



State Strategies for Preventing Child and Adolescent Injuries and Violence Health

NATIONAL CONFERENCE *of* STATE LEGISLATURES | AUG 2017



Introduction

Since childhood and adolescence are critical times for growth and development, injuries and exposure to violence during these ages may be particularly damaging and costly. Early life events and circumstances—whether beneficial or harmful—can help shape someone’s health status throughout his or her lifetime. Injuries and violence, like other events that occur during childhood and adolescence, can have lasting effects on one’s development, health and overall well-being. They can also lead to long-term medical costs and lost productivity.

As more evidence becomes available about the long-lasting effects of early harmful events—including their personal and financial impacts—policymakers are increasingly exploring whether states have a role in preventing and mitigating such experiences.

Research shows that positive experiences and circumstances that promote health, well-being and resiliency in children—along with safe, stable, nurturing relationships and environments—can help shape a trajectory for good health throughout a person’s lifetime. Conversely, traumatic events or injuries can cause developmental problems and lead to worse health status throughout adulthood. For example, a [traumatic brain injury](#) during childhood can impact thinking and memory skills, vision, hearing and emotional functioning—potentially affecting brain abilities and health throughout the child’s lifetime.¹ Similarly, someone exposed to [childhood violence](#) and other traumatic events has a higher risk of developing chronic health conditions later in life, compared to a child without these experiences.²

Unintentional injuries and injuries resulting from violence, including those sustained in motor vehicle crashes or teen dating violence, can lead to lifelong disability or chronic health conditions. Injury is the leading cause of death for people ages 1 to 44, causing more deaths each year than non-communicable and infectious diseases combined. Injuries and violence across all age groups in the United States were estimated to cost [\\$671 billion](#) in lifetime medical expenses and lost productivity in 2013.³ And youth injury may be particularly costly due to potential health consequences over the decades to come. [Research](#) from the American Public Health Association found that child and adolescent injuries cost \$106 billion in 2000 in lifetime medical expenses and work loss.⁴

Proven strategies and interventions can help prevent the costly health conditions associated with child and adolescent injury. In addition, preventing exposure to violence early in life can help reduce cyclical or intergenerational violence—children who experience abuse, neglect or other types of violence are more likely to commit a violent crime, or abuse or neglect their own children. Successful prevention activities can interrupt this cycle, with youth and future generations reaping the benefits. Numerous policy options exist that aim to prevent injuries and violence among children and teens.

This brief outlines background information and prevention strategies for four injury and violence topics:

- Child abuse and neglect
- Traumatic brain injury
- Sexual and dating violence
- Motor vehicle injuries

Life Course Perspective

The “life course perspective” is a public health concept that looks at the connection between early life events and future health status. Whether beneficial or harmful, early life events and circumstances can play a large role in shaping health trajectories. The federal [Maternal and Child Health Bureau](#) states that the “interplay of risk and protective factors, such as socioeconomic status, toxic environment exposures, health behaviors, stress and nutrition [during early life] influence health throughout one’s lifetime.” There are time periods in early life when critical abilities, such as speaking and memory, are formed. Circumstances and events that take place during these critical periods can have an especially large impact on health potential. For example, infants who receive adequate nutrition and affectionate care measure [better on brain function tests](#) at age 12 compared to children who grew up in less advantageous circumstances.

Sources: Health Resources and Services Administration, Maternal and Child Health Bureau; United Nations Children’s Fund.

Child Abuse and Neglect

Hundreds of thousands of children each year experience abuse and neglect, which is one of the injury and violence issues with clearly understood immediate and lifetime effects. [Child abuse and neglect](#) includes physical, sexual and emotional abuse and neglect from a parent or other caregiver that results in harm, potential harm or threat of harm.⁵ According to the [Centers for Disease Control and Prevention \(CDC\)](#) and [National Survey of Children's Exposure to Violence](#), a quarter of children have experienced abuse or neglect during their lifetime, and one in seven children has been the victim of abuse or neglect within the past year.^{6,7}

Physical injuries or emotional and psychological issues, such as post-traumatic stress disorder and anxiety, can manifest in the immediate aftermath of abuse or neglect. In addition, the [CDC](#) reports that childhood violence increases the risk for problems with brain development, social skills and language abilities, as well as heart disease, cancer and obesity. Children who experience abuse and neglect are more likely to become teen parents, use drugs and undergo arrest as a juvenile.⁸

The impact of child abuse and neglect can go beyond one person's lifespan through cyclical and intergenerational effects. Children who are abused or neglected are more likely to [commit a violent crime](#) and may be at [higher risk](#) of maltreating their own children.^{9,10} Children who experience abuse and neglect are also at higher risk for becoming victims of other forms of violence in their lifetime.

