



Child and Youth Mortality Review Committee

Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi

Fifth Report to the Minister of Health Reporting mortality 2002–2008

Chapter 3 The Risk Taking Years – Unintentional Injury in Young People

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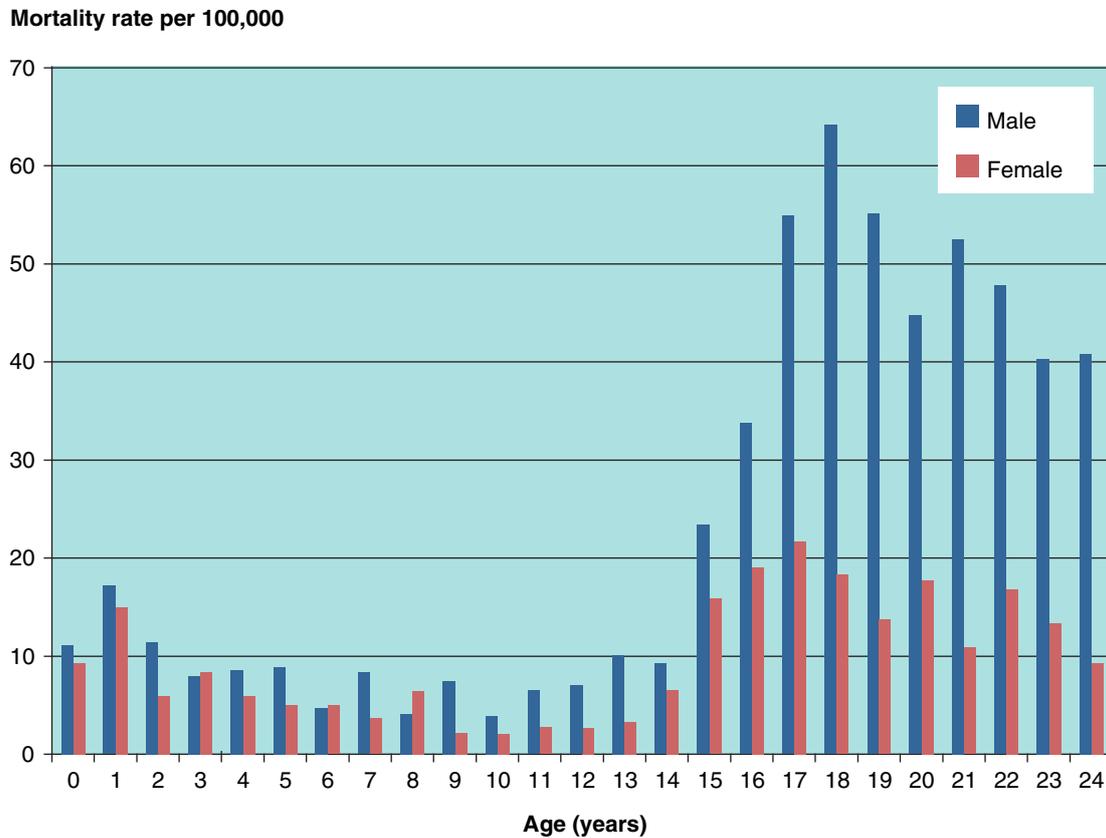
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3 The Risk Taking Years – Unintentional Injury in Young People

3.1 Introduction

New Zealand youth face significant threats to their health and wellbeing. After the relative safety of the middle years of childhood, rates of death increase dramatically from the age of 14 onwards, especially for young men (see Figure 3.1). This change coincides with young people becoming more independent from their parents, spending more time away from home, being exposed to more dangerous situations and taking more risks. Between 15 and 24 more than two thirds of fatalities are due to injury (see Figure 3.3) including both intentional injury (considered in Chapter 4) and unintentional injury, which is considered in this chapter.

Figure 3.1 Unintentional mortality rates, by age and gender, 2003–2007 combined³⁶



Injury also contributes substantially to morbidity rates and life long disability. While accurate routinely collected mortality data is presented in this report similar data reflecting the burden of morbidity from injury is not routinely available. It has, however, been reported that for 15–19-year-olds there were six serious injures and 17 moderate injures for each motor vehicle related fatality (Trotter, Russell, Langley, and Casey 2005). The improved collection and linking of data would further support efforts to understand, prioritise and prevent injury.

³⁶ Data including 2008 is included in the Appendices. 2008 data is not used in this Chapter for rate calculations because some cases are still awaiting the coroner’s report.

A high proportion of the unintentional injury mortality among young people is due to risk-taking³⁷ and experimentation that are a normal part of growing up, as is argued by Dr Simon Denny in the box entitled 'Why young people take risks'.

