American Medical Association
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Connecting the Dots to Prevent Youth Violence

A Training and Outreach Guide for Physicians and Other Health Professionals

Lyndee Knox, PhD, *Author*

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This Training and Outreach Guide is a companion to the Commission for the Prevention of Youth Violence report: *Youth and Violence: Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence*. The American Medical Association (AMA) convened this Commission in October 1999, with funding by The Robert Wood Johnson Foundation, to apply the skills, scientific rigor, and insight of medical, nursing, and public health professionals to the issue of youth and school violence. While the report has been widely disseminated and well received, the Commission felt that an additional component was needed to help physicians and other health professionals advocate for violence prevention in their communities and practices.

This guide was developed by Lyndee Knox, PhD, of the Southern California Center of Academic Excellence for Youth Violence Prevention with the assistance of AMA staff. The Robert Wood Johnson Foundation provided funding. We hope this guide and the Commission report will motivate physicians, nurses, mental health professionals, community leaders, youth, and others to learn more about this problem and, more importantly, to make a difference in their families, schools, and communities.

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Introduction and Overview

Purpose of the guide

This training and outreach manual was developed to assist physicians and other health professionals increase awareness of colleagues and community groups about the serious and pervasive nature of youth violence and the possibilities that now exist for prevention.

The materials contained in this manual are designed for use in a variety of settings, from medical grand rounds to Parent-Teacher Association meetings, and are geared toward a broad range of audiences, including other health care professionals, students of the health professions, and adult and youth members of the community. These materials are not intended to substitute for expert knowledge or in-depth training.

About this guide

This manual supplies all the information and materials needed to deliver a speech or half-day workshop on youth violence prevention for health and non-health professional audiences. Information is based on the report *Youth and Violence: Connecting the Dots to Prevent Youth Violence* (www.ama-assn.org/violence) *and Youth Violence: A Report of the Surgeon General* (www.surgeongeneral.gov/library/youthviolence) and is based on training principles for youth violence prevention developed by researchers and educators from the Youth Violence Prevention Centers of Academic Excellence, funded by the Centers for Disease Control and Prevention. A complete list of these principles can be found in *Youth Violence and the Health Professions: Core Competencies for Effective Practice* (www.stopyouthviolence.ucr.edu).

The remainder of this guide is divided into the following sections:

Section 1: Preparing the Presentation

- Goals and objectives for the speech
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- Identifying a co-speaker
- Preparing materials and physical layout
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Section 1

Preparing the Presentation

- Goals and objectives for the speech
- Main messages
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- Preparing materials and physical layout
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Preparing the Presentation

Establish presentation objectives

The objectives for this guide are to:

- Define youth violence as a public health problem
- Describe extent of the problem, with specifics on local situation when available
- Identify risk and protective factors for violence
- Describe intervention strategies and models that are effective
- Encourage audience to take action
- Provide resources to support action by audience members

Know what this guide is not

This guide is intended to assist you in outreach and raising awareness about the problem of youth violence with a wide range of audiences. It is not intended to be a substitute for expert knowledge or in-depth training in violence prevention interventions. Occasionally, you may need to remind your audience of this fact. Acknowledge that you may not know the answers to all of the questions your audience may ask. Welcome a spirit of inquiry in your audience members and encourage them to join you in searching for information that you may not have immediately available.

Determine the length of your presentation

The materials in this speaker's guide can be used for presentations ranging from a 45-minute talk to a 2-hour mini-workshop. In the case of the mini-workshop, the presenter would give the overview talk and then engage the audience in discussions around the 3 case studies contained in this guide.

Estimated length of presentation:

Speech with question/answer .....1 hr

Speech, 1 case and question/answer .....1 hr 20 min

Speech, 2 cases and question/answer .....1 hr 40 min

Speech, 3 cases and question/answer .....2 hrs

Recruit a community member to co-present with you (optional)

While this step is optional, the strength of your presentation can be greatly increased by including a community member. This individual could be a representative from a local community-based organization working in violence prevention, a professional from another sector such as law enforcement, or a youth activist from the local community.

You can incorporate the co-presenter into the presentation, by dividing the materials to be presented or by periodically asking your co-presenter to contribute information about the local situation, related resources, and personal experiences in violence prevention work.

Conduct on-line search for recent data and news on youth violence

At the end of this section, you will find links to useful on-line information sites for accessing: (a) recent news stories on youth violence across the nation; (b) the most recent national—and, where available, statewide and local—statistics on youth violence; and (c) information on resources in your community (where available) for violence prevention.

While it is not necessary to complete this part of the guide, doing so will allow you to personalize your presentation with recent news stories and with information on the most recent youth violence statistics and prevention resources relevant to your area. It is much more difficult to obtain information on the local level, as much of the data currently collected on youth violence is gathered at county and state levels. However, where possible, we have tried to provide recommendations on how to access information on local statistics and community resources.

Preparing the Presentation *(continued)*

Modify speaker's notes by adding local facts and personal stories

While the speeches contained in this guide are complete and ready to present, we have identified places in the speaker's notes where you and/or your co-presenter might wish to insert information about your own experiences working with youth and violence prevention. The speeches are available in PDF (view only) and text (ASCII) formats. The text file can be modified to accommodate content and formatting changes to better suit your needs.

A note on the power of stories. A good presentation can become a great presentation through the use of carefully selected stories. Take the time to add stories about your work and about the community to the speaker's notes. You will find places scattered throughout the speeches that are designed for this purpose. One word of caution: be careful to maintain the confidentiality of any people you mention in your stories.

Think of ways to involve the audience in your talk. It is particularly important when you speak to community and youth audiences to engage them as much as possible in the presentation, through questions and eliciting their own stories and thoughts about youth violence and methods for its prevention. Encourage community members and youth to share their own knowledge, their own solutions, and their own perceptions of the problem of youth violence, even before you share yours. Recognize that they are the true experts on their own community and involve them almost as co-presenters in your talk by asking them what they think is important and if they have any ideas on the subject. This helps stimulate conversation and create a sense of collaboration between the presenter and the audience.

Download slides/overheads from the Internet and personalize them.

Slides to accompany both the health professional and the youth/community speech are located at www.ama-assn.org/violence or www.stopyouthviolence.ucr.edu. They are available in PowerPoint format. You can download the presentations and load them onto your computer, or print them out and use them as masters to make transparencies. You can personalize the title slide to reflect your name and institution, and add slides to reflect local information you obtain during your preparation for the talk.

Review, select, and copy case studies, fact sheets, and other handouts

Thoroughly familiarize yourself with the content of the case studies, issue briefs, and handouts contained in this guide as well as the contents of the companion report, *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence* (available online at: www.ama-assn.org/violence). Other good resources are the Surgeon General's reports on youth violence and suicide prevention. These are available online at: www.surgeongeneral.gov/library/.

Suggestions for using the case studies

The three case studies included in this guide are designed to give audience members an opportunity to apply the concepts discussed during the lectures and to "think-through" how they might respond to a young person in their practice or community who is at-risk for involvement in youth violence. The cases deal with common issues that audience members might be expected to encounter including media violence, bullying, and access to firearms. Each of the three cases includes a cover sheet that can be copied and distributed to the audience that provides a "case scenario" and discussion questions. Explanations for each question are provided for the speaker to use that outline key points that should be covered in the discussion. The speaker may chose to read these out loud to the audience following the open discussion of each question, or he or she may prefer to use them as a reference. Each case presentation and discussion should take about 10-20 minutes to complete.

Preparing the Presentation *(continued)*

In a typical case presentation, the speaker will read the case scenario to the audience and then lead the audience in a discussion using the questions provided with the case as a starting point. The more you are able to encourage audience members to share their own thoughts and experiences related to the individual case scenarios, the more successful the case presentation will be. Use open-ended questions and liberal praise to encourage audience members to speak-out. Helpful prompts can include: "Tell me more about that," "Ms. [Smith] tell me some of your thoughts on this," "Good point," "Interesting," "Humm," etc. Breaking into smaller groups of 5-8 members to discuss the case studies can also encourage greater audience participation.

