Teens Behind the Wheel: Graduated Driver Licensing

Two out of five deaths among U.S. teens result from motor vehicle crashes. In 2002, more than 5,000 teens ages 16 to 19 died of injuries caused by motor vehicle crashes (CDC 2004). The risk of motor vehicle crashes is higher among 16- to 19-year-olds than other age groups. Per mile driven, teen drivers ages 16 to 19 are four times more likely than older drivers to crash (IIHS 2004). Add to this, in 2002, the estimated economic cost of police-reported crashes (fatal and nonfatal) involving drivers ages 15 to 20 was $40.8 billion (NHTSA 2003).

How Do Teens Safely Gain Driving Experience?

Graduated Driver Licensing (GDL) systems address the high risks new drivers face by allowing them to get their initial driving experience under low-risk conditions. CDC’s Injury Center supported several publications on the topics of young drivers and GDL:


Parents and guardians can use the basic principles of GDL to help teen drivers gain experience under low-risk conditions. Read the National Safety Council’s Teen Driver: A Family Guide to Teen Driver Safety for helpful tips and suggestions.

CDC Facts, Activities, and Research

- CDC Fact Sheet about Teen Drivers
- CDC Activities Related to Teen Drivers
- CDC Transportation Injury Research Priorities, as described in the CDC Injury Research Agenda

Online Resources

- Insurance Institute for Highway Safety, Teenage drivers
- National Safety Council, Teen Driver: A Family Guide to Teen Driver Safety
References


Graduated Driver Licensing

Graduated driver licensing (GDL) systems address the high risks faced by new drivers by first granting learners permits (supervised practice stage), followed by a provisional license that temporarily restricts unsupervised driving (Williams and Ferguson 2002). Two commonly imposed restrictions include limits on nighttime driving and limits on the number of passengers. These restrictions are lifted as new drivers gain experience and when teenage drivers mature (full licensure) (NCUTLO 2003). Although requirements for advancing through GDL’s three stages—learners permit, provisional licensure, and full licensure—vary across jurisdictions (IIHS 2003), GDL provides a protective environment while new drivers gain experience.

The elevated crash risk for beginning drivers is universal, and GDL has consistently proven effective in reducing such risk. Peer-reviewed evaluations of GDL’s effectiveness in New Zealand, Canada, and the United States show that crashes involving new drivers have been reduced by 9% to 43% (Shope and Molnar 2003; Simpson 2003; Begg and Stephenson 2003). The reasons for these reductions are not clear; however, it is generally accepted that GDL’s safety benefits result both from reductions in the amount of driving by inexperienced drivers and from improvements in driving skills under low-risk conditions.

GDL can apply to all newly licensed drivers—not just those who are young. Research clearly demonstrates that older new drivers experience higher crash rates than drivers of the same age with several years of experience. For this reason, in Canada and New Zealand, where many new drivers are not young, GDL is required of all beginners, regardless of age. Even countries that have a higher licensing age than those in North America can benefit from the introduction of GDL.

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References


Williams AF, Ferguson SA. Rationale for graduated licensing and the risks it should address. Injury Prevention 2002;8 Suppl 2:ii9–14; ii14–6.
Teen Drivers

Motor vehicle-related injuries are the biggest health threat to teenagers in the United States, accounting for two out of five deaths among teens ages 16 to 19 (IIHS 2004b). More than 4,700 teens in this age group died in motor vehicle crashes in 2001 (CDC 2004). In fact, drivers in this age group are four times more likely to crash per mile driven than older drivers (IIHS 2004b). Crash risk is particularly high during the first years that teenagers are eligible to drive (IIHS 2004b). The presence of teen passengers increases the crash risk for unsupervised teen drivers, and the more passengers, the greater the risk (Chen et al. 2000). In 2001, fatal and nonfatal crashes involving drivers ages 15 to 20 cost Americans $40.8 billion (NHTSA 2003d).

