fourth leading cause of death for children between the ages of 10 and 14 (Friday, 1995). By some estimates, up to ten per cent of teens attempt suicide each year (Simpson, 2001). 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, parental divorce, alcoholism, domestic violence or sexual abuse (Mullen, 1996). 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.** 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

(Mullen, 1996; Simpson, 2001). If a troubled teenager feels that he or she cannot confide in parents, a more neutral person--a counselor, grandparent, member of the clergy, school advisor, or family doctor--should be enlisted to provide support.

- **Alleviate pressures experienced by gay teens.** Gay teens are at especially high risk of suicide. According to a report from the US Dept of Health and Human Services (1989), gay youth are two to three times more likely to attempt suicide than other young people. 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. Youths who are at the greatest risk for suicide are the ones who are least likely to reveal their sexual orientation; suicide may be a way of keeping the secret (Remafedi, 1991). Mental Health and youth service agencies can provide support for gay and lesbian teens; schools can protect gay youth from abuse from peers and provide accurate information about sexual orientation to families and peers (U.S. Dept of Health and Human Services, 1989; Peterson, 1991).
- **Increase public awareness of signs of teen depression.** Adults who spend time with teens need to know about behaviors and remarks that may be signs of depression or otherwise indicate a risk of suicide: talk of suicide; withdrawal from friends and family; an extreme inability to concentrate; dramatic changes in personal appearance; loss of interest in favorite activities; expressions of hopelessness or excessive guilt; self-destructive behavior (such as reckless driving, drug abuse, and promiscuity); preoccupation with death; and bequeathal of favorite possessions (Simpson, 2001).

Adolescence is one of the most important, challenging transitions in the life span. 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 well-being, such as easy access to

lethal weapons and drugs (Carnegie Corporation of New York, 1995). But others meet problems that undermine their physical and emotional health, and some do not survive the teen years. Helping adolescents avoid risk requires broad, multi-faceted efforts that target not only specific hazards, but also the broader forces that threaten teens' well-being.

## ***References***

Aber, J. Lawrence; Brown, Joshua L. & Henrich, C.C. (1999). Teaching conflict resolution: An effective school-based approach to violence prevention.

Annie E. Casey Foundation (1999). *Teen childbearing in America's largest cities*. Baltimore, MD.

Blumenthal, S.J. 1999. *Young women and smoking*. Washington, DC: U.S. Public Health Service's Office on Women's Health, Department of Health and Human Services.

Blumenthal, S, and Kupfer, D. (1990) *Suicide across the life cycle*. Washington, DC: American Psychiatric Press, Inc..

Brener N.D., Simon T.R., Krug E.G.& Lowry R. (1999) Recent trends in violence-related behaviors among high school students in the United States. *Journal of the American Medical Association*; 282(5):440-446.

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

Carnegie Corporation of New York (1995). *Great Transitions: Preparing Adolescents for a New Century*. New York.

Centers for Disease Control and Prevention (1994) *Programs for the prevention of suicide among adolescents and young adults; and suicide contagion and the reporting of suicide: Recommendations from a national workshop*. Atlanta, GA.

Centers for Disease Control and Prevention (1994) Homicide among 15-19 year old males—United States, 1963-1991. *MMWR*, 43(40):725-27.