Instructions for conducting an on-line search for recent data and news on youth violence and its prevention

Finding statewide and local statistics on youth violence will allow you to tailor your presentation to your particular audience, making it more relevant to them and to you.

In this section, we provide you with Web sites that contain local, state, and national statistics on issues related to youth violence. We also provide links to information on programs and/or resources for violence prevention in your community or state, as well as some news clipping services that allows you to review recent news stories on youth violence. Please note: It is sometimes difficult to find this information on a local level, but we recommend checking the sites suggested as well as contacting your local law enforcement and health agencies.

Things to consider as you incorporate current statistics into your presentation:

- Understand the meaning behind the statistics
- Use them appropriately
- Know the source of the numbers, how they were collected, and how recent and reliable they are

Accessing statistics online

You can access links to all of the sites listed on the following pages at: www.stopyouthviolence.ucr.edu.

National statistics

Causes of Death by Age Group

Leading Causes of Death
http://webapp.cdc.gov/sasweb/ncipc/leadcaus.html

Child Abuse

Statistics and Facts on Child Abuse
http://www.ncvc.org/Infolink/Infolink_frames2.htm

Child Well-Being

2000 Kids Count Data Book Online
http://www.aecf.org/kidscount/kc2001/

Dating Violence

Fact Sheet
http://www.cdc.gov/ncipc/factsheets/datviol.htm

Statistics and Facts on Teen Dating Violence
http://www.ncvc.org/stats/teen.htm

Firearms

Firearm Injuries and Fatalities
http://www.cdc.gov/ncipc/

Firearm and Crime Statistics
http://www.ojp.usdoj.gov/bjs/guns.htm

Gangs

Highlights of the 1999 National Youth Gang Survey
http://www.ncjrs.org/pdffiles1/ojjdp/fs200020.pdf

School Violence

National Center for Education Statistics
http://nces.ed.gov/fastfacts/display.asp?id=54

Hamilton Fish Institute
http://www.hamfish.org/data/national/csi/index.html

Preparing the Presentation *(continued)*

Substance Abuse

Juveniles and Drugs—Prevalence Estimates
http://www.whitehousedrugpolicy.gov/drugfact/juveniles/prev_estimates.html

Suicide

Injury Mortality Data
http://webapp.cdc.gov/sasweb/ncipc/mortrate.html

Suicide in the United States
http://www.cdc.gov/ncipc/factsheets/suifacts.htm

Youth Arrest Rate

FBI Arrest Statistics
http://ojjdp.ncjrs.org/ojstatbb/ezaucr/

Youth Homicide Rate

WISQARS (Web-based Injury Statistics Query and Reporting System)
http://www.cdc.gov/ncipc/osp/data.htm

Youth Risk Behavior Trends

Youth Risk Surveillance Survey Information
http://www.cdc.gov/nccdphp/dash/yrbs/index.htm

Health Risk Behavior Trends
http://www.cdc.gov/nccdphp/dash/yrbs/trend.htm

State and local statistics*

Causes of Death by Age Group

Leading causes of death
http://webapp.cdc.gov/sasweb/ncipc/leadcaus.html

Child Well-Being

2000 Kids Count Data Book Online
http://www.aecf.org/kidscount/kc2001/

Costs of Injury

State by State Information on the Costs of Violent Crime
http://www.injuryprevention.org/info/data.htm

Crime Mapping of Your Community
http://www.ojp.usdoj.gov/cmrc/weblinks/welcome.html

Health Risk Behaviors

Youth Risk Surveillance Survey Information
http://www.cdc.gov/nccdphp/dash/yrbs/pies99/index.htm

Youth Risk Behavior Trends
http://www.cdc.gov/nccdphp/dash/yrbs/trend.html

Suicide

Regional Variations in Suicide Rates – United States, 1990-1994
http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00049117.htm

Injury Mortality Data
http://webapp.cdc.gov/sasweb/ncipc/mortrate.html

Youth Arrest Rates

FBI Arrest Statistics
http://ojjdp.ncjrs.org/ojstatbb/ezaucr/

Youth Homicide Rates

WISQARS
http://www.cdc.gov/ncipc/osp/data.htm

* Contact your local police and health departments to ask about youth violence prevention activities and obtain information on data in your area. You can find your state and local government offices at this site: http://www.statelocalgov.net/index.cfm.

Programs and resources on national level

Child Abuse

National Clearinghouse on Child Abuse and Neglect Information
http://www.calib.com/nccanch/pubs/index.cfm#Resource

Dating Violence

Safe Schools and Healthy Students Action Center (clearinghouse)
http://www.sshsac.org/

Firearms

SafeCities
http://www.safecities.gov

Join Together Online
http://www.jointogether.org

Preparing the Presentation *(continued)*

Gangs

National Youth Gang Center
850 385-0600
http://www.iir.com/nygc/

School Violence

National Resource Center for Safe Schools
http://www.safetyzone.org/

Substance Abuse

Join Together Online
http://www.jointogether.org

Suicide

National Strategy for Suicide Prevention
http://www.mentalhealth.org/suicideprevention/index.htm

National Hopeline Network
1-800-SUICIDE

Youth Development

National Resource for Youth Development Programs
http://www.ncfy.com/ydorgs2.htm

Youth Violence

National Youth Violence Prevention Center
http://www.safeyouth.org

Safe Schools/Healthy Students Action Center (clearinghouse)
http://www.sshsac.org/

Programs and resources on state and local level*

Child Abuse

State Resources (click child abuse)
http://ojjdp.ncjrs.org/resources/asp/search_states.asp

National Clearinghouse on Child Abuse and Neglect Information Organization Database
http://www.calib.com/nccanch/Scripts/SearchPg.cfm

Dating Violence

Safe Schools and Healthy Students Action Center (clearinghouse)
http://www.sshsac.org/

Gangs

Gangs or Us – Gangs in the United States
http://www.gangsorus.com

Mental Health Services

Center for Mental Health Services
http://www.mentalhealth.org/

School Violence

National Resource Center for Safe Schools
http://www.safetyzone.org/

Substance Abuse

Drug Treatment Finder–SAMSHA
http://findtreatment.samhsa.gov/

Suicide

National Strategy for Suicide Prevention – State by State
http://www.mentalhealth.org/suicideprevention/stateprograms.htm

Prevention Web – State by State
http://www.edc.org/HHD/csn/StateResources/state.htm

Suicide Hotlines
http://suicidehotlines.com

Youth Violence

Partnerships Against Violence (PAVNET) Programs
http://www.pavnet.org

Community Justice Exchange
http://www.communityjustice.org/

Prevention Web – State by State
http://www.edc.org/HHD/csn/StateResources/state.htm

SafeCities
http://www.safecities.gov

* Contact your local police and health departments to ask them about youth violence prevention activities and obtain information on data in your area. To find state and local government offices: http://www.statelocalgov.net/index.cfm

Section 2

Speeches

- Speech for health professional audience
- Speech for youth and community audience

Health Professional Audience

Reminders

Estimated length of speech: 1 hour

Preparing for the speech

- Recruit co-presenter from community if desired.
- Conduct on-line search for recent news stories, local and national data on violence and prevention programs.
- Personalize speaker's notes using this information. You can make notes directly on the hardcopy of this speech or incorporate content and formatting changes using the Microsoft Word file, which is provided with the electronic version of this guide (www.ama-assn.org/violence).
- Review issue briefs and on-line information resource sites contained in this manual.
- Download and copy overhead masters onto transparencies or load PowerPoint presentation on computer.
- If possible, send the PowerPoint slides to the person who will be providing the audio/visual support for your presentation (3 to 7 days in advance).

Room set-up and preparation of materials

- Arrange room for presentation. Stadium-style seating arrangements are appropriate for the basic presentation. If case studies are to be presented, it is optimal if seating allows audience members to move into small groups of 5 to 6.
- Arrange for overhead projector or computer projector.
- Make copies of appropriate handouts, issue briefs, and resource list.

Health Professional Audience *(continued)*

[Slide #1]

Introduction

A generation ago, a controversial political activist asserted that "violence is as American as cherry pie."[1] Today, that statement has become chillingly accurate for our nation's youth.