Research

Young drivers and fatal alcohol-related motor vehicle crashes, 1982–2001 —

CDC researchers found that between 1982 and 2001, the rate of alcohol-related fatal crashes among drivers ages 16 to 20 years decreased almost 60%, suggesting that prevention measures specific to this age group have been effective. However, drinking and driving remains a serious public health problem for drivers of all ages (CDC 2002).

Do parents influence teen driving behavior? Young inexperienced drivers intervention study —

CDC scientists collaborated with the National Institutes of Health to evaluate a brief intervention with parents and teens designed to increase parental restrictions of teen driving privileges. Results showed that intervention parents reported more driving rules, restricted driving, limits for high-speed roads, weekend night restrictions, and overall driving limits for their teens than did parents in the control group (Simons-Morton, Haritos, and Beck 2004).

Graduated driver licensing —

Graduated driver licensing (GDL) programs—restriction son young drivers that are lifted as they gain driving experience and competence—are an effective strategy for promoting safe development of driving skills. CDC supported research at the Southern California Injury Prevention Research Center in Los Angeles to examine the effectiveness of GDL in California. Results from this study showed a 17% to 18% decrease in crash rates for drivers ages 16 to 17 after GDL (Rice, Peek-Asa, and Kraus 2003).

Reducing motor vehicle crashes among young drivers —

To address young driver issues, CDC helped fund and contributed to a series of five research papers, published in a September 2002 supplement of Injury Prevention (Simons-Morton and Hartos 2002). The articles review the current status of research on young drivers and make a compelling case for GDL programs, which gradually introduce young drivers into the driving population and are effective in reducing the high risk of crashes among teenage drivers.

Symposium on Graduated Driver Licensing: Documenting the Science of GDL —

CDC helped fund and organize a recent symposium on the science of graduated driver licensing, at which scientists documented the effectiveness of GDL programs, the need for GDL program implementation, and the role of parents. As a result of this symposium, the National Safety Council is supporting an annual
update of GDL research that will assess completed and ongoing evaluations. CDC also contributed to a special edition of the Journal of Safety Research (Lin 2003), a collection of 12 scientific papers and other presentations that resulted from the GDL symposium.
Research Update: Reducing Motor Vehicle Crashes Among Young Drivers


Motor vehicle-related injuries are the biggest health threat to teenagers in the United States, accounting for two of five deaths among teens ages 16 to 19 years. The crash risk is highest for drivers 16 years of age due to their immaturity and limited driving experience. A series of five research papers published in a September 2002 supplement of *Injury Prevention* address reducing the crash risk among young drivers. The papers make a compelling case for graduated driver licensing (GDL), the system of laws and practices that gradually introduce young drivers into the driving population.

A summary of the supplement appears below. *Injury Prevention* subscribers can access the full online supplement. CDC's Injury Center has a limited number of print copies available. To request a copy, send an e-mail to OHCINFO@cdc.gov.

- **Traditional driver education is insufficient for reducing the high risk of teen crashes (Mayhew & Simpson, pp. ii3–ii8).**
  Most traditional driver education provides classroom training about the rules of the road and a few hours of behind-the-wheel training. Research suggests that this approach is not effective in reducing the crash risk among newly-licensed teen drivers. Driver education programs may be improved by teaching psychomotor, perceptual, and cognitive skills that are critical for safe driving, and by addressing inexperience, risky behaviors, and other age-related factors that increase the crash risk among young drivers. However, more research into these factors is needed before they can be addressed effectively.

- **Important risk factors highlight the need for graduated driver licensing (Williams & Ferguson, pp. ii9–ii16).**
  Young, beginning drivers have an extremely high crash risk. Certain situations contribute to even greater risk, most notably nighttime driving and driving with teen passengers. The GDL approach addresses the high risks faced by young drivers by requiring an apprenticeship of planned and supervised practice, followed by a provisional license that places temporary restrictions on unsupervised driving in some higher-risk situations.