Why young people take risks

by Dr Simon Denny, youth health physician at Kidz First Children's Hospital in Auckland

Young people need to take risks. It is an important part of growing up and learning from new experiences. Adolescents need to discover their own strengths and weaknesses in a variety of different situations, not only to experience success but to learn to cope with adversity and defeat (Konopka 1973). Ongoing research suggests that remarkable changes occur in the brain during the teenage years and into early adulthood. Specifically, between childhood and adulthood the 'wiring' of the brain becomes more complex and more efficient, especially in the brain's prefrontal cortex. The prefrontal cortex is responsible for skills such as impulse control, planning and focusing attention. It is thought that these neurobiological factors may underlie some – but not all – of the reasons that young people take risks.

Although this new research on brain development shows that the frontal lobe is still developing through the teen years and into the early 20s, young people have the same cognitive ability as adults in terms of understanding the consequences of risky behaviours. Research studies have shown that young people have similar abilities to adults in terms of understanding hypothetical situations and logical reasoning from about the age of 13 years upwards (Millstein and Halpern-Felsher 2002). This suggests that young people can understand the risks but are more willing to disregard the risks associated with their choice of action.

Risk-taking during adolescence, therefore, needs to be understood from a wider ecological framework, acknowledging the social, physical and emotional environments in which young people live. For example, laboratory studies of simulated driving have shown that there are few differences between older adolescents and adults in crash rates when tested while driving alone, but when young people are tested while driving with peers in the room their rates of crashes are more than doubled (Gardner and Steinberg 2005). This is also seen in real-life crash statistics, where crash rates are higher when young people drive with peers and increase with the number of passengers in the car (Chen and Baker 2000). The findings of these studies imply that risk-taking during adolescence is also embedded within the social and emotional environments young people find themselves in. This means that while risk-reduction driver education may be feasible, education alone will do little to reduce youth risk-taking in the absence of a wider social-developmental approach.

Risk taking often has other adverse health consequences such as alcohol and drug dependency, unsafe sexual activity, violence, and driving under the influence of drugs or alcohol. These behaviours can have far reaching social consequences such as poor educational performance, unwanted pregnancy and criminal behaviour which impact on more than one generation (OECD 2009a). The OECD has suggested using the birth rate to mothers age 15–19, the number of 15-year-olds who smoke regularly and the number of 13–15-year-olds who report having been drunk more than twice as indicators of the level of risk taking in a community. Rates of youth suicide, death from motor vehicle injuries, unplanned pregnancy and drug and alcohol use in New Zealand continue to be among the highest in the Western world (Ministry of Health 2002; OECD 2009b). Overall New Zealand was ranked 24th out of 30 countries for risk behaviours (OECD 2009b).

37 Risk taking is defined as active voluntary behaviours associated with heightened risk of injury or death such as reckless use of alcohol, motor vehicles or natural hazards. Different types of risk-taking behaviours tend to cluster.

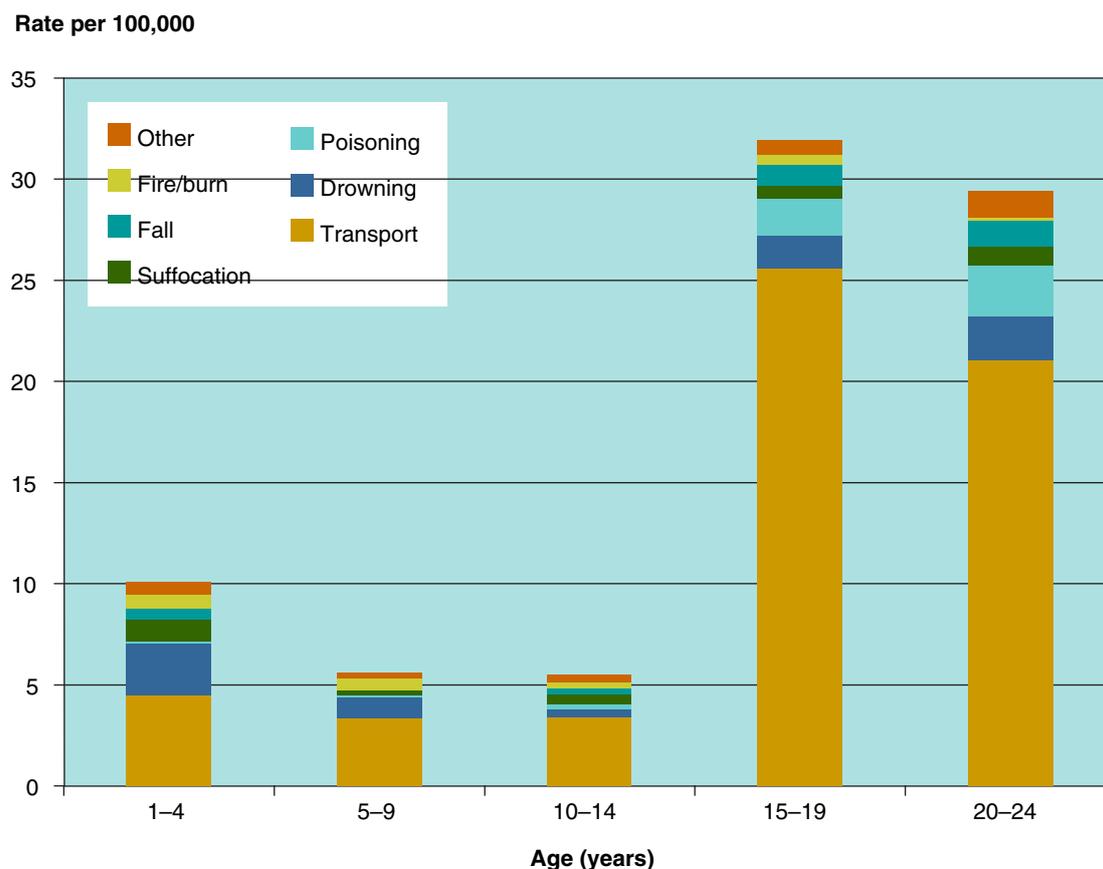
Furthermore, alcohol use contributes to the high rates of death by injury, including motor vehicle deaths, suicide, poisoning and drowning. Almost one-quarter of adolescents have recently been in a car driven by someone who was potentially drunk (Adolescent Health Research Group 2008a: 29). Alcohol is the most common drug used by New Zealand youth, and binge drinking puts youth at risk for a number of poor outcomes. CYMRC has commissioned a separate report on alcohol related deaths which will be published in 2010 and will give clearer information on the associations between alcohol and injurious death.