Child abuse and neglect is also considered by experts to be an [adverse childhood experience](#)—a stressful or traumatic experience during childhood that can impact lifelong health and well-being. Brain development research shows that chronic stress and early adversity, such as child abuse and neglect, can be toxic to developing brains. In particular, adverse childhood experiences have been shown to increase the chances of risky health behaviors, chronic health conditions, poor academic achievement and workforce performance, and financial stress, among other outcomes. They can even increase the risk of dying early. People with six or more adverse experiences are more likely to die 20 years earlier, on average, than people who did not have such experiences.¹¹

Due to the array of potential lifelong health effects and high prevalence of child abuse and neglect, the financial costs associated with this issue are high. Lifetime [costs](#) from child abuse and neglect in the United States in 2008 dollars total approximately \$124 billion each year in child and adult health care, productivity losses, child welfare, criminal justice and special education.¹²

States have taken several policy approaches to address this issue, many of which focus on the *social determinants of health*, or the environments and contexts in which abuse and neglect occurs. Policies may aim to reduce *risk factors*, or circumstances or characteristics that increase risk for child abuse and neglect (e.g., family financial stress), or promote *protective factors*—conditions or resources that prevent or lessen the harms of maltreatment (e.g., nurturing caregivers with enhanced parenting skills).

The CDC provides a [technical package](#) that identifies strategies and approaches shown to prevent child abuse or neglect, or risk factors for child abuse and neglect.¹³ These strategies, which may be implemented in combination, include supporting positive parenting, strengthening economic supports to families, and intervening to lessen the harms of child abuse and neglect.

NCSL's Injury Prevention Legislation Database tracks legislation introduced in all 50 states and the District of Columbia on 10 injury prevention topics, including child abuse and neglect, teen dating violence and traumatic brain injury. Visitors to the database can search for legislation by injury prevention topic, state, year and more.

Adverse Childhood Experiences

Adverse childhood experiences—or “ACEs”—are stressful or traumatic experiences during childhood. An ACE score is calculated by adding up the number of types of adverse experiences a person had, with risk for negative outcomes increasing as the ACE score increases. A study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente from 1995 through 1997 first revealed that ACEs are common and increase the risk for many negative health and well-being indicators. Among the 17,000 Southern Californian adult study participants, almost two-thirds had at least one type of adverse childhood experience and more than 20 percent had three or more ACEs. The most common ACEs were physical or sexual abuse, exposure to substance abuse or mental illness, and parental separation or divorce.

State leaders are increasingly interested in legislation specifically targeting ACEs. As of March 2017, at least 38 bills were pending or sent to the governor in at least 18 states. These bills included appropriating funds for ACEs prevention, establishing task forces or study committees, and requiring or encouraging health care providers to use an ACE screening tool with their patients.

Sources: Centers for Disease Control and Prevention, 2016; NCSL, 2017.

Social Determinants of Health

Social determinants of health are the conditions in which we live, learn, grow and age, according to the [World Health Organization](#). They include access to health care, economic stability, educational status, and access to high-quality foods and housing. All of these factors affect health, functioning and quality of life. For example, higher educational attainment is associated with better health status. In addition, people living in neighborhoods with high rates of violence may not have the opportunity to engage in sufficient physical activity because they feel unsafe on the streets outside their homes, and the [design of communities and streets](#) can affect rates of pedestrian, bicycle and motor vehicle-related injuries.

Sources: World Health Organization; U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

[Home visiting programs](#) are one way states are helping enhance parenting skills and support families. Such programs support nurses, social workers, early childhood educators or other trained professionals who visit families in their homes during pregnancy and early childhood. Services provided by home visiting programs can include health education, screenings, connections to other services, building parenting skills and more. Many home visiting programs are [cost-effective and evidence-based](#), or shown through scientific evidence to be effective in lowering the risk of child abuse and neglect, improving maternal and child health, and promoting child development and school readiness. States support home visiting programs through a combination of federal, state, local and private funds. The federal [Maternal, Infant and Early Childhood Home Visiting Program](#), for example, provides funding for all 50 states, the District of Columbia and five territories to operate home visiting programs for at-risk pregnant women and parents with infants or young children.¹⁴ Recent [state efforts](#) include:

- The Rhode Island General Assembly enacted the [Rhode Island Home Visiting Act](#) in 2016, which requires the Department of Health to implement a statewide home visiting system using evidence-based models.
- Oklahoma lawmakers enacted the [Family Support Accountability Act](#) in 2015, which mandates that home visiting programs work in partnership and sets minimum outcomes that programs must achieve.
- In 2013, the Arkansas legislature enacted [Senate Bill 491](#), which requires the implementation of statewide, voluntary home visiting services. The legislation also requires 90 percent of home visiting funding to support models that are designated as evidence-based or promising practices.

Other state strategies aim to provide children with high-quality care and education, or support programs that intervene and provide treatment to children who have experienced abuse or neglect. Approaches may also focus on the broader physical and social environments in which abuse and neglect occur. For example, [access](#) to adequate housing, health care and social services may reduce a child’s risk of abuse or neglect.¹⁵ States have also considered policies related to strengthening economic supports to families and promoting family-friendly [workplace policies](#), or policies that support employees in balancing both work and family responsibilities, which can reduce stress, a risk factor for child abuse and neglect.¹⁶

- At least three states (California, New Jersey and Rhode Island) currently offer paid family and medical leave, with New York also offering these benefits beginning in January 2018, and Washington, D.C. offering them in 2020.
- At least six states (Arizona, Connecticut, California, Massachusetts, Oregon and Vermont) require certain employers to provide paid sick leave.

Youth Traumatic Brain Injury

Traumatic brain injury (TBI)—a “disruption in the normal function of the brain that can be caused by a bump, blow or jolt to the head, or penetrating head injury”—takes a significant financial and health toll.¹⁷ Associated **costs** for the estimated annual **2.8 million** TBI-related emergency department visits, hospitalizations and deaths totaled approximately \$76.5 billion in direct and indirect medical costs in 2010—and health consequences can be severe.^{18,19,20} **Potential effects** of a TBI include impaired thinking, memory, movement and emotional functioning.²¹

Traumatic brain injury poses a particular threat to the health and development of children and adolescents—one of the groups at elevated risk for injury. Common causes include unintentional falls, being struck by or against an object, and motor vehicle crashes.²² In addition, brain injuries sustained by this age group frequently occur during sports or recreation activities. A recent research report **estimates** that nearly 330,000 children and adolescents received emergency department treatment for a sports and recreation-related TBI in 2012.²³ And between 2001 and 2012, the rate of youth visits to emergency departments for sports and recreation-related TBIs more than doubled.²⁴

According to the life course perspective, youth may be particularly vulnerable to the consequences of TBI, including changes in thinking and behavior, as their brains are still developing. Children can also experience symptoms such as headaches and sleep difficulties that can impact their daily lives. Children and teens experiencing TBIs may need to stay home from school and let the brain rest and heal, which could potentially affect school performance, academic achievement and social participation. The **cumulative effects** of repeated TBIs within a short time frame, such as hours, days or weeks, can be life-threatening.²⁵

In response to findings about children and teens’ increased vulnerability to TBI, as well as the high health and financial costs, states have taken steps to help prevent brain injuries among this age group. **Since 2007**, all 50 states and the District of Columbia have enacted legislation to prevent youth sports-related TBI, primarily through prevention protocols in public school settings. Most of these laws create rules around removing a youth athlete from play or practice in the event of a suspected concussion, as well as requirements for returning an athlete to practice or play after evaluation and clearance by a designated health care provider. These laws aim to prevent dangerous repeat TBIs among children and teens in organized sports.

Most state youth TBI laws also require education or training for coaches on recognizing and responding appropriately to a suspected TBI. **Indiana Senate Bill 234** (2016), for example, requires coaches to complete a certified education course with information on concussions before starting coaching duties, and at least once every two years after. Rhode Island’s **School and Youth Programs Concussion Act** requires school districts to use the CDC’s **HEADS UP** concussion training materials, or similar materials, with coaches and trainers. Policies may also require schools to provide student athletes and their parents with information to help recognize and prevent TBIs.

Several states have taken steps in recent years to strengthen their youth TBI laws, such as by establishing penalties for non-compliance, or by expanding the scope of the policies beyond public school settings, such as in private schools and youth sports leagues. For example:

- **New Mexico Senate Bill 137**, enacted in 2016, establishes brain injury protocols for youth athletic activities located outside of school settings.
- **Delaware House Bill 404**, also enacted in 2016, includes a range of measures to prevent TBI among youth athletes playing in events sponsored by leagues, clubs and other organizations.