Option: *begin with a statement on violence made by a local leader or your favorite quote on youth violence in lieu of statement above.*

The epidemic of youth violence only occasionally warrants headlines and extended television coverage, but it is a disturbing ongoing reality that poses one of the most significant public health risks of our times.[2]

Youth violence today is more devastating to our young people than polio, AIDS, or motor vehicle crashes. One can debate the label of 'epidemic,' but not the facts behind it—starting with the fact that the United States has the highest youth homicide and suicide rates among the world's 25 wealthiest nations.[3]

[Slide #2]

Why is youth violence relevant to health professionals?

Why is a health professional talking to other health professionals about youth violence? Isn't it a criminal justice issue? A problem for the police?

In fact, youth violence is a problem that involves all of us—from police to schools to health professionals to faith institutions to families, communities, and policy makers. Youth violence is not just a criminal justice problem, it is a public health problem—and a serious one. Consider this:

[Slide #3]

- Homicide is the second leading cause of death among teenagers and young adults in this country.[4]
- Each year, the medical costs of firearm injuries alone are estimated to be $2.3 billion, which includes lifetime costs of these injuries.[5]

Health Professional Audience *(continued)*

[Slide #4]

- And finally, consider this: scientists have recently shown that exposure to extreme and extended situations of violence or trauma can change the structure and function of the brain in ways that can interfere with academic performance, mood, and behavior.[6]

[Slide #5]

The public health approach

Defining violence as a public health problem brings a new set of resources to bear on the problem in addition to those of the criminal justice system. Defining violence as a public health problem offers the youth and families of this country hope—not just of "controlling" violence through incarceration, but of preventing it altogether.[7]

When polio was prevalent in this country, we did not blame our children for falling victim to it, nor did we expect to eradicate it by relying on young people to always make the right choices. Neither, now, should we blame our children or parents or communities for succumbing to an epidemic of violence.[8, 9]

From the public health perspective, youth violence is not an inevitable fact of life. It is a social problem that can be prevented, using the same rational approach that had such great effect on other public health challenges such as drunk driving, use of seat belts, and smoking.[10, 11]

[Slide # 6]

The causes of violence

From research we now know that certain factors place children at risk for violence—as victims, as perpetrators, and as witnesses. We also know that other things protect them. Of the things that put them at risk, most importantly, we know that violence is learned.[2, 12]

[Slide #7]

Children learn violence from being victimized

- In 1999, roughly 826,000 children in the United States were the victims of maltreatment.[13]

Health Professional Audience *(continued)*

- Experiencing child abuse and neglect increases the likelihood of arrest as a juvenile by 53% and of committing violent crime by 38%.[14]

[Slide #8]

Children learn violence from watching violence in the home

There are intimate links between family violence and youth violence—these links create a "cycle of violence."

- More than 3.3 million children witness physical and verbal abuse in their homes each year, with some estimates as high as 10 million.[15-18]
- Children exposed to violence in the home are more likely to be victimized in intimate relationships as adults. They are also more likely to become an adult perpetrator or victim of violence on the streets.[14]

[Slide #9]

Children learn violence from watching violent media

- The average child watches 28 hours of television a week and will see 200,000 violent acts by age 18.[8, 19]
- Studies of the effects of TV violence suggest that children confronted incessantly by violent images in the media may become immune to the horror of violence. Not only that, they may come to accept violence as a way to solve problems.[20, 21]

Some other factors also increase the possibility that children will become perpetrators or victims of violence

[Slide #10]

Alcohol and drugs

A strong link exists between alcohol use and violence.

- Half of youth homicide victims have elevated blood alcohol levels on autopsy.[22-24]
- Those who commit homicide are also found to have elevated blood alcohol levels when apprehended and tested.[22-24]

Health Professional Audience *(continued)*

Another risk factor is gangs

Youth gangs are responsible for a disproportionate share of all criminal offenses, both violent and nonviolent.[25]

[Slide #11]

And finally, there is the risk created by guns.

- The rise in murders of juveniles from the mid-1980s through the peak year of 1993 was significantly related to firearms.[25, 26]
- In some states, firearms have surpassed auto crashes as the leading cause of death among children and youth.[27]
- Teenage boys are more likely to die from gunshot wounds than from all natural causes combined.[28]
- At least 25 million households keep handguns, and 50% of their owners keep them loaded.[29]
- Handgun owners typically indicate they keep the guns for self-defense, but suicides, homicides, and accidental deaths outnumber deaths associated with self-defense by 43 to 1.[30]
- Family and friends are the primary sources of guns for young people; only 5% have asked someone else to purchase a gun for them from legal or illegal sources.[29]

[Slide #12]

Finally, we know that the causes of violence are not simple. No single factor causes violence, rather it is the result of a combination of many factors—individual, familial, societal, and situational.[31]

With this background on the different factors that produce youth violence, I'd like to shift briefly to talk about youth violence in this community.

Option: *Insert stories about violence in local area (3-5 minutes). Insert information gathered from your on-line search.*

Health Professional Audience *(continued)*

[Slide #13]

What can physicians and other health professionals do?

So what can you as a health professional do to help prevent further death and injury to the young people in your community?

First, you can educate your patients, screen for risk factors and exposure, and refer young persons and their families to effective mental health and support services in the community.[32-34]

[Slide #14]

It can be helpful to view violence prevention activities as occurring at different stages in the injury process. The Haddon Matrix, a tool used in identifying opportunities to prevent injury, identifies three stages during the injury process where interventions can occur: the pre-injury stage, the moment of injury and, finally, after the injury has occurred.[35]

The most obvious opportunities for health professionals to intervene occur during the pre-injury and post-injury stages. I'd like to take a few moments and give you an overview of the types of interventions that health professionals can provide at these times. First, let's discuss post-injury interventions.

Health care interventions during post-injury

Health professionals have a unique opportunity to help prevent re-injury of a young person at the time he or she presents with injuries. In its most obvious manifestation, this is the child who presents in the clinic or emergency department with violent injuries such as contusions, broken bones, or at the most extreme, knife and gun shot wounds. In these cases:

You can:

[Slide #15]

Educate

- Educate parents on steps they can take to help their child avoid re-injury and cope with the emotional trauma resulting from violence.
- Educate young people on these same topics.

Option: *Insert your own methods of educating and stories of clinical work.*

[Slide #16]

Assess

- Thoroughly document the injuries and events surrounding them, as they could be important to any legal proceedings.
- Gather information about risk factors for re-injury, for example, in the case of youth-on-youth violence:[33]
  - Is the conflict settled?
  - Does the young person feel safe leaving the hospital?
  - Is he or she thinking about revenge?
  - Is there a safe place to go while things cool off?
  - Is further psychological assessment indicated?

Option: *Insert your own methods of assessing and stories about clinical work.*

[Slide #17]

Refer

- Refer young people and their families to mental health and crisis intervention services, as well as long-term supportive services. Short-term services are rarely, if ever, adequate to prevent future violence.
- Notify the local Department of Social Services in the case of abuse or neglect, and tell the police if plans for revenge warrant breaching a young person's confidentiality.

Option: *Places/programs to refer in this county and stories about clinical work.*

Health Professional Audience *(continued)*

[Slide #18]

Health care interventions during post-injury: Responding to youth with psychological injuries

Let me pause here for a moment and say that interventions during the post-injury stage are not just for youth with physical injuries. As health professionals, it is important for us to recognize that many of the injuries caused by violence are not physical. Many young people who witness violence sustain serious emotional and psychological injuries, even though they may not suffer physical injury. And more times than not, these "invisible injuries" of violence often go unrecognized and untreated. To give you some idea, a recent study found that 51% of youth from high-crime communities had symptoms of post traumatic stress disorder.[36] Or consider this, children are present in 40% of the homes in which intimate partner violence occurs.[18] Even if they are not battered themselves, it is highly likely that they witnessed violence. In a vicious "cycle of violence," many young perpetrators of violence were witnesses to serious violence when they were young, and sustained psychological injuries.[14]

[Slide #19]

Health professionals can use similar processes of screening, educating and referring with these young people, as they do with young people who present with obvious physical sequelae of violence

Option: *Insert your own methods of referral and stories about clinical work.*

[Slide #20]

Interventions during the pre-injury stage

Now I'd like to shift from discussing post-injury interventions and talk about interventions you can use at the pre-injury stage.