- Coulton, C.C. (1996). Effects of neighborhoods on families and children: Implications for services. In A.J. Kahn and S.B. Kamerman, eds. *Children and their families in big cities: Strategies for service reform*. New York: Columbia University School of Social Work.
- Elkind, David. (1981) *The hurried child: Growing up too fast too soon*. Reading, Massachusetts: Addison-Wesley.
- Ellis, T.M. and Lenczner, S.J. (2000). *S.J. Lessons for the field: Community anti-drug coalitions as catalysts for change*. A report to the Annie E. Casey Foundation from Community Anti-Drug Coalitions of America. Alexandria, VA: Community Anti-Drug Coalitions of America.
- Friday, J. C. “ The Psychological Impact of Violence in Underserved Communities”  
Journal of Health Care for the Poor and Underserved, Vol 6, No. 4, 1995, pp. 403-409.
- Furstenberg, F. (1999). *Managing to make it. An afterthought*. Philadelphia, PA: University of Pennsylvania.
- Fursetenberg F. F.,Cook, T. D., Eccles, J. Elder, G. H. & Sameroff, A. ( 1999) *Managing to Make It: Urban Families and Adolescent Success*. Chicago: University of Chicago Press.
- Hyde, Margaret O. and Elizabeth H. Forsythe. (1987) *Suicide: The hidden epidemic*. New York: Franklin Watts.
- Kachur S.P., Stennies G.M., Powell K.E., et al (1996). School-associated violent deaths in the United States, 1992-1994. *Journal of the American Medical Association*, 275:1729-1733
- Kann, L., Kinchen S.A. & Williams B.I., et al. (1998) Youth risk behavior surveillance, 1997. Atlanta, GA: Centers for Disease Control and Prevention.
- Mullen, P.E. et. al., (1996) “ The Long-term Impact of Physical, Emotional and Sexual Abuse of Children: A Community Study, “ *Child Abuse & Neglect*, Vol. 20, No. 1, pp. 7-21.

National Center for Injury Prevention and Control (1999) *National Summary of Injury Mortality Data, 1981-1997*. Atlanta, GA: Centers for Disease Control and Prevention, (available on CDC web site).

National Council of Economic Advisors (2000) *Teens and their parents in the 21<sup>st</sup> century: An examination of trends in teen behavior and the role of parental involvement*. Washington, DC.

National Highway Safety Administration (1999)

National Research Council (1998) Forum on Adolescence.

Office of the Surgeon General. (2000). Children and mental health. *Mental health: A report of the Surgeon General*. Washington, DC.

Peterson PK, ed. (1991) Special symposium: gay and lesbian youth. In: *American Academy of Pediatrics, Adolescent health section newsletter*; 12 (1):3-41

Potter L.B., Powell K.P. and Kachur S.P. (1995), Suicide prevention from a public health perspective. *Suicide and life-threatening behavior*, 25(1):82-91.

Remafedi G., Farrow J.A. ,& Deisher R.W. (1991), Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics* , 87:869-875

Simpson, A.R. ( 2001) *Raising teens: A synthesis of research and a foundation for action. Project on the Parenting of Adolescents*. Boston: Center for Health Communication. Harvard School of Public Health.

Tremblay, Pierre J. (1997). *Gay and bisexual male youth: Overrepresented in suicide problems and associated risk factors*. Paper presented at the Third Bi-Regional Adolescent Suicide Prevention Conference, Breckenridge, Colorado. (Available at [www.virtualcity.com/youthsuicide/colorado.htm](http://www.virtualcity.com/youthsuicide/colorado.htm))

U.S. Department of Health and Human Services (1989) “ Report on the Secretary’s Task Force on Youth Suicide.

***For More Information:***

[www.KidsHealth.org](http://www.KidsHealth.org)

Neil Izenberg

Editor-in-Chief, KidsHealth.org

Director, Nemours Center for Children's Health Media

The Nemours Foundation

[izenberg@KidsHealth.org](mailto:izenberg@KidsHealth.org)

**Youth Violence and Suicide Prevention Team**

National Center for Injury Prevention and Control

4770 Buford Highway, MS K-60

Atlanta, GA 30341

770-488-4646

<http://www.cdc.gov/ncipc/dvp/yvpt/solution.htm>

**MADD (Mothers Against Drunk Driving)**

P.O. Box 541688

Dallas, TX 75354-1688

800-GET-MADD

Offers a free web download or interactive CD-ROM program called The Key for parents and teens to promote sober, safe driving

[www.madd.org](http://www.madd.org)

**SA\VE - Suicide Awareness \ Voices of Education**

(612) 946-7998

<http://www.save.org>

**American Foundation for Suicide Prevention**

(888) 333-AFSP

<http://www.afsp.org>

**National Center for Injury Prevention and Control**

**Division of Unintentional Injury Prevention**

4770 Buford Highway NE

Atlanta, GA 30341-3724

(770) 488-4652

**The American Academy of Child and Adolescent Psychiatry**

3615 Wisconsin Ave., N.W., Washington, D.C. 20016-3007

(202) 966-7300 fax: (202) 966-2891

<http://www.aacap.org>