“Return to Learn” After Traumatic Brain Injury

Another area of growing state interest focuses on the return of children and teens to classroom learning following a traumatic brain injury. These students may need special accommodations and supports during recovery, or a plan developed by school personnel to ensure a smooth transition back to school. The Virginia General Assembly, for example, enacted legislation ([House Bill 954](#)) in 2016 requiring each local school division to include a “return to learn” protocol as part of its TBI policies and procedures. The law requires school personnel to be alert to potential cognitive and academic issues among students returning to school after a brain injury, and to accommodate a gradual return to full participation in academic activities. During the 2017 legislative session, at least four states (Hawaii, Indiana, Minnesota and West Virginia) considered bills related to return to learn protocols.

Source: NCSL, 2017.

Sexual and Dating Violence

Another issue gaining increasing attention among lawmakers, the media and the public is teen and young adult sexual and dating violence. [Research](#) shows that youth and adolescence may be times of particular vulnerability to [sexual violence](#), which can include attempted and completed rape, sexual coercion, and unwanted sexual contact and other experiences.^{26,27} The [Centers for Disease Control and Prevention](#) reports that approximately one in five women in the United States has experienced rape or attempted rape in her lifetime. More than three-quarters of female rape victims were first raped when they were younger than 25 years old, and approximately 40 percent were first raped before they were 18 years old.²⁸ An estimated [one in five women](#) is sexually assaulted while in college.²⁹

The trends are similar for male victims, with a majority first experiencing sexual violence during adolescence or young adulthood. Certain racial and ethnic and sexual minority groups are also [disproportionately affected](#) by sexual violence. For example, multiracial women and American Indian/Alaska Native women are disproportionately impacted by rape or attempted rape.³⁰

A related issue, teen dating violence, also has a high burden among young people. [Teen dating violence](#) can include sexual violence, as well as physical, psychological or emotional violence, within a dating relationship, and can occur in person or electronically.³¹ Recent data from the [Youth Risk Behavior Surveillance System](#) revealed that approximately 10 percent of high school students reported physical victimization and approximately 11 percent reported sexual victimization from a dating partner during the 12 months prior to being surveyed.³² Rates are even higher among female students, with approximately 12 percent experiencing physical violence and 16 percent experiencing sexual violence from a dating partner within the past 12 months.³³

Like other types of injury and violence, experiencing dating or sexual violence as a teen or young adult can have severe impacts on development and future health status. The [CDC reports](#) that experiencing teen dating violence can negatively affect emotional development and health, and even increase risk for future violence and risk-taking behaviors.³⁴ Teen victims of dating violence are at higher risk for victimization during college. They are also more likely to practice unhealthy behaviors such as alcohol, drug and tobacco use, as well as experience symptoms of depression and anxiety and thoughts of suicide.³⁵ The statistics are similar for sexual violence, with victims commonly experiencing physical injuries, depression, anxiety, suicidal thoughts and post-traumatic stress disorder.³⁶

States have taken several approaches to preventing teen and young adult dating and sexual violence, including efforts that take place at high schools or on [college campuses](#). For example:

- At least 22 states have laws that allow, urge or require school boards to develop or include curriculum on teen dating violence. Several of these states also require schools to develop teen dating violence policies.

- The Virginia General Assembly enacted legislation ([House Bill 659](#)) in 2016 that requires high school family life education curricula to incorporate age-appropriate elements of effective and evidence-based programs on the prevention of dating violence, domestic abuse, sexual harassment and sexual abuse.
- The Connecticut General Assembly enacted comprehensive prevention legislation ([House Bill 5029](#)) in 2014. The law requires institutes of higher education to provide annual sexual assault, stalking and intimate partner violence prevention and awareness programming for all students and employees, as well as ongoing prevention and awareness campaigns.