The battle against polio was not won by only treating the victims of the epidemic. It was won through primary prevention—in this case, the discovery and use of a vaccine.

The same is true for youth violence. The epidemic will not end only by caring for those who are already injured. It will end through the primary prevention of violence, by developing a "vaccine" against violence so to speak.

From research on risk and protective factors, we know this vaccine will be very different from that developed for polio. It will, in fact, be much more complex and difficult to administer.

It will have many different components—some that require broad social changes that do not involve the health professional directly, such as reducing poverty, improving schools, community support for family development, and reducing youth access to firearms and drugs.

But there are parts of this vaccine that do require the involvement of health professionals—and, in fact, cannot be constructed without them. Health professionals should help parents build protective socioemotional competencies in their children; and work with them to reduce children's exposure to "risk" agents like violent media and unsecured firearms.

In your practice you can:

[Slide #21]

Educate

- Work with parents, starting with prenatal care, to design a "strategic plan" for building protective emotional and social competencies in their children.
- Educate parents and young people about the effects of media violence and how to reduce exposure to it.
- Educate parents on the dangers associated with firearms and ways to reduce this danger—such as storing firearms safely and removing guns from homes with depressed and suicidal children.

Health Professional Audience *(continued)*

Option: *Insert your own methods of educating and stories about clinical work.*

[Slide #22]

Screen

- Identify children who are at-risk for violence—in other words, children who are exposed to the risk factors we discussed earlier—through screening.
- An example of a screening approach is the FISTS mnemonic, which can guide you through the questions needed to assess an adolescent's risk for violence.[37]

F–Fighting

(How many fights were you in last year? When was the last?)

I–Injuries

(Have you ever been injured? Have you ever injured someone else?)

S–Sex

(Has your partner hit you? Have you hit your partner? Have you ever been forced to have sex?)

T–Threats

(Has someone with weapon threatened you? What happened? Has anything changed to make you feel safer?)

S–Self-defense

(What do you do if someone ties to pick a fight? Have you carried a weapon in self-defense?)

Option: *Insert your own methods of screening and stories about clinical work.*

[Slide #23]

Refer

- Connect young people and their families to programs in their communities and schools that are comprehensive and reflect the characteristics of effective violence prevention programs.
- Effective programs start early in a child's life. They are long-term, intense, and involve many hours of contact. They build strong relationships between adults and children, and are comprehensive, meaning they involve many sectors of society, and focus on building positive skills in youth.[9, 34, 38-41]
- The Surgeon General's recent report on youth violence provides descriptions of specific programs that have been proven to reduce or prevent youth violence. Some programs that are effective in reducing youth violence include positive youth development programs and multisystemic family therapy with a trained counselor.[2]
- Ineffective programs include boot camps, residential treatment, and stand-alone peer mediation and counseling programs.[2]

[Slide #25]

Preventing violence

Before I close, I want to leave you with a success story. One that proves the statement I made at the beginning of this speech—that violence can be prevented. That it is not inevitable. That story takes place in Galveston, Texas.

In the late 80s and early 90s, violent crime in Galveston dropped by 78% compared to the national decline of 19%.[42]

Why did this happen? It happened in large part because of a highly comprehensive series of violence interventions implemented in the

city, with each designed to address different risk factors for youth violence at different developmental stages.

The interventions included social problem-solving skills training in elementary school, supervised recreation programs to reduce truancy, youth courts that involved young people convicted of misdemeanors in community work and education, and intensive home-based counseling services for frequent or violent offenders.

Option: *Insert stories about local programs here (3-4 minutes).*

[Slide #26]

Get involved

So get involved. Youth violence *is* relevant to health care professionals, and there are concrete things you can do in your daily practice to help end the epidemic of violence. Never forget that small changes can have big effects.

Incorporate basic educating, screening, and referral as part of your daily practice. And think about moving beyond your practice setting:

- Start an intervention such as the one in Galveston, Texas.
- Work with the schools in your area to develop violence prevention plans.
- Work with local community coalitions and groups.
- And advocate with local and national policy makers for broader implementation of effective programs, more research, and the resources needed to carry these out.

Option: *Provide information on ways in which the audience might become involved. Provide information on needs in local schools, information on local coalitions, and relevant legislation.*

Health Professional Audience *(continued)*

[Slide #27]

Concluding statements

In the United States, we have become accustomed to the televised sights and sounds of war in faraway lands. But for our country's youngest citizens, our own streets, schools, and homes have increasingly become danger zones in which many of our children regularly encounter violence.

We, as health professionals, have a unique role to play in addressing this threat to our children's safety and to our country's health. When we step forward and do our part, we help ensure that our youth will have what they deserve—the opportunity to grow, thrive, and develop into healthy adults who can contribute to a great society.

Thank you

Annotated Bibliography

1 Attributed to H. Rap Brown, a member of the Student Nonviolent Coordinating Committee during the 1960s civil rights movement. Later he is believed to have become disillusioned with nonviolent methods and became a member of the Black Panthers. Most recently he was convicted for the murder of a law enforcement officer. Excerpted from Christoffel T, Gallagher S. *Injury Prevention and Public Health: Practical Knowledge, Skills, and Strategies*. Gaithersburg, MD: Aspen Publishers, Inc;1999.

2 US Department of Health and Human Services. *Youth Violence: a Report of the Surgeon General.* Rockville, MD: Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; and the National Institutes of Health, National Institute of Mental Health; 2001.

The Surgeon General's report summarizes recent research on the causes and prevention of youth violence. The report provides an overview of prevalence; findings on the developmental dynamics of youth violence; risk and protective factors; and model, promising, and ineffective prevention and intervention programs. Risk and protective factors are reviewed by domain—individual, family, school, peer group, and community. Programs are categorized as primary, secondary, and tertiary prevention programs. Effective primary prevention strategies include: skills training, behavior monitoring and reinforcement, building school capacity, and positive youth development, among others. Effective secondary prevention strategies include: parent training, home visitation, and social problem-solving, among others. Effective tertiary prevention strategies include: multimodal intervention, skills training, and marital and family therapy by clinical staff, among others. Ineffective programs include: peer counseling and mediation, gun buyback programs and firearm training, boot camps, residential programs, waivers to adult court, and individual counseling.

3 Centers for Disease Control and Prevention. Rates of homicide, suicide, and firearm-related death among children: 25 industrialized countries. *Morb Mortal Wkly Rep*.1997;46:101-105.

4 Cohen L, Potter L. Injuries and violence: risk factors and opportunities for prevention during adolescence. *Adolesc Med.* 1999;10:125-135.

More adolescents in the United States die from injuries than from any other cause. This article describes the three leading causes of death among adolescents—interpersonal violence, suicide, and motor vehicle-related injuries. The authors examine risks associated with alcohol use and access to firearms as well as injuries that occur at work and while playing sports, and provide recommendations for preventing adolescent injuries for health care providers, schools and communities.

5 Cook PJ, Lawrence A, Ludwig J, Ludwig M, Miller TR. The medical costs of gunshot injuries in the United States. *JAMA.* 1999;282:447-454.

This study estimates costs for firearm injury, including lifetime costs associated with this type of injury. The analysis is based on emergency department data from hospitals in three different states, as well as databases such as the National Electronic Injury Surveillance System. Furthermore, the authors delineate the burden of these costs (namely, government and private sector). They also produce a mean cost-per-injury as they illustrate the effect of gun violence on the medical sector.

6 Niehoff D. *The Biology of Violence: How Understanding the Brain, Behavior, and Environment Can Break the Vicious Circle of Aggression.* New York, NY: The Free Press; 1999.

7 Rosenberg M, Fenley MA. *Violence in America: A Public Health Approach.* New York, NY: Oxford University Press; 1991.

Violence in America provides an overview of different forms of violence (assault, child abuse, child sexual abuse, rape and sexual assault, spouse abuse, elder abuse, and suicide) and discusses implications for intervention from a public health perspective. The authors contend that violence is as much a public health issue as one of criminal justice, and that the public health approach of surveillance, risk factor identification, intervention, and evaluation and implementation can assist in the prevention of violence among adults and children.