3.2 Statistics on unintentional youth mortality from the CYMRC database

The increase in rates of death from the age of 14 onwards is largely due to increasing rates of unintentional injury and suicide during that time of life. As Figures 3.2 and 3.3 show, transport is the most common cause of death from unintentional injury. Slightly more than 70% of unintentional deaths were the result of a transport-related event. This represents an average mortality rate of 11.09 per 100,000 over the 5-year period.

Over the period 2003 to 2007 62 young people (age 15–24) died of poisoning at a rate of 2.10 per 100,000. Poisoning caused 7.1% of unintentional deaths in this age group, which is a similar proportion to that reported in European countries (Kumpula, Heli and Paavola, Meri 2008). Poisoning often occurred in the context of risk taking and experimentation. As in Europe, alcohol features strongly in New Zealand deaths. (Further analysis from the CYMRC on alcohol related death will be available in 2010). Death from poisoning also occurred as a result of drug abuse, pharmaceuticals, inhalation of hydrocarbons and pesticides. More detailed analysis of poisoning cases in New Zealand is required.

Figure 3.2 Unintentional injury mortality (rate per 100,000), by age group and injury type, 2003–2007 combined



Note: 'Other' includes: adverse effect of medical treatment, cut/pierce, firearm, fall, natural/environmental/animal, struck by/against, or electrocution.

Drowning is the third most common cause of unintentional injury death in the age group 15 to 24 years with 54 deaths during the period 2003–07 (a rate of 1.82 per 100,000) making up 6.1% of unintentional injury deaths.

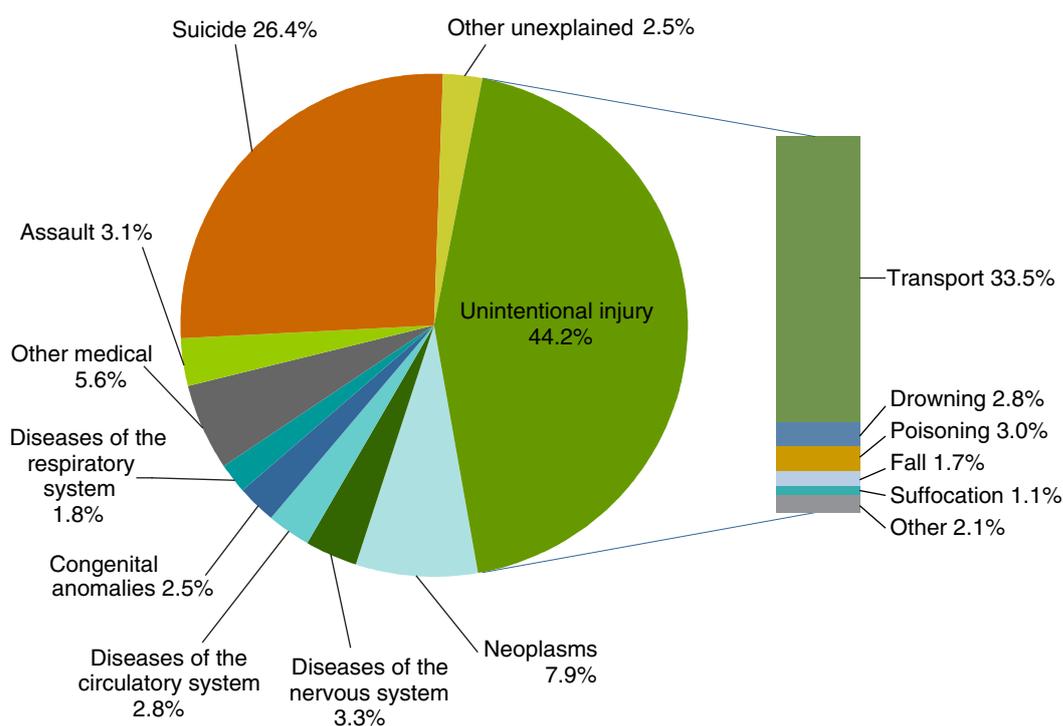
In young people aged between 15 to 19 years, rivers were the major site of drowning (54%) with a further 33% drowned at the beach. In the 20–24 year age group, 55% occurred at the beach; 17% were river-related, with boating and drowning in lakes accounting for a further 10% each (see Chapter 2 Figure 2.2).