Several states have considered incorporating information on affirmative consent—ensuring verbal consent before engaging in sexual contact—in sex education classes. [California requires](#) public high schools to teach affirmative consent. [At least four states](#) in 2016 and at least three states in 2017 considered legislation related to consent and sexual education.³⁷

Other strategies to prevent youth dating and sexual violence focus on requiring or supporting evidence-based programs that have been rigorously evaluated and shown to be effective, many of which also take place in schools. The CDC released a [technical package](#) that compiles the best available evidence of how to prevent sexual violence.³⁸ The CDC also maintains and updates a [list of sexual violence prevention programs](#) it identifies as effective or promising, many of which focus on youth or young adult populations. Effective programs may focus on teaching skills to prevent sexual violence, such as healthy relationship skills. For example:

- [Safe Dates](#), a school-based prevention program for eighth- and ninth-grade students, has been shown to reduce sexual violence perpetration and victimization throughout a four-year follow-up period.³⁹
- Recently, [Green Dot](#), a bystander intervention program, was [shown to be effective](#) in preventing sexual and dating violence in 26 Kentucky high schools. Green Dot teaches students how to speak up or intervene when they witness harassment, bullying or abuse.⁴⁰

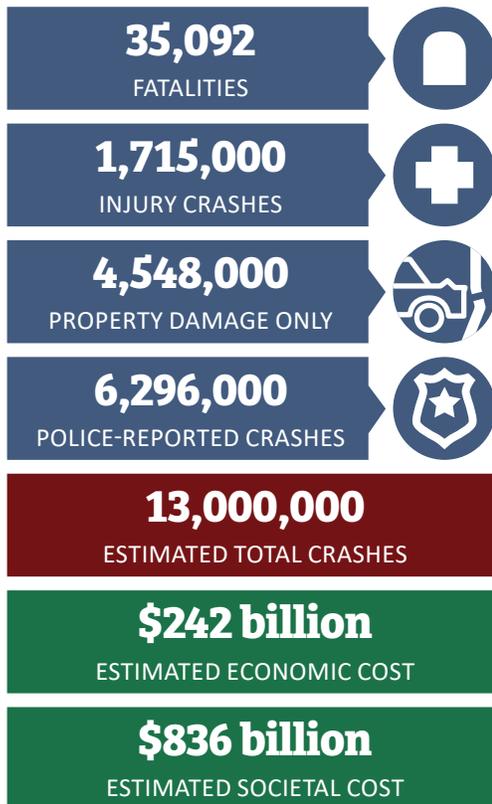
The Economic Impact of Sexual Violence

In addition to its significant health and social costs, youth dating and sexual violence take an economic toll on individuals and states. A recent [study](#) found that the lifetime cost to society for each victim of rape is \$122,461, including costs stemming from short- and long-term medical care, criminal justice system activities and lost productivity. Victims of sexual violence, on average, have more and costlier medical care compared to non-victims. Sexual violence can also affect productivity, including ability to work, diminished performance and job loss. Loss of productivity can influence the earning power and economic well-being of victims of sexual violence. State budgets are similarly affected. A [2009 study](#) in Iowa, for example, found that costs resulting from sexual violence totaled \$4.7 billion annually (or about \$1,580 per resident) in quality of life, work loss, medical care and criminal justice proceedings. Similarly, a [Utah study](#) found that in 2011, sexual violence-associated costs totaled almost \$5 billion, or nearly \$1,700 per Utah resident.

Sources: American Journal of Preventive Medicine, 2017; American Journal of Preventive Medicine, 2014; Utah Department of Health, 2015.

Crashes by Severity, 2015

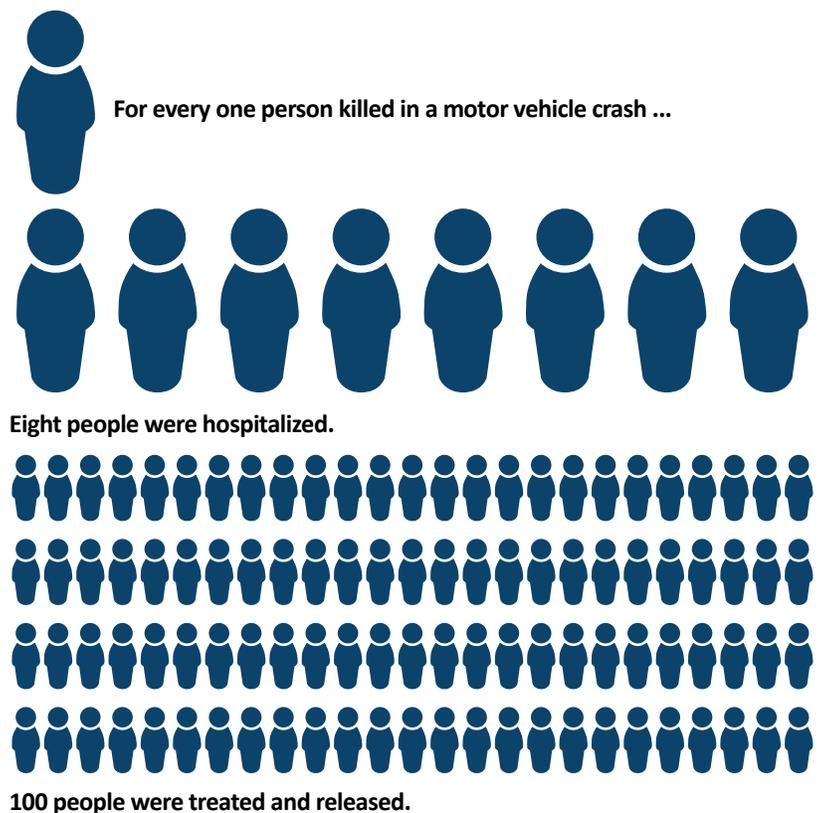
Among Americans of all ages.