8 Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago, IL: The American Medical Association; 2000:28.

Health Professional Audience *(continued)*

9 Task Force on Violence, American Academy of Pediatrics. The role of the pediatrician in youth violence prevention in clinical practice and at the community level, policy statement. *Pediatrics.* 1999;103:173-171.

10 Centers for Disease Control and Prevention. Ten great public health achievements-United States, 1990-1999. *Morb Mortal Wkly Rep*. 1999;48:241-243.

During the 20th century, the health and life expectancy of persons residing in the United States improved dramatically. Since 1900, the average lifespan of persons in the United States has lengthened by more than 30 years; 25 years of this gain is attributable to advances in public health. To highlight these advances, MMWR profiles 10 public health achievements.

11 Hawley T. *Safe Start: How Early Experiences Can Help Reduce Violence*. Chicago, IL: The Ounce of Prevention Fund; 2000.

Many initiatives have been proposed and implemented to reduce the incidence of violent crime, including community policing, stiffer sentences for convicted criminals, and programs to keep adolescents involved in positive activities and "off the streets." However, many communities have overlooked what a national organization of law enforcement officials and crime victims cite as the most promising approach to reducing violence: prevention and intervention programs for very young children aged birth to 5 years. Built on decades of research on child development, these programs are making lasting differences and helping young children receive a safer start in life.

12 da Silva JM, Sterne M, Anderson P. *ACT (Adults and Children Together) Against Violence.* Washington, DC: American Psychological Association, National Association for the Education of Young Children; 2001.

13 US Department of Health and Human Services. *Ten Years of Reporting Child Maltreatment 1999.* Washington, DC: US Government Printing Office; 1999.

The project spans 10 years of research on the methods by which child maltreatment is assessed and reported in the United States. The study is nationwide and focuses on the mode by which referrals parlay into investigation by child protective services. It also provides demographic information on the children as well as the characteristics of the perpetrators. The future of child protective services is analyzed in the context of the information provided within this project.

14 Widom CS. The cycle of violence. *Research in Brief.* Washington DC: US Department of Justice, Office of Justice Programs; 1992.

This longitudinal study tested the cycle of violence hypothesis by tracking more than 1,500 cases from childhood to adulthood. The study utilized a multi-method research design by incorporating arrest data, interviews, and comparison groups. The focus encompassed various forms of abuse, including neglect, in the overall effect on future violent behavior.

15 Carlson BE. Children's observations of interparental violence. In: Roberts AR, ed. *Battered Women and Their Families.* New York, NY: Springer; 1984:147-167.

16 Horn D. *Bruised Inside: What Our Children Say About Youth Violence, What Causes It and What We Need to Do About it.* Washington, DC: National Association of Attorneys General; 2000.

This report chronicles meetings held with youth, parents, teachers, and school administrators. It is a description of the findings from these meetings. The authors recommend steps that can be taken by parents, youth, schools, communities of faith, and others to help prevent youth violence, and describe state-by-state efforts that attorneys general are making to curb youth violence.

17 Jaff PG, Wolfe D, Wilson S. *Children of Battered Women.* Newbury Park, CA: Sage Publications;1990.

18 Rennison CM, Welchans S. Intimate partner violence. *Bureau of Justice Statistics Special Report.* Washington, DC: US Department of Justice; 2000.

19 American Psychiatric Association, Fact Sheet. *Psychiatric Effects of Media Violence.* Available at: http://www.psych.org/public_ info/media_ violence.cfm.

20 American Medical Association. *Physician's Guide to Media Violence.* Chicago, IL: American Medical Association; 1996.

This guide provides suggestions and options for dealing with violence in the media and for protecting our children from its notorious and insidious effects. It primarily addresses television, where the most evidence exists, but other media are implicated as well, and these effects are also reviewed. It offers physicians an overview of the health consequences of such exposure and offers specific recommendations about reducing the effects of media violence for physicians to pass onto parents.

Health Professional Audience *(continued)*

21 Donnerstein E, Slaby R, Eron L. The mass media and youth violence. In: Murray J, Rubenstein E, Comstock G, ed. *Violence and Youth: Psychology's Response, Vol. 2.* Washington, DC: American Psychological Association; 1994.

This chapter contributes to the literature on media effects and violence. It reinforces the findings over a span of 20 years about this relationship. Specifically, violence in media can lead to aggression and aggressive attitudes as well as desensitize youth to violence and the use of violence in interpersonal relationships.

22 Adams PF, Schoenborn CA, Moss AJ. *Health Risk Behaviors Among Our Nation's Youth: United States, 1992.* (DHHS publication 95-1520). Hyattsville, MD: National Center for Health Statistics; 1994.

23 Mann RP, Borosowsky I, Stolz A, Latts E, Cart C, Brindis C. *Youth Violence: Lessons From the Experts.* Washington, DC: Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, US Department of Health and Human Services; 1998.

This report presents responses from both professionals and youth as to what professionals, parents, youth, and citizens can do to protect themselves from violence. It also includes descriptions of some violence prevention programs that appear to have a good chance of success. This is a tool for health professionals and educators; maternal and child health directors and adolescent health coordinators, societies, and professional organizations that work with children and youth; and the hundreds of government policymakers at local, county, and state levels.

24 Prothrow-Stith D, Spivak HR. Violence. In McAnarney ER , Kreipe RE, Orr DP, Comerci GD, eds. *Textbook of Adolescent Medicine.* Philadelphia, PA: Harcourt Brace Jovanovich; 1992;1113-1118.

25 Snyder H, Sickmund M. *Juvenile Offenders and Victims: 1999 National Report.* Washington, DC: US Department of Justice; 1999.

This report offers a comprehensive overview of the pervasive problems of juvenile crime and reviews the response of the juvenile justice system. It contains statistics from a variety of sources on a wide array of topics, including juvenile population characteristics, juvenile victims, juvenile offenders, juvenile justice system structure and process, law enforcement and juvenile crime, juvenile courts, and juveniles in correctional facilities.

26 Federal Bureau of Investigation (various). Supplementary Reports for the Years 1980-1997 [machine-readable data files]. Washington, DC: FBI.

27 Fingerhut LA, Jones C, Makuc DM. Firearm and motor vehicle injury mortality—variations by state, race and ethnicity: United States, 1990-1991. *Advance Data From Vital and Health Statistics*, No. 242. Hyattsville, MD: National Center for Health Statistics; 1994.

This study is part of the Healthy People 2000 initiative that seeks to reduce both fatal motor vehicle accidents and homicides. The initiative's focus is on individuals aged 15-24 years as well as the impact on people of color. The study compares death rates in these two categories delineated by race and age as well as within the states. Furthermore, the analysis compares across states by these variables.

28. Coordinating Council on Juvenile Justice and Delinquency Prevention. *Combating Violence and Delinquency: The National Juvenile Justice Action Plan/Report.* Washington, DC: US Department of Justice; 1996.

The report builds on the *Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (Wilson and Howell, 1993) and describes federal activities and resources to help communities address eight critical objectives. The overarching goal is to rebuild community confidence in the system's ability to have an impact on this serious problem.

29 Sheley J, Wright J. High school youths, weapons, and violence: a national survey. *Research in Brief.* Washington, DC: National Institute of Justice, US Department of Justice; 1998.

This Research in Brief examines the extent to which a national sample of male high school sophomores and juniors was involved in, or otherwise affected by, firearm-related activity. Surveys were mailed to high school students that sought information on their firearm and crime-related activities for the 12 months prior to the survey as well as social, demographic, and personal information for each respondent.

Health Professional Audience *(continued)*

30 Kellermann AL, Reay DT. Protection or peril? An analysis of firearm-related deaths in the home. *N Engl J Med.* 1986;314:1557-1560.