The highest rate of death from drowning occurs in the 1–4 year olds. After a lower rate in the 5–14 year age group the drowning rate increases again in the 15–24 year group (see Chapter 2 Table 2.1, Figure 2.1 and Figure 2.2). The increased rate of drowning after age 13 occurs despite increasing physical ability, strength and swimming skills. This trend and its causes need further analysis. However, it seems to reflect increasing exposure to risky situations, as in surf and rivers, less supervision and poor perception of risk, including some deliberate risk taking, together with the influences of drugs and alcohol (McDonald et al 2005).

The relationship between drowning and swimming skills is complex and may include a trend for good swimmers to take risks that poor swimmers would never consider (Brenner et al 2003). Future work of the CYMRC is needed to explore these issues, especially drowning at beaches and in rivers, as well as the reasons for ethnic disparities in drowning rates (see Chapter 2 Table 2.1).

As illustrated in Figures 3.3 and 3.4, transport related deaths make up the vast majority of injury cases in this age group; therefore, the rest of this chapter focuses on transport.

Figure 3.3 Cause of mortality in youth aged 15–24 years (%), by category of death, 2003–2008 combined (2366 deaths)



3.3 Statistics on transport mortality

Motor vehicle crashes are the leading cause of death for young people in New Zealand. Table 3.1, based on the CYMRC data, shows the mortality rate for males in transport-related events (16.32 per 100,000) is more than twice the rate for females (7.07 per 100,000), and the Māori rate (19.06) is almost double the non-Māori rate (9.85).

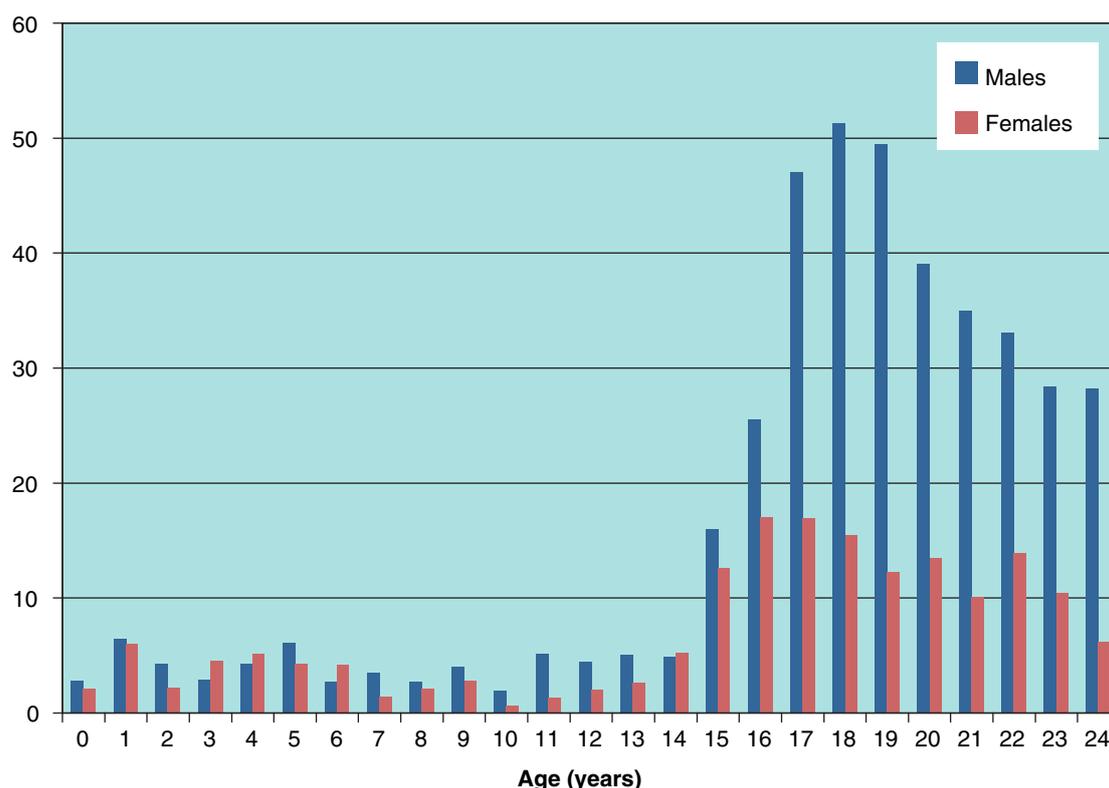
Over the five years reported, on average, 165 young people aged 15–24 years died on New Zealand roads each year while more than 4000 sustained non-fatal injuries. In comparison to EU-countries, New Zealand has high rates of young people dying from motor vehicle crashes (Ministry of Transport 2004; Kumpula, Heli and Paavola, Meri 2008). Young people account for 14% of the total population but make up almost 33% of all motor vehicle crash deaths (Ministry of Transport 2008). The majority of young people who die in motor vehicle crashes are male (75%). Although only 25% of deaths are female, young women are more likely to die in a motor vehicle crash than older women (ibid). The societal cost of motor vehicle crashes was estimated to be \$1.1 billion in 2007, which is approximately 10% of the total health expenditure in New Zealand (ibid). From a public health perspective, motor vehicle crashes are among the most serious issues facing young people (National Research Council et al 2007).