- **Developmental characteristics of young drivers may contribute to their crash risk (Arnett, pp. ii17–ii23).**
  Inexperience increases the crash risk for new drivers of all ages. However, younger novice drivers crash at higher rates than older novice drivers. These higher crash rates may be due in part to developmental factors such as peer influence, poor perception of risk, and high emotionality. Research about such developmental characteristics could increase our understanding about why young drivers have higher crash rates and could help to improve driver
education programs and licensing policies.

- **Greater parental involvement is needed (Simons-Morton et al., pp. ii24–31).**
  A growing body of research indicates that close parental management of teen drivers can lead to less risky driving behavior, fewer traffic tickets, and fewer crashes. However, many parents tend to be less involved than they could be. A recent study indicates that parents can be motivated to increase restrictions on their newly-licensed teens, at least during the critical first few months of licensure. A model intervention, the Checkpoint Program, led to increased parental limits on teenage driving at licensure and three months after licensure.

- **GDL works (McKnight & Peck, pp. ii32–ii38).**
  GDL has consistently proven effective in reducing new driver crash risk. While research is still needed to better understand which components of GDL are essential, it remains a promising solution for improving teen driver safety. It may also provide the best context for improving driver education and increasing parental involvement, both of which could also reduce the crash risk for teen drivers.
Impaired Driving

Overview

Alcohol-related motor vehicle crashes kill someone every 31 minutes and nonfatally injure someone every two minutes (NHTSA 2004a).

Occurrence and Consequences

- During 2003, 17,013 people in the U.S. died in alcohol-related motor vehicle crashes, representing 40% of all traffic-related deaths (NHTSA 2004a).

- In 2002, about 1.5 million drivers were arrested for driving under the influence of alcohol or narcotics (NHTSA 2004a). That’s slightly more than one percent of the 120 million self-reported episodes of alcohol-impaired driving among U.S. adults each year (Dellinger 1999).

- Drugs other than alcohol (e.g., marijuana and cocaine) are involved in about 18% of motor vehicle driver deaths. These other drugs are generally used in combination with alcohol (NHTSA 2003).

- More than two-thirds of child passengers ages 14 and younger who died in alcohol-related crashes during 1997–2002 were riding with the drinking driver; only 32% of them were properly restrained at the time of the crash (Shults 2004).

Cost

Each year, alcohol-related crashes in the United States cost about $51 billion (Blincoe 2002).

Groups at Risk

- Male drivers involved in fatal motor vehicle crashes are almost twice as likely as female drivers to be intoxicated with a blood alcohol concentration (BAC) of 0.08% or greater (NHTSA 2004b). A BAC of 0.08% is equal to or greater than the legal limit in most states.

- At all levels of blood alcohol concentration, the risk of being involved in a crash is greater for young people than for older people (Zador 2000). In
2003, 25% of drivers ages 15 to 20 who died in motor vehicle crashes had been drinking alcohol (NHTSA 2004c).

- Young men ages 18 to 20 (under the legal drinking age) reported driving while impaired almost as frequently as men ages 21 to 34 (Liu 1997).

- Among motorcycle drivers killed in fatal crashes, 30% have BACs of 0.08% or greater (Paulozzi 2004).

- Nearly half of the alcohol-impaired motorcyclists killed each year are age 40 or older, and motorcyclists ages 40 to 44 years have the highest percentage of fatalities with BACs of 0.08% or greater (Paulozzi 2004).

- Of the 2,136 traffic fatalities among children ages 0 to 14 years in 2003, 21% involved alcohol (NHTSA 2004d).

**Risk Factors**

- Nearly three quarters of those convicted of driving while impaired are either frequent heavy drinkers (alcohol abusers) or alcoholics (alcohol dependent) (Miller 1986).

- Among drivers involved in fatal crashes, those with BAC levels of 0.08% or higher were nine times more likely to have a prior conviction for driving while impaired (DWI) than were drivers who had not consumed alcohol (NHTSA 2004a).