Source: National Highway Traffic Safety Administration, 2016

The Full Impact of Motor Vehicle Crashes

Among Americans of all ages.



Source: Centers for Disease Control and Prevention, 2012

Motor Vehicle Injuries

Motor vehicle injuries also pose a significant threat to children's and teens' health. In 2015, motor vehicle traffic crashes were the **leading cause of injury deaths** for people ages 5 to 24 and the second leading cause for children ages 1 through 4.⁴¹ Although child injuries and deaths in motor vehicle crashes have declined since 1975, on average, three children were killed and an average of 487 children were injured every day in the United States in 2015.⁴² In the same year, 1,886 young drivers between ages 15 and 20 were killed in car crashes and 715 passengers under age 21 were killed in vehicles operated by young drivers.⁴³ This reflects a 9 percent increase in fatalities and a 14 percent increase in injuries from 2014.

Teen drivers are at higher risk of dying in an alcohol- or distraction-related crash compared to other drivers, and children and teens may be particularly vulnerable to the lifelong consequences of injuries sustained during motor vehicle crashes. States continue to take action to address child and teen motor vehicle injuries by passing laws related to child passenger protection, graduated driver's licensing, teen distracted driving, teen impaired driving, and safety measures associated with travel to and from school.

Child Passenger Protection

The most effective way to keep children safe in cars is to ensure that they are properly restrained in appropriate child restraint systems in the back seat. [The National Highway Traffic Safety Administration \(NHTSA\)](#) estimates that child safety seats reduce the risk of fatal injury in passenger cars by 71 percent for infants and 54 percent for toddlers.⁴⁴

CDC Child Restraint Guidelines

REAR-FACING CAR SEAT	FORWARD-FACING CAR SEAT	BOOSTER SEAT	SEAT BELT
<p>Birth up to age 2</p> <p>Buckle children in a rear-facing seat until age 2 or when they reach the upper weight or height limit of that seat.</p>	<p>Age 2 up to at least age 5</p> <p>When children outgrow their rear-facing seat, they should be buckled in a forward-facing car seat until at least age 5 or when they reach the upper weight or height limit of that seat.</p>	<p>Age 5 up until seat belts fit properly</p> <p>Once children outgrow their forward-facing seat, they should be buckled in a booster seat until seat belts fit properly. The recommended height for proper seat belt fit is 57 inches tall.</p>	<p>Once seat belts fit properly</p> <p>Children no longer need to use a booster seat once seat belts fit them properly—when the lap belt lays across the upper thighs (not the stomach) and the shoulder belt lays across the chest (not the neck).</p>

Sources: American Academy of Pediatrics; Centers for Disease Control and Prevention

All states and the District of Columbia have child restraint laws that require children of certain ages and sizes to ride in appropriate, federally approved child safety restraint systems. The age and size requirements vary by state. The Centers for Disease Control and Prevention provides [restraint use fact sheets](#) for all 50 states.⁴⁵ In the past few years, state lawmakers have enacted legislation to improve child passenger safety. For example:

- Florida lawmakers enacted booster seat legislation ([House Bill 225](#)) in 2014. The law requires children to ride in some type of “child restraint device” until they reach age 6.
- In 2015, California amended its rear-facing child restraint use law to include children under age 2 unless the child weighs more than 40 pounds ([Assembly Bill 53](#)). New Jersey ([Assembly Bill 3161](#)) and Oklahoma ([House Bill 1847](#)) lawmakers enacted similar rear-facing provisions for younger children and now also require older kids to remain in booster seats until they are age 8 or older or 57 inches tall. The Kentucky legislature enacted a similar booster seat provision ([House Bill 315](#)).
- In 2016, Pennsylvania began requiring all children under age 2 who haven’t outgrown manufacturers’ weight limits to be buckled into an approved rear-facing child safety seat in the back seat. For the first year, officers will give verbal warnings to parents but, after that, each violation will carry a \$75 penalty plus other fees ([Senate Bill 1152](#)).