The paper reviews deaths that occurred in King County, Washington, from 1978 through 1983 due to firearms. A total of 743 firearm-related deaths occurred during the six-year period, of which 54% occurred in homes where firearms were kept. For every case of self-protection homicide involving a firearm kept in the home, there were 1.3 accidental deaths, 4.6 criminal homicides, and 37 suicides involving firearms. Only 2 of the 398 deaths involved an intruder shot during attempted entry. Handguns were used in 70.5% of these deaths.

31 National Youth Violence Prevention Resource Center. *Risk and Protective Factors for Youth Violence.* Available at: http://www.safeyouth.org/topics/risk.htm. Accessed: June 2001.

Current research indicates that the presence of a single risk factor in an individual does not, by itself, cause antisocial or violent behavior. Rather, it is now generally believed that multiple factors combine to contribute to and shape behavior over the course of adolescent development. Studies suggest it is the confluence of certain "risk" factors that contributes to violent behavior, and the existence of certain "protective" factors that creates resiliency. The design of effective prevention and intervention strategies should take into consideration the dynamics and inter-relationship of both types of factors.

32 Brandt EN. Curricular principles for health professions education about family violence. *Acad Med.* 1997; 72: 51-58.

33 Sege R, Licenziato V, eds. *Recognizing and Preventing Youth Violence: A Guide for Physicians and Other Health Care Professionals.* Waltham, MA: Massachusetts Medical Society; 2001.

The purpose of this guide is to incorporate physicians and other health care professionals into the prevention of youth violence. The guide provides extensive materials in an easily assessable format on issues such as the basics of youth violence, screening for risk factors, and the utilization of protective factors. Furthermore, the guide gives concrete suggestions for prevention from a health care perspective as well as advocates the need for health care professionals as leaders to help prevent youth violence.

34 Cohn F, Salmon ME, Stobo JD, eds. *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence.* Washington, DC: National Academy Press; 2001.

35 National Committee for Injury Prevention and Control. *Injury Prevention: Meeting the Challenge*. New York, NY: Oxford University Press (published as a supplement to the *Am J Prev Med.* 1989; 5:4-8).

36 Nadel H, Spellmann M, Alvarez-Canino T, Lausell-Bryan LL, Landsberg G. The cycle of violence and victimization: a study of the school-based intervention of a multidisciplinary youth violence-prevention program. *Am J Prev Med.* 1996; 12 (5 Suppl):109-119.

This study evaluates a multi-disciplinary school-based intervention for youth violence. The findings illustrate that violence is pervasive in the lives of these youth at home, in the community, and at school. The study reports on large percentages of exposure to violence in these environments as well as some of the norms and beliefs surrounding violence on a societal level and community level.

37 Alpert E, Bradshaw S, Ylisabyth S, Sege RD. Interpersonal violence and the education of physicians. *Acad Med.* 1997; 42:541-551.

38. Burt M, Resnick G, Matheson N. *Comprehensive Service Integregation Programs for At Risk Youth: Final Report.* Washington, DC: Urban Institute;1992.

39 Dryfoos J. *Adolescents at Risk: Prevalence and Prevention.* New York, NY: Oxford University Press; 1990.

40 Dryfoos J. *Full Service Schools: A Revolution in Health and Social Services for Children, Youth and Families.* San Francisco, CA: Jossey-Bass; 1995.

41 Knox L. *Youth Violence Prevention and the Health Professions: Core Competencies for Effective Practice.* Riverside, CA: Southern California Developing Center on Youth Violence Prevention; 2001.

42 Thomas C, Holzer C, Wall J. The Island Youth Programs: community interventions for reducing youth violence and delinquency. *Adolesc Psychiatry.* 2002;26:125-143.

Youth and Community Audience

Reminders

Estimated length of speech: 1 hour

Preparing for the speech

- Recruit co-presenter from community if desired
- Conduct on-line search for recent news stories, local and national data on violence and prevention programs.
- Personalize speaker's notes using this information. You can make notes directly on the hardcopy of this speech or incorporate content and formatting changes using the Microsoft Word file, which is provided with the electronic version of this guide (www.ama-assn.org/violence).
- Review issue briefs and on-line information resource sites contained in this manual.
- Download and copy overhead masters onto transparencies or load PowerPoint presentation on computer.
- If possible, send the PowerPoint slides to the person who will be providing the audio/visual support for your presentation (3 to 7 days in advance).

Room set-up and preparation of materials

- Arrange room for presentation. Stadium-style seating arrangements are appropriate for the basic presentation. Arrange for overhead projector or computer projector.
- Make copies of appropriate handouts, issue briefs, and resource list.

Note: This talk is intended to be more interactive than the health professional speech. It includes several opportunities for discussion among the participants about issues related to youth violence.

Youth and Community Audience *(continued)*

[Slide #1]

Introduction

It is a pleasure to be here with all of you today. I hope to help you think in new ways about an enormous challenge that faces our country: The problem is youth violence.

Option: *Insert local story on youth violence (3-4 minutes)*

[Slide #2]

The United States is one of the most violent nations in the world. We have the *highest* youth homicide and suicide rates among the world's 25 wealthiest nations.[1]

[Slide #3]

Youth violence is an epidemic that has been more devastating to our young people than polio, AIDS, or motor vehicle crashes.[2, 3]

- Violence is the second leading cause of death among young people ages 15 to19 in this country and suicide is the third leading cause of death.[4]
- Sixteen million adolescents in the United States have witnessed some type of violent assault in their lifetime.[2]
- Each year the medical cost of firearm injuries alone is estimated to be $2.3 billion, which includes lifetime costs of these injuries.[5]

There is a common belief that a certain amount of youth violence is an inevitable reality of the world we live in. All too often our daily news is punctuated by stories of random acts of violence, from hate crimes to tragic school shootings, from workplace rampages to attacks on churches and community centers.

[Slide # 5]

Yet violence is not inevitable; it can be prevented. Youth violence has damaged many, many young lives. But it doesn't have to continue to be such a destructive force.

We have real reasons for hope. In fact, the numbers show that progress is being made, because youth violence has been in decline from 1994 to 1999.[6, 7]

Youth and Community Audience *(continued)*

The causes of violence

A British author once said "Violence among young people is an aspect of their desire to create. They don't know how to use their energy creatively, so they do the opposite and destroy."[8] I'd like to take a moment to hear some of your own perspectives.

[Slide #6]

Do you think this man was right? What do you believe causes young people to act violently?

Stop for discussion (3-4 minutes)

Research findings agree with some of the opinions you have just expressed. This is what experts tell us about violence:

[Slide #7]

We know that violence is learned, and that children often learn it in their homes [2, 9]

- More than 3.3 million children witness physical and verbal abuse in their homes each year, with some estimates as high as 10 million.[10-13]
- Witnessing domestic violence, even among very young children, can result in depression and anxiety, attention and learning problems, and a greater likelihood of developing aggressive and anti-social behavior.[14]

[Slide #8]

We know that children learn violence by being victimized by family members or other intimates

- In 1999, roughly 826,000 children in the United States were victims of abuse.[15]
- Experiencing abuse increases the likelihood that a child will be arrested as a juvenile by 53% and will commit a violent crime by 38%.[16]

Youth and Community Audience *(continued)*

[Slide #9]

We know that children learn violence by being victimized by peers

- One in 7 school children is either a bully or has been a victim of a bully.[17,18]
- Between 10% and 30% of teens are victims of dating violence.[19]

[Slide # 10]

We know that children learn violence through watching violent media

- The average child watches 28 hours of television a week and will see 200,000 acts of violence by age 18.[3]
- Research suggests that young people who are confronted by frequent violent images in the media can become immune to the horror of violence, and come to accept violence as a way to solve problems.[20]

[Slide #11]

What are some examples of violent media that concern you?

Stop for discussion (3-4 minutes)

Other factors also increase risk

[Slide #12]

Alcohol and drugs. Research has found that substance abuse is one of the risk factors that is most predictive of violence.