**CDC Activities**

**Actions to decrease alcohol-related fatal crashes involving young drivers have been effective**
Over the past 20 years, alcohol-related fatal crash rates have decreased by 60 percent for drivers ages 16 to 17 years and 55 percent for drivers ages 18 to 20 years. However, this progress has stalled in the past few years. To further decrease alcohol-related fatal crashes among young drivers, communities need to implement and enforce strategies that are known to be effective, such as minimum legal drinking age laws and "zero tolerance" laws for drivers under 21 years of age.


**Sobriety checkpoints reduce alcohol-related crashes**
Fewer alcohol-related crashes occur when sobriety checkpoints are implemented, according to a CDC report published in the December 2002 issue of Traffic Injury Prevention. Sobriety checkpoints are traffic stops where law enforcement officers systematically select drivers to assess their level of alcohol impairment. The goal of these interventions is to deter alcohol-impaired driving by increasing drivers’ perceived risk of arrest. The conclusion that they are effective in reducing alcohol-related crashes is based on a systematic review of research about sobriety.
checkpoints. The review was conducted by a team of experts led by CDC scientists, under the oversight of the Task Force on Community Preventive Services—a 15-member, non-federal group of leaders in various health-related fields. (Visit www.thecommunityguide.org for more information.) The review combined the results of 23 scientifically-sound studies from around the world. Results indicated that sobriety checkpoints consistently reduced alcohol-related crashes, typically by about 20 percent. The results were similar regardless of how the checkpoints were conducted, for short-term "blitzes," or when checkpoints were used continuously for several years. This suggests that the effectiveness of checkpoints does not diminish over time.


Stronger state DUI prevention activities may reduce alcohol-impaired driving

Strong state activities designed to prevent driving under the influence (DUI), including legislation, enforcement, and education, may reduce the incidence of drinking and driving, according to a study from the Centers for Disease Control and Prevention (CDC). For the study, which was published in the June 2002 issue of Injury Prevention, CDC analyzed data from the 1997 Behavioral Risk Factor Surveillance System (BRFSS) national telephone survey, and the Mothers Against Drunk Driving (MADD) Rating the States 2000 survey, that graded states on their DUI countermeasures from 1996-1999. Results showed that residents of states with a MADD grade of "D" were 60 percent more likely to report alcohol-impaired driving than were residents from states with a MADD grade of "A." MADD based the grades on 11 categories of prevention measures, including DUI legislation; political leadership; statistics and records availability; resources devoted to enforcing DUI laws; administrative penalties and criminal sanctions; regulatory control and alcohol availability; youth DUI legislation; prevention and education; and victim compensation and support.

The study also found that 4 percent of the residents who consume alcohol reported they had driven after having too much to drink at least once during the previous month. Men were nearly three times as likely as women to report alcohol-impaired driving, and single people were about 50 percent more likely to report alcohol-impaired driving than married people or those living with a partner.


Research leads to bills that protect children from drinking drivers

CDC’s findings about the number of children killed in cars driven by drinking drivers has led legislators in several states to introduce bills to help protect them from drinking drivers. Such legislation creates special penalties under state child abuse laws for persons who transport children while driving drunk. Results from the study showed that nearly two-thirds of children killed in drinking driver-related crashes were riding with the impaired driver. Fewer than 20 percent of the children killed were properly restrained at the time of the crash, and restraint use decreased as the driver’s blood alcohol concentration increased.

Research identifies effective interventions against alcohol-impaired driving

CDC and the Task Force on Community Preventive Services—an independent, nonfederal panel of community health experts—published systematic reviews of the literature for five community-based interventions to reduce alcohol-impaired driving. The reviews revealed strong evidence of effectiveness for 0.08% blood alcohol concentration (BAC) laws, minimum legal drinking age laws, and sobriety checkpoints. They also found sufficient evidence of effectiveness for lower BAC laws specific to young or inexperienced drivers (zero tolerance laws) and intervention training programs for alcohol servers. A detailed description of the sobriety checkpoints systematic review was published in the December 2002 issue of Traffic Injury Prevention. The systematic review of the effectiveness of 0.08% BAC laws for drivers was helpful in establishing a 0.08% standard nationwide. The review revealed that state laws that lowered the illegal BAC for drivers from 0.10% to 0.08% reduced alcohol-related fatalities by a median of 7 percent, translating to 500 lives saved annually. With this evidence, the Task Force on Community Preventive Services strongly recommended that all states pass 0.08% BAC laws. In October 2000, the President signed the Fiscal Year 2001 transportation appropriations bill, requiring states to pass the 0.08% BAC law by October 2003 or risk losing federal highway construction funds. As of October 1, 2003, 45 states and the District of Columbia had enacted 0.08% BAC legislation.