Safety on the Way to School

States are also concerned about preventing injury among children traveling to and from school. The percentage of school children who walked to and from school both increased by around 3 percent between 2007 and 2013. Several states have Safe Routes to School programs that work to ensure the safety of children walking and bicycling to school.

School bus safety remains an issue of concern. From 2006 to 2015, 301 school-age children died in school transportation-related crashes. Fifty-four of those children were in school transportation vehicles. Fifteen states have laws allowing the use of video cameras on school-bus stop arms in order to detect vehicles that pass a stopped school bus. A number of states have considered legislation that would require installation and use of seat belts on large school buses. Currently, eight states have some variation of a law requiring seat belts on school buses.

NCSL's [Traffic Safety Legislation Database](#) tracks legislation introduced in all 50 states and the District of Columbia on 14 traffic safety topics, including child passenger protection, impaired driving, teen drivers and school bus safety. Visitors to the database can search for legislation by traffic safety topic, state, year and more to stay up to date on state traffic safety actions across the country.

Teen Drivers

GRADUATED DRIVER'S LICENSING

Every state has enacted some type of law intended to protect young drivers as they develop skill and experience. Commonly referred to as graduated driver's licensing (GDL), the laws provide a gradual process for teen drivers to gain experience in a safer environment. According to the [CDC](#), components of comprehensive GDL systems include:⁴⁶

- A minimum age of 16 years for obtaining a learner's permit
- A mandatory holding period of at least 12 months for learner's permits
- Nighttime driving restrictions between 10 p.m. and 5 a.m. (or longer) for intermediate or provisional license holders
- A limit of zero or one young passenger who can ride with intermediate or provisional license holders without adult supervision
- A minimum age of 18 years for unrestricted licensure/full licensing

All states have instituted at least one of the GDL components. In recent years, a few states have enacted legislation modifying their state's GDL law. For example:

- In 2015, Alabama lawmakers amended the GDL law to increase the number of hours of required supervised driving from 30 to 50 (House Bill 20).
- Arkansas allows teens to apply for an instruction permit at age 14. In 2015, the state enacted legislation increasing the waiting period from six to 12 months before a license can be obtained for drivers under age 16 ([Senate Bill 49](#)).
- In 2016, the Virginia General Assembly enacted legislation prohibiting the holder of a learner's permit from having more than one passenger under the age of 21 in the vehicle ([Senate Bill 555](#)).

TEENS AND DISTRACTION

Nine percent of teen drivers who were involved in fatal crashes were distracted at the time of the crash in 2015. According to the CDC, drivers under the age of 20 have the highest proportion of distraction-related fatal crashes. Thirty-seven states and Washington, D.C., prohibit the use of cell phones by novice drivers. Additionally, Missouri and Texas ban texting while driving for young drivers. Other recent state action includes:

- In the past two years, Maine ([Senate Paper 267](#)) and Virginia ([Senate Bill 555](#)) passed laws prohibiting the use of hand-held electronic devices by drivers with a learner's permit.
- In 2016, Oklahoma ([House Bill 2298](#)) and New Hampshire ([Senate Bill 357](#)) both passed legislation requiring driver's education courses to provide information on the dangers of distracted driving.

TEENS AND IMPAIRMENT

According to NHTSA, teens are at far greater risk of death in an alcohol-related crash than the overall population, even though they are below the minimum drinking age in every state. In 2015, 21 percent of drivers between the ages of 15 and 20 who were killed in crashes had a blood alcohol content over 0.08 (the legal limit for drivers aged 21 years and older). The CDC provides [drunk driving fact sheets](#) for every state.⁴⁷ States have taken a variety of approaches to address the dangers of teen impaired driving. For example:

- The Tennessee General Assembly enacted legislation in 2016 that authorizes judges to order the use of a restricted license or an interlock device for 16- and 17-year-olds convicted of underage driving while impaired ([Senate Bill 1317](#)).
- Legislation in Connecticut enacted in 2016 allows a court to send individuals under age 21 charged with certain offenses, including driving violations and underage drinking offenses, to a program that will provide education on the dangers of underage drinking and risky driving behaviors ([House Bill 5629](#)).