- Half of youth homicide victims have elevated blood alcohol levels at autopsy.[21-23]
- Those who commit homicide also have elevated blood alcohol levels when apprehended and tested.[21-23]

Youth and Community Audience *(continued)*

[Slide #13]

Another risk factor is gangs. Youth gangs are responsible for a disproportionate share of all criminal offenses, both violent and nonviolent.[6]

[Slide #14]

And finally, guns. The rise in murders of juveniles from the mid-1980s through the peak year of 1993 was *mainly* firearm-related, as was the subsequent decline in juvenile murders through 1997.[6, 7]

- In some parts of the country, firearms have surpassed auto crashes as the leading cause of death among children and youth.[24]
- Teenage boys are more likely to die from gunshot wounds than from all natural causes combined.[25]
- Guns are easy for young people to get. Family and friends are the primary source of guns for young people.[26]

[Slide #15]

What risk factors do you see in your community (school)? Which ones concern you the most?

Stop for discussion (3-4 minutes)

Preventing violence

Just as there are many risk factors for violence—we just covered a few of the most important ones—there also are many factors that can prevent violence.

[Slide #16]

These include:[2, 27]

- Having a strong relationship with a caring, responsible adult
- A positive and welcoming school environment and experiencing success in school
- Having dreams and plans for the future (future orientation)
- Having the ability to not act on strong emotions and impulses (impulse control)

Youth and Community Audience *(continued)*

- Effective prevention programs—like family counseling with a trained clinician and positive youth development programs.

[Slide #17]

At the beginning of this speech, I made the statement that violence is not inevitable, and that it can be prevented. To prove it, I want to tell you about a success story. In the 1990s, violent crime across the nation declined 19%, but in Galveston, Texas, it dropped by 78%.[28]

This was due in part to the Galveston Island Youth Programs. These programs included supervised recreational activities, training in critical social and problem-solving skills in elementary school, peer courts, and intensive home-based counseling services for frequent or violent offenders.

Insert local success story (3-4 minutes)

[Slide #18]

Do you have programs like this in your community? What resources are there for violence prevention in your community? What can you do to prevent violence in your community?

Stop for discussion (3-4 minutes)

Those are some great ideas. And here are a few more ideas you may not have thought of (include as needed)[3]:

[Slide #19]

- *First and most important. Get involved!* Many people get the idea that the problem is too big and there is nothing they can do. But even just a few of you can make a big difference in your community (schools, homes). So get involved. Get a group of your friends together and work with your school or with a program in your community to increase the peace. Start a program like Galveston. Always think you can make a difference.

Youth and Community Audience *(continued)*

- *Let others know that violence isn't normal and that it can be prevented.* Tell them about the success stories you learned about during this presentation today. Sometimes people just need a little inspiration.

[Slide #20]

- *Become informed consumers of the media.* Be critical about what you and your family see on TV or at the movies, what you listen to on the radio, and look at on the computer. Watching excessive violence can make you a different person—and not a better one.

[Slide #21]
optional

Optional: Mini-Skill-Building Exercise in Media Literacy:

Visit the American Academy of Pediatrics "Media matters" Web site for recommendations for teaching media literacy skills: http://www.aap.org/advocacy/mmguide.pdf.

[Slide #22]
[Slide #23]

- *Don't keep guns in the home. If you must, use safe storage procedures.*[29] Keep guns unloaded and store guns and ammunition separately. Store both in locked containers, with a responsible adult holding the keys or access codes securely on his/her person at all times. Use trigger locks and other devices to immobilize firearms. And remember, young people are not only at risk in their own homes. Be sure other homes your children or siblings visit use safe firearm storage procedures as well.

Youth and Community Audience *(continued)*

[Slide #24]

- *For young people: talk to a trusted adult about problems with violence and walk away if you see a firearm.* If you or one of your friends is having a problem with violence—such as bullying or gangs or violence in the home—talk to a trusted adult about this. The adult may be a parent, a teacher, even a parent of one of your friends. Let them know what is going on and ask for their help. It's not "tattling"—it's being responsible and a good friend. If you are in a situation where firearms are present, even if one of your friends is just "showing off," walk away and tell a responsible adult about the weapon. Again, it's not " tattling"—it's being responsible and a good friend.

[Slide #25]

Concluding statements

Some years ago, a wise person wrote, "In violence we forget who we are."[30] The tragedy of youth violence is that so many young people, who either caused violence or were themselves the victims, lost the chance to find out who they really were. We must work together to stop the violence. Get involved so that all young people will have a chance to discover who they are.

Thank you

Annotated Bibliography:

1 Centers for Disease Control and Prevention. Rates of homicide, suicide, and firearm-related death among children: 26 industrialized countries. *Morb Mortal Wkly Rep.* 1997; 46:101-105.

2 US Department of Health and Human Services. *Youth Violence: A Report of the Surgeon General.* Rockville, MD: Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; and the National Institutes of Health, National Institute of Mental Health; 2001.

The Surgeon General's report summarizes recent research on the causes and prevention of youth violence. The report provides an overview of prevalence, findings on the developmental dynamics of youth violence, risk and protective factors, and model, promising, and ineffective prevention and intervention programs. Risk and protective factors are reviewed by domain—individual, family, school, peer group, and community. Programs are categorized as primary, secondary, and tertiary prevention programs. Effective primary prevention strategies include: skills training, behavior monitoring and reinforcement, building school capacity, and positive youth development, among others. Effective secondary prevention strategies include: parent training, home visitation, and social problem solving, among others. Effective tertiary prevention strategies include: multimodal intervention, skills training, and marital and family therapy by clinical staff, among others. Ineffective programs include peer counseling and mediation, gun buyback programs and firearm training, boot camps, residential programs, waivers to adult court, and individual counseling.

3 Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence*. Chicago, IL: American Medical Association; 2000:31.

4 Cohen L, Potter L. Injuries and violence: risk factors and opportunities for prevention during adolescence. *Adolesc Med.* 1999;10:125-135.

More adolescents in the United States die from injuries than from any other cause. This article describes the three leading causes of death among adolescents—interpersonal violence, suicide, and motor vehicle-related injuries. The authors examine risks associated with alcohol use and access to firearms as well as injuries that occur at work and while playing sports, and provide recommendations for preventing adolescent injuries for health care providers, schools, and communities.

5 Cook P, Lawrence J, Bruce A, Ludwig J, Miller, TR. The medical costs of gunshot injuries in the United States. *JAMA.* 1999; 282:447-454.

This study estimates costs for firearm injury, including lifetime costs associated with this type of injury. The analysis is based on emergency department data from hospitals in three different states, as well as databases such as the National Electronic Injury Surveillance System. Furthermore, the authors delineate the burden of these costs (namely, government and private sector). They also produce a mean cost-per-injury as they illustrate the effect of gun violence on the medical sector.

6 Snyder H, Sickmund M. *Juvenile Offenders and Victims: 1999 National Report.* Washington, DC: US Department of Justice; 1999.

This report offers a comprehensive overview of the pervasive problems of juvenile crime, and it reviews the response of the juvenile justice system. It contains statistics from a variety of sources on a wide array of topics, including juvenile population characteristics, juvenile victims, juvenile offenders, juvenile justice system structure and process, law enforcement and juvenile crime, juvenile courts, and juveniles in correctional facilities.

7 Federal Bureau of Investigation (various). Supplementary reports for the years 1980-1997 [machine-readable data files]. Washington, DC: FBI.

8 Anthony Burgess (b. 1917), In: Independent L. ed. London 1990.

9 da Silva, Julia M, Sterne M, Anderson P. *ACT (Adults and Children Together) Against Violence.* Washington, DC: American Psychological Association, National Association for the Education of Young Children; 2001.

Youth and Community Audience *(continued)*

10 Horn D. *Bruised inside: What our Children Say About Youth Violence, What Causes It and What We Need to Do About It.* Washington, DC: National Association of Attorneys General; 2000.

This report chronicles meetings held with youth, parents, teachers, and school administrators. It is a description of the findings from these meetings. The authors recommend steps that can be taken by parents, youth, schools, communities of faith, and others to help prevent youth violence and describe state-by-state efforts that attorneys general are making to curb youth violence.

11 Carlson BE. Children's observations of interparental violence. In: Roberts AR, ed. *Battered Women and Their Families.* New York, NY: Springer; 1984:147-167.