Table 3.1 Summary of transport deaths, ages 0–24 years, 2003–2007

	Deaths					Total	%	Average rate
	2003	2004	2005	2006	2007			
	178	173	178	142	176	847	–	11.77
Gender								
Male	125	115	134	97	126	597	70.48	16.32
Female	53	58	44	45	50	250	29.52	7.07
Age category								
Under 1 year	–	4	–	1	2	7	0.83	2.47
1–4 years	10	9	14	6	10	49	5.79	4.49
5–9 years	9	11	10	12	7	49	5.79	3.42
10–14 years	12	6	12	9	13	52	6.14	3.63
15–19 years	83	86	89	63	73	394	46.52	27.51
20–24 years	64	57	53	51	71	296	34.95	20.66
Ethnicity								
Māori	60	55	64	58	50	287	33.88	19.06
Non-Māori	118	118	114	84	126	560	66.12	9.85

Figure 3.4 Transport mortality rates, by age and gender, 2003–2007 combined

Mortality rate per 100,000



Note: As transport is the major contributor of unintentional injury deaths, Figure 3.4 shows a similar pattern to Figure 3.1.

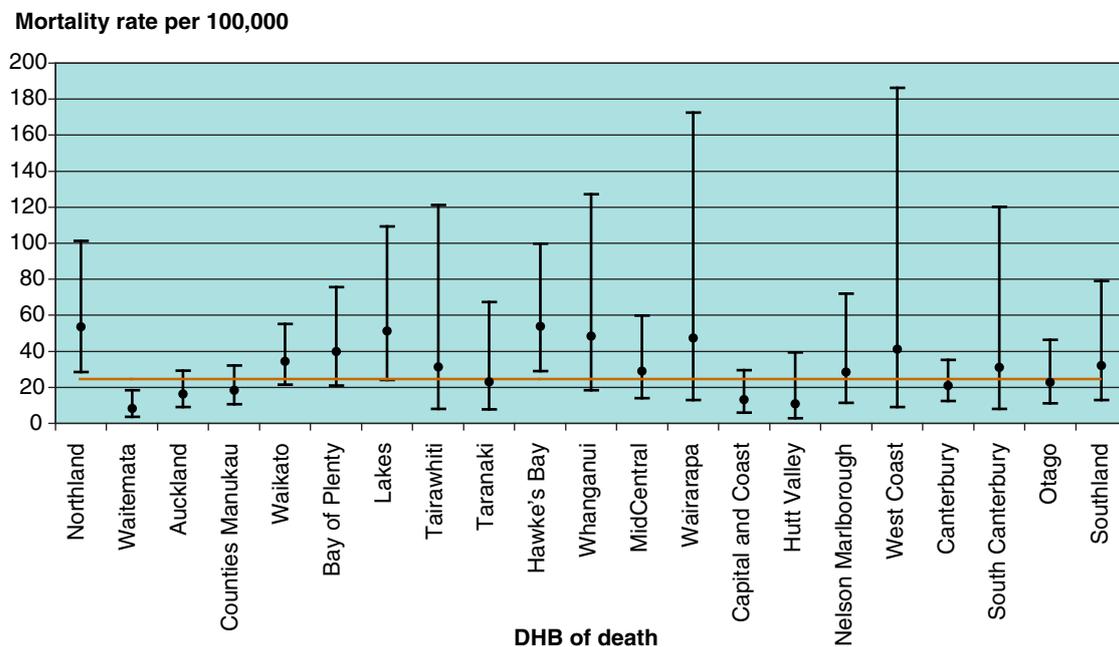
A closer look at the differences in the death rate between males and females, by age in years, for the five years 2003 to 2007 combined, reveals that:

- males between their 17th and 20th birthdays have the highest rates of death
- 16- and 17-year-old females have the highest rates of death for females

- the rate of death for 18-year-old males is 2.75 times higher than the rate for 17-year-old females
- the rate of death for 24-year-old males is four times higher than the rate for 24-year-old females.