In June 2001, Tommy G. Thompson, Secretary of the Department of Health and Human Services, awarded the Secretary’s Award for Distinguished Service to the systematic review team for their contribution to the field. The team is currently conducting systematic reviews of mass media campaigns, school-based education programs, and designated driver programs, which are scheduled for publication in 2004.

The Guide to Community Preventive Services


Prevention Strategies

Effective measures to prevent injuries and deaths from impaired driving include:

- Promptly suspending the driver’s licenses of people who drive while intoxicated (DeJong 1998).
- Lowering the permissible levels of blood alcohol concentration (BAC) for adults to 0.08% in all states (Shults 2001).
- Zero tolerance laws for drivers younger than 21 years old in all states (Shults 2001).
• Sobriety checkpoints (Shults 2001).

• Multi-faceted community-based approaches to alcohol control and DUI prevention (Holder 2000, DeJong 1998).

• Mandatory substance abuse assessment and treatment for driving-under-the-influence offenders (Wells-Parker, 1995).

Other suggested measures include:

• Reducing the legal limit for blood alcohol concentration (BAC) to 0.05% (Howat 1991; National Committee on Injury Prevention and Control 1989).

• Raising state and federal alcohol excise taxes (National Committee on Injury Prevention and Control 1989).

• Implementing compulsory blood alcohol testing when traffic crashes result in injury (National Committee on Injury Prevention and Control 1989).

References


Community-Based Interventions to Reduce Motor Vehicle-Related Injuries: Evidence of Effectiveness from Systematic Reviews

Motor vehicle-related injuries kill more children and young adults than any other single cause in the United States.

More than 41,000 people in the United States die in motor vehicle crashes each year, and crash injuries result in about 500,000 hospitalizations and four million emergency department visits annually. The economic burden of motor vehicle-related deaths and injuries is also enormous, costing the United States more than $150 billion each year.

The American Journal of Preventive Medicine (AJPM) recently released a special supplement containing systematic reviews and recommendations regarding 13 community-based interventions to reduce motor vehicle-related injuries and deaths. The Guide to Community Preventive Services. Reducing Injuries to Motor Vehicle Occupants: Systematic Reviews of Evidence, Recommendations from the Task Force on Community Preventive Services, and Expert Commentary highlights results from systematic reviews of scientific literature on interventions to decrease alcohol-impaired driving, increase the use of child safety seats, and increase use of safety belts. The Task Force on Community Preventive Services, an independent, nonfederal panel of community health experts, issued their recommendations, based on demonstrated evidence of effectiveness from the reviews coordinated by CDC.

An overview of the interventions and descriptions of the strongly recommended and recommended interventions are available on the Community Guide web site.

This AJPM issue is the third in a series of supplements on the effectiveness of public health interventions. In 2002, these will be compiled into the Guide to Community Preventive Services, a resource for policymakers and public health practitioners. The findings can be used to support or expand local motor vehicle injury prevention programs and to promote the adoption, maintenance, or strengthening of state or national traffic safety laws. To learn more about the Guide to Community Preventive Services, go to www.thecommunityguide.org.