MV PICCS Helps Policymakers Prioritize Strategies

[Motor Vehicle PICCS](#) (Prioritizing Interventions and Cost Calculator for States) is an interactive online calculator from the CDC that can help state decision-makers prioritize and select motor vehicle injury prevention strategies from a suite of 14 interventions, such as alcohol interlock devices and high-visibility enforcement of seat belt and child restraint and booster laws. MV PICCS calculates the costs of implementation, taking into account the state's available resources.

Source: Centers for Disease Control and Prevention, 2015.

Conclusion

Given the high costs and potential lifelong health effects, youth injury and violence pose a public health threat to individuals, families and states. Policies that prevent injury and violence among this age group may have the greatest impact in reducing lifelong disease and disability, as well as reducing costs stemming from health care services and lost productivity. While the range of prevention policies varies widely by the issue, policymakers may wish to consider several overarching strategies to reduce injuries and violence. These strategies focus on using research and data to identify the most effective policies and the groups most in need of services, targeting the social determinants of health, and collaborating across sectors.

- Learn about existing evidence-based prevention efforts underway in your state, in order to avoid duplication of efforts. Investigate gaps in injury and violence policies and populations served.
- Evaluate existing or new prevention approaches to identify strategies that are effective in different communities and among different populations. Research also enables state leaders to target resources to approaches that are shown to be most effective in preventing child and adolescent injury and violence.
- Support needs assessment and data collection. Needs assessments may be a useful tool for policymakers aiming to identify top issues for youth and teens in their states. In addition, needs assessments and data collection allow leaders to target scarce resources to populations most in need of prevention services, better understand high-risk activities, and evaluate the effectiveness of prevention efforts.
- Consider policies that address the social determinants of health or the contexts in which injury and violence occur. For example, policies that promote family financial well-being may reduce risk for child abuse and neglect, and promoting healthy relationship norms may help prevent teen dating violence.
- Look into opportunities for collaboration across sectors, given the multitude of policy areas (e.g., health, transportation, housing, criminal justice) that influence risk for child and adolescent injury and violence. Similarly, consider policy options that take a comprehensive prevention approach.

Notes

- 1 Centers for Disease Control and Prevention, Division of Unintentional Injury Prevention, “TBI: Get the Facts” (Atlanta, Ga.: CDC, April 27, 2017), https://www.cdc.gov/traumaticbraininjury/get_the_facts.html.
- 2 Centers for Disease Control and Prevention, “About Adverse Childhood Experiences” (Atlanta, Ga.: CDC, April 1, 2016), https://www.cdc.gov/violenceprevention/acestudy/about_ace.html.
- 3 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, “Cost of Injuries and Violence in the United States” (Atlanta, Ga.: CDC, July 29, 2016), https://www.cdc.gov/injury/wisqars/overview/cost_of_injury.html.
- 4 Ted R. Miller, A. Eric Finkelstein, Eduard Zaloshnja, and Delia Hendrie, “Chapter 2: The Cost of Child and Adolescent Injuries and the Savings From Prevention,” in *Injury Prevention for Children and Adolescents* (American Public Health Association: Aug. 9, 2012), <http://ajph.aphapublications.org/doi/abs/10.2105/9780875530055ch02>.
- 5 B.L. Fortson, J. Klevens, M.T. Merrick, L.K. Gilbert, and S.P. Alexander, *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities* (Atlanta, Ga.: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016), <https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf>.
- 6 Ibid.
- 7 D. Finkelhor, H.A. Turner, A. Shattuck, and S.L. Hamby, “Prevalence of childhood exposure to violence, crime, and abuse: Results from the National Survey of Children’s Exposure to Violence.” *JAMA Pediatrics* 169, no. 8: 746-754, <http://www.unh.edu/ccrc/pdf/CV331.pdf>.
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This publication was made possible by grant number 5U50CE002586-02 from the Centers for Disease Control and Prevention. Its contents and the links to non-CDC websites are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention, the National Center for Injury Prevention and Control, or the U.S. Department of Health and Human Services.

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