An examination of the 16 deaths of 14-year-olds, an age at which young people are not legally allowed to drive motor vehicles, shows 38% (six) were *driving* either a car or motorcycle, and 44% were passengers in motor vehicles; 43% of the passengers were in vehicles whose driver was aged 21 or younger, and 43% of the passengers were reported as not wearing seatbelts at the time of the accident. (Note that use of seat-belts is not always able to be determined at the time of the accident.)

Figure 3.5 Youth (15–24 years) transport mortality rates per 100,000, by DHB of death, 2003–2007 combined



Notes: The line shows the national youth (15 to 24 years) transport mortality rate per 100,000 estimated residential population. The mortality rate by DHB of death uses the same denominator for each year; that is, the population by DHB according to the 2006 Census. No attempt has been made to estimate population by DHB for the years 2003–2005 and 2007. The exact method of Agresti and Coull has been used to estimate 95% confidence intervals.

Figure 3.5 shows that Northland and Hawkes Bay have rates of transport deaths that are significantly higher than the national rate. Waitemata is the only DHB with a rate significantly less than the national rate. While not significant for the individual DHBs, it is interesting to note that all the DHBs with lower than average death rates contain major metropolitan centres. These trends need further analysis to consider impact of public transport, lower speed limits and easier access to health care as being potentially protective, while rural roads with the associated increased distance driven at higher speeds may contribute to risk.

Why are young people most at risk for motor vehicle fatalities?

by Dr Simon Denny, youth health physician at Kidz First Children's Hospital in Auckland

Driving is a dangerous activity for everyone, but it is particularly dangerous for young people. Young drivers (15 to 24 years old) are 3 to 4 times more likely to die in a motor vehicle crash than older drivers. Young male drivers are particularly at risk, with almost twice the number of young men dieing from motor vehicle crashes compared to young female drivers. Furthermore, newly licensed drivers (those in their first six months of driving) are about eight times more likely to be involved in fatal crashes than more experienced drivers (National Research Council et al 2007). In New Zealand, 62% of crash deaths among 15–19-year-olds are among drivers on their restricted or learner licence (Transport NZ 2008).

Lack of experience appears to be independent of the age of the driver. In other words, there is a learning curve for all new drivers. However, although driving becomes less risky with experience, young people are still more likely to underestimate dangerous situations than older drivers (Jonah and Dawson 1987). Other factors that potentially make driving dangerous for young people include driving at night, driving in the presence of peers, driving under the influence of alcohol and fatigue.

What do we know about New Zealand teenagers and their behaviours in motor vehicles?

A large national survey of New Zealand secondary school students in 2007 found that substantial numbers of young people take risks when driving or being driven in motor vehicles (Adolescent Health Research Group 2008a). Specifically:

- during the previous month, nearly one-quarter (24%) of students had been driven by someone driving dangerously
- during the previous month, 23% of students rode in a car that was driven by someone who had been drinking alcohol
- during the previous month, 10% of 17-year-olds had driven a car after they had drunk more than two glasses of alcohol in the two hours before driving
- more than one-quarter (26%) of students do not always wear a seatbelt when driving or being driven in a car.

3.4 Themes from the CYMRC database and local review process

During the period 2003–2008 a large number of cases involving the unintentional injury deaths of young people in New Zealand were considered by local child and youth mortality review groups.

The groups were often left with a feeling of frustration that many deaths from injury were preventable but it was unclear how and if the behaviour of young people could be changed. It seemed that existing injury control policies and programmes did not sufficiently address risk taking in young people.

On occasions, young people engaged in extremely risky behaviour and seemed completely incompetent at assessing the level of risk they were taking. At times, groups were left uncertain as to whether death was intentional or not. Few interventions seemed to focus on building

“risk competence”³⁸ amongst young people. It was felt that young people need to learn to manage complex and hazardous situations and avoid harm and that this should be part of life skill acquisition. If such an approach was successful, alternative behaviours could develop for handling risky situations, to reduce the risk of injury. The sort of work is discussed below in the context of building resilience and has been attempted over seas (eg, European AdRisk 2008).

For the review of transport related deaths, information provided by police and the serious crash units was a very important part of these reviews. A number of themes and recommendations emerged from these reviews. Many of the drivers were young and inexperienced. The sudden transition that occurs with transition from restricted to full licence which allows driving alone or with peers, at night, and after consuming alcohol, appears a factor in a number of cases. Furthermore, training did not appear to equip young people with the skills required for difficult driving conditions. Common conditions associated with mortality were night driving, high speeds, and driving on rural roads, which are often gravel roads.