<table>
<thead>
<tr>
<th>Interventions to Increase the Use of Child Safety Seats</th>
<th>Strength of Evidence Scale</th>
</tr>
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<tbody>
<tr>
<td>Child Safety Seat Use Laws</td>
<td><strong>Recommended</strong> (strong evidence)</td>
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<tr>
<td>Community-Wide Information + Enhanced Enforcement Campaigns:</td>
<td><strong>Recommended</strong> (sufficient evidence)</td>
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<td>Distribution + Education Programs:</td>
<td><strong>Recommended</strong> (strong evidence)</td>
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### Incentive + Education Programs

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### Education-Only Programs

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<td>Insufficient Evidence</td>
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### Interventions to Increase the Use of Safety Belts

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<th>Recommendation</th>
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### Interventions to Reduce Alcohol-Impaired Driving

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<th>Intervention</th>
<th>Recommendation</th>
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<tr>
<td>Sobriety Checkpoints</td>
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<td>&quot;Zero Tolerance&quot; Laws for Young Drivers (Versus Secondary Enforcement Laws)</td>
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[http://www.cdc.gov/ncipc/factsheets/teenmvh.htm](http://www.cdc.gov/ncipc/factsheets/teenmvh.htm)
Teen Drivers: Fact Sheet

Overview

Two out of five deaths among U.S. teens are the result of a motor vehicle crash (CDC 2004).

Occurrence and Consequences

- In 2002, more than 5,000 teens ages 16 to 19 died of injuries caused by motor vehicle crashes (CDC 2004).

- The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group. In fact, per mile driven, teen drivers ages 16 to 19 are four times more likely than older drivers to crash (IIHS 2004).

- Teenagers represented 10% of the U.S. population in 2002 and accounted for 14% of all motor vehicle-related deaths (IIHS 2004).

- The presence of teen passengers increases the crash risk of unsupervised teen drivers; the risk increases with the number of teen passengers (Chen 2000).

Cost

In 2002, the estimated economic cost of police-reported crashes (both fatal and nonfatal) involving drivers ages 15 to 20 was $40.8 billion (NHTSA 2003).

Groups at Risk

- In 2002, the motor vehicle death rate for male occupants age 16 to 19 was nearly twice that of their female counterparts (23 per 100,000 compared with 12 per 100,000) (CDC 2004a).

- Crash risk is particularly high during the first years that teenagers are eligible to drive (IIHS 2004).

Risk Factors

- Teens are more likely than older drivers to underestimate hazardous situations or dangerous situations or not be able to recognize hazardous
situations (Jonah 1987).

- Teens are more likely than older drivers to speed, run red lights, make illegal turns, ride with an intoxicated driver, and drive after using alcohol or drugs (Jonah 1987).

- Compared with other age groups, teens have the lowest rate of seat belt use. In 2003, 18% of high school students reported they rarely or never wear seat belts when riding with someone else (CDC 2004b).

  - Male high school students (22%) were more likely than female students (15%) to rarely or never wear seat belts (CDC 2004b).

  - African-American students (21%) and Hispanic students (20%) were more likely than white students (17%) to rarely or never wear seat belts (CDC 2004b).

- At all levels of blood alcohol concentration (BAC), the risk of involvement in a motor vehicle crash is greater for teens than for older drivers (IIHS 2000).

  - In 2003, 25% of drivers ages 15 to 20 who died in motor vehicle crashes had a BAC of 0.08 g/dl or higher (NHTSA 2004).

  - In a national survey conducted in 2003, 30% of teens reported that within the previous month, they had ridden with a driver who had been drinking alcohol. One in eight reported having driven after drinking alcohol within the same one-month period (CDC 2004b).

  - In 2003, among teen drivers who were killed in motor vehicle crashes after drinking and driving, 65% were unrestrained (NHTSA 2004).

- In 2002, 52% of teen deaths from motor vehicle crashes occurred on Friday, Saturday, or Sunday; 41% occurred between 9 p.m. and 6 a.m. (IIHS 2004).

Back to Top

Resource

The Guide to Community Preventive Services
Offers recommendations about motor vehicle injury prevention issued by the Task Force on Community Preventive Services.

References


Chen L, Baker SP, Braver ER, Li G. Carrying passengers as a risk factor for crashes fatal to 16- and 17-year old drivers. JAMA 2000;283(12):1578–82.