The reviews also suggested that drivers were often distracted: cell phone use while driving was a theme. Other common themes were not wearing seatbelts, unlicensed drivers, driving too fast, alcoholic intoxication, driving with peers, passengers consuming alcohol in vehicles while being driven, unlicensed and unwarranted vehicles and falling asleep at the wheel.

Alcohol is an important theme seen in many different types of death. A specific CYMRC report on the contribution of alcohol will be published in 2010. Recent New Zealand publications elsewhere highlight four key facts related to transport deaths in young people.

- Alcohol contributes to a higher proportion of fatal crashes in the 15–24 age group than in any other age group (Ministry of Transport 2009: 13).
- Alcohol has a greater effect on driving performance at lower levels for young people compared to older age groups (Ministry of Transport 2009: 16).
- Young drivers under 25 are less safe, considering fatal and serious injury, than they were a decade ago (Ministry of Transport 2009: 16).
- “The greatest risk period for young drivers is in the first six months of driving solo (ie, the first six months of gaining a restricted licence)” (Ministry of Transport 2009: 16).

In considering how to lessen the negative impact of alcohol on young people it is important to listen to the views of young people. In August this year, in the youth consultation on the *Safer Journeys* discussion document, 60% of young respondents supported the reduction of Blood Alcohol Content (BAC) for drivers under 20. Moreover, 68% supported the reduction of BAC for all adult drivers.³⁹ In the 2008 consultation on the National Alcohol Action Plan a majority of young people who took part in focus group discussions supported a zero Blood Alcohol Content level for all ages. In the last Youth Parliament in 2007, the Youth Transport Select Committee supported the reduction of the Blood Alcohol Content to zero for young drivers and for adult drivers. These are very wise comments in light of the fact that alcohol at all levels impairs driving competence (Ministry of Transport 2009: 13).

Case control studies in the United States comparing states that have moved to zero BAC for young people with states that have not, have shown a significant (22%) reduction in fatal

38 Risk competence is the capacity of individuals to recognize risk and dangers, to handle and cope with them, to make responsible decisions to avoid harm and the ability to learn about and integrate challenges.

39 Cited by Susan Wauchop, Ministry of Youth Development and Advisor to the CYMRC, in an email on 23 October 2009.

crashes involving single vehicles at night. Where a lesser reduction in BAC was made, no significant reduction of fatalities occurred (Hingson R, Heeren T, Winter M, 1994). CYMRC supports zero BAC for young and/or novice drivers.⁴⁰ While there was concern that this might be seen as discrimination on the basis of age the committee believes the risks that cluster in this age group and while gaining driving skills justify such action. The community might also wish to consider having a zero BAC for all drivers of all ages in view of the harm caused.

In some cases it was clear that contact with health services had not resulted in the identification of risks. It was therefore suggested that risk assessment be routinely incorporated into youth health care practice as happens for family violence screening. To make a difference screening would need to be followed by interventions to reduce risk. In fact such risk screening is accepted as best practice and highlighted in the *Health and Disability Sector Standards (Child and Young People) Audit Workbook* (Standards New Zealand 2004).

Recent declines in motor vehicle crash deaths

by Dr Simon Denny, youth health physician at Kidz First Children's Hospital in Auckland

Over the past three decades motor vehicle crash deaths have been decreasing in New Zealand and internationally. Since the late 1980s the motor vehicle crash rate decreased from 20 deaths per 100,000 to approximately 10 deaths per 100,000 by 1995 (Ministry of Transport 2008). A similar reduction in motor vehicle crash deaths was observed for 15–24-year-olds over this time period. During the late 1980s approximately 300 young people (aged 15–24 years) died in motor vehicle accidents each year, which had halved to approximately 150 young people per year by 2000 (Ministry of Transport 2008).

This reduction in motor vehicle crash deaths is substantial. Although the exact causes for these reductions are unclear, the fact that the reductions were uniform across the population and were also seen in other OECD countries suggests that environmental improvements, rather than individual behaviours, contributed to these reductions. It is likely that the combination of safer cars, better roads and fewer alcohol-related crashes were significant. For young people, the graduated driving licence system introduced in 1987 may also have played a part, although this is somewhat controversial (Kingham et al 2008). Internationally, graduated licensing schemes are seen as an important initiative to reduce youth transport injury and death (Peden 2008).

40 The Committee hopes further collection of information from the CYMRC database will allow a more specific statement around definitions of young and novice.

Implications for policy

Although risk-taking during adolescence is normal, biologically driven and to some extent inevitable, there are several successful approaches to reducing risk-taking among young people or mitigating the effects of their risky behaviours. The first broad approach is to ensure the environments and settings that young people are growing up in are safer and healthier. A multi-pronged environmental approach would include policy changes, changes to the physical environment, improved access to social and health services, and community shifts in expected norms and behaviours. A reduction in motor vehicle crash rates will probably require approaches such as zero tolerance for alcohol when driving, changes to car design, re-engineering of dangerous roads, and measures to slow traffic. The focus of these approaches is not to change young people's behaviours directly, but to enable safer choices within a safer environment.

The second broad approach attempts to enhance the resiliency of individuals and the individual's propensity to engage in risky behaviours. Almost all the existing research on risk-taking by adolescents highlights the importance of caring and supportive parents in the lives of young people. Those young people who feel connected to their parents exhibit much lower levels of risk-taking behaviours in terms of sexual health, motor vehicle risk-taking, substance use and violence (Resnick et al 1997). Parents play an important role in the lives of teenagers, and they need to be aware of this.

Parents also need to be educated on the risks facing young people so that they can provide support and guidance. For example, parents need to understand the high-risk situations young people can encounter when they first start driving, such as driving at night, driving with peers, driving under the influence of alcohol and driving when fatigued. This is so parents can help teenagers identify these high-risk situations and monitor their behaviours to avoid potentially fatal motor vehicle crashes and reduce the number of young people dying from motor vehicle crashes on our roads.

3.5 Observations by the CYMRC on youth risk taking and injury

Mortality dramatically increases after age fourteen; risk taking behaviour is a major contributing factor. Risk taking substantially contributes to many different sorts of injury related deaths and high levels of non fatal injury. New Zealand has high levels of risky behaviour amongst youth people. It appears that existing injury control programs focus on specific policy areas, eg, transport, water, sport, workplace, school. Less effort is put into an approach that focuses on understanding the developmental context in which risk taking occurs. The fact that in Europe many similar countries have huge disparities in rates of unintentional injury death in young people suggests that risk factors may be modifiable through efforts at prevention (AdRisk 2008).

3.6 Recommendations by the CYMRC on preventing death by unintentional injury

Legislation

1. The allowable breath alcohol level for young and/or novice drivers should be lowered to zero.
2. Develop strategies to improve the safety of the environment. Such strategies might include the following:
 - a. change regulations regarding access to alcohol
 - b. change the Ministry of Transport regulations for licensing young drivers, introducing a system with more steps that better acknowledge the time taken to acquire the necessary skills
 - c. encourage initiatives to reduce driver distraction and fatigue, such as the November 2009 ban on hand held cell phones
 - d. review enforcement to ensure strategies used achieve increased safety.

Policy

3. Recognise injury as one of the most important health threats for young people and include it in the health policy agenda, including specific elements related to risk taking.⁴¹
4. Improve the collection and linkage of data about serious injury to allow better surveillance, analysis and reporting of the huge burden that injury imposes.
5. Youth health promotion, life skill programmes and injury prevention should include strategies to build risk competence and resilience that involve both young people and their parents.⁴²

District Health Boards

6. Care pathways should be developed to support universal opportunistic psychosocial screening of young people which are linked to effective interventions to reduce risk if positive screening occurs.

Practice points

7. Health professionals should provide opportunistic psychosocial screening (as in the HEADSS assessment⁴³) to all young people seen in health services. This includes screening for risky motor vehicle behaviours, especially in conjunction with alcohol use.
8. Health professionals need to support parents and acknowledge the importance they play in the wellbeing of teenagers in their care. This includes educating parents on the hazards associated with learning to drive and using motor vehicles.

41 The European Commission has commissioned a series of documents that outline related issues. See <http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/l3launchofresults.htm?OpenDocument>.

42 Parents of young people often need to be empowered to recognise their continuing role in parenting, which involves recognising risks and helping to modify behaviours.

43 The HEADSS assessment is a tool that measures risk and resilience. HEADSS stands for a number of categories: Home, Education, Activities, Drugs & Alcohol, Sexuality, and Suicide.

9. Health professionals need to help others to understand the development of young people and work with communities to create opportunities that build risk competence and resilience especially for young men.

Community messages

- Young people are supported by, and connected best with, services when leadership results in services that connect to each other, collaborate and are cohesive.
- It is inevitable that young people will take risks, it is a part of normal development. Communities need to ensure that learning opportunities and stimulating environments are available where young people can explore and develop their physical, psychological and social skills without undue risk of injury.
- Environments where young people take risks and try out new experiences need to be as safe as possible and not isolated from all adult support and supervision.
- Schools, sporting groups and communities need to recognise the harm that alcohol contributes to the lives of young people, ensure appropriate role modelling, and make events and activities safe with alternatives to alcohol abuse and misuse being available.
- Parents need to understand their changing role as their children grow into young people. At this time the challenges of parenting become different, but that does not mean parenting becomes less important. Parents should strive to remain connected and support their young people in risk recognition and safe decision-making.
- Parents also need to be educated on the risks adolescents face when beginning to drive, especially in high-risk situations such as driving with friends, driving at night and driving under the influence of alcohol.
- Parents need to recognise that friends are extremely important for young people's healthy development, but young people still need their parents' support and guidance as they navigate potentially unsafe situations that are exacerbated when they are with their friends.