12 Jaff PG, Wolfe D, Wilson S. *Children of Battered Women.* Newbury Park, CA: Sage Publications; 1990.

13 Rennison CM, Welchans S. Intimate partner violence. *Bureau of Justice Statistics Special Report.* Washington, DC: US Department of Justice; 2000.

14 Hawley T. *Safe Start: How Early Experiences Can Help Reduce Violence.* Chicago, IL: The Ounce of Prevention Fund; 2000.

Many initiatives have been proposed and implemented to reduce the incidence of violent crime, including community policing, stiffer sentences for convicted criminals, and programs to keep adolescents involved in positive activities and "off the streets." However, many communities have overlooked what a national organization of law enforcement officials and crime victims cites as the most promising approach to reducing violence: prevention and intervention programs for very young children ages birth to 5. Built on decades of research on child development, these programs are making lasting differences and helping young children receive a safer start in life.

15 US Department of Health and Human Services. *Ten Years of Reporting Child Maltreatment 1999.* Washington, DC: US Government Printing Office; 1999.

The project spans 10 years of research on the methods by which child maltreatment is assessed and reported in the United States. The study is nationwide and focuses on the mode by which referrals parlay into investigation by child protective services. It also provides demographic information on the children as well as the characteristics of the perpetrators. The future of child protective services is analyzed in the context of the information provided within this project.

16 Widom CS. The cycle of violence. *Research in Brief.* Washington, DC: US Department of Justice, Office of Justice Programs; 1992.

This longitudinal study tested the cycle of violence hypothesis by tracking more than 1,500 cases from childhood to adulthood. The study utilized a multi-method research design by incorporating arrest data, interviews, and comparison groups. The focus encompassed various forms of abuse including neglect in the overall effect of future violent behavior.

17 Brooks K, Schiraldi V, Ziedenberg J. *School House Hype: Two Years Later: Executive Summary*. Washington, DC: Justice Policy Institute, Children's Law Center; April 2000.

18 Batsche G, Moore B. Bullying fact sheet. In: *Behavioral Interventions: Creating a Safe Environment in Our Schools.* Bethesda, MD: National Mental Health and Education Center for Children and Families, National Association of School Psychologists;1998:14-16.

19 American Medical Association Alliance, Inc. *SAVE (Stop America's Violence Everywhere) Schools From Violence.* Chicago, IL: AMA Alliance, Inc; summer 1999.

20 Donnerstein E, Slaby R, Eron L. The mass media and youth violence. In: Murray J, Rubenstein E, Comstock G. eds. *Violence and Youth: Psychology's Response,* Vol. 2. Washington, DC: American Psychological Association; 1994.

This chapter contributes to the literature on media effects and violence. It reinforces the findings over a span of 20 years about this relationship. Specifically, violence in media can lead to aggression and aggressive attitudes as well as desensitizing youth to violence and the use of violence in interpersonal relationships.

21 Adams PF, Schoenborn CA, Moss AJ. *Health Risk Behaviors among our Nation's Youth: United States, 1992* [DHHS publication 95-1520]. Hyattsville, MD: National Center for Health Statistics; 1994.

22 Prothrow-Stith D, Spivak HR. Violence. In: McAnarney ER, Kreipe RE, Orr DP, Comerci GD, ed. *Textbook of Adolescent Medicine.* Philadelphia, PA: Harcourt Brace Jovanovich; 1992:1113-1118.

Youth and Community Audience *(continued)*

23 Mann RP, Borosowsky I, Stolz A, Latts E, Cart C, Brindis C. *Youth Violence: Lessons From the Experts.* Washington, DC: Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service; US Department of Health and Human Services; 1998.

This report presents responses from both professionals and youth as to what professionals, parents, youth, and citizens can do to protect themselves from violence. It also includes descriptions of some violence prevention programs that appear to have a good chance of success. This is a tool for health care professionals and educators; maternal and child health directors and adolescent health coordinators, societies, and professional organizations that work with children and youth; and the hundreds of government policymakers at local, county, and state levels.

24 Fingerhut LA, Jones C, Makuc DM. Firearm and motor vehicle injury mortality—variations by state, race and ethnicity: United States, 1990-1991. *Advance Data From Vital and Health Statistics, No. 242.* Hyattsville, MD: National Center for Health Statistics; 1994.

This study is part of the Healthy People 2000 initiative, which seeks to reduce both fatal motor vehicle accidents and homicides. The initiative's focus is on individuals aged 15 to 24 years as well as the impact on people of color. The study compares death rates in these two categories delineated by race and age as well as within the states. Furthermore, the analysis compares across states by these variables.

25 Coordinating Council on Juvenile Justice and Delinquency Prevention. *Combating Violence and Delinquency: The National Juvenile Justice Action Plan/Report.* Washington, DC: US Department of Justice; March 1996.

26 Sheley J, Wright J. High school youths, weapons, and violence: a national survey. *Research in Brief.* Washington, DC: National Institute of Justice, US Department of Justice; 1998.

This Research in Brief examines the extent to which a national sample of male high school sophomores and juniors was involved in, or otherwise affected by, firearm-related activity. Surveys were mailed to high school students that sought information on their firearm—and crime-related activities for the 12 months prior to the survey as well as social, demographic, and personal information for each respondent.

27 Search Institute. *40 Developmental Assets.* Available at:http://www.search-institute.org/assets/forty.htm. Accessed: May 23, 2000.

28 Thomas C, Holzer C, Wall J. The Island Youth Programs: community interventions for reducing youth violence and delinquency. *Adolesc Psychiatry.* 2002; 26:125-143.

29 TIPP. *The Injury Prevention Program: Firearms Injury Prevention.* Elk Grove Village, IL: American Academy of Pediatrics; 2000.

30 McCarthy (1912-1989). In: *Characters in Fiction, On the Contrary,* pt. 3; 1961.

Section 3

Slides

- Master list of slides for health professional speech
- Master list of slides for youth and community speech

Slides

Slides to accompany speeches

A good speech includes effective audiovisual materials. Slides are available for you to use with each speech and can be downloaded free of charge from http://www.stopyouthviolence.ucr.edu and http://www.ama-assn.org/violence.

The slides are available in Powerpoint and can be modified to include your name and institution, and information on the local community you identify during your online search.

Based on the resources available to you at the presentation site, you may decide to download the PowerPoint presentation and use a computer projector to display the images directly from your computer; or you may opt to download the files and print the visual aids onto transparencies for use with an overhead projector.

To increase the visual appeal of your slide presentation, consider adding photographic images to the PowerPoint file. Two good sites for viewing and purchasing images are: http://www.fotosearch.com and http://www.blackstar.com. These sites allow you to purchase single images or an entire series of images related to specific themes.

Health Professional Presentation

Introduction

American Medical Association
Physicians dedicated to the health of America

Connecting the Dots to Prevent Youth Violence

A Training and Outreach Guide for Physicians and Other Health Professionals

Slide 1

Youth violence opportunities for prevention

Name
Date
Institution
Health Professional Training

Slide 2

The problem

- The United States has highest youth homicide and suicide rate among the wealthiest developed nations *(Task Force on Violence, 1999)*.

Health Professional Presentation *(continued)*

Slide 3

Impact of violence on health

- Homicide is second leading cause of death for youth ages 15-19 *(Cohen & Potter, 1999)*.
- Medical costs just for firearm injuries are estimated at $2.3 billion a year *(Cook et al, 1999)*.

Slide 4

Impact on health

- Recent research shows changes to brain structure and chemistry following exposure to extreme violence *(Niehoff,1999)*.

Slide 5

The public health approach

- Like polio and other public health threats, violence can be prevented.

Health Professional Presentation *(continued)*

Slide 6

The causes of youth violence

↑ Risk factors

↓ Protective factors

Slide 7

Violence is learned by being victimized

- Approximately 826,000 children were victims of maltreatment in 1999 *(US DHHS)*.
- Experiencing child abuse and neglect increases the likelihood of arrest as a juvenile by 53% and of committing violent crimes by 38%. *(Widom, 1992)*.

Slide 8

Violence is learned

- The 3.3 million children who witness domestic abuse each year are 15 times more likely to become victims or perpetrators of violence *(Carlson, 1994; Horn, 2000)*.
- They are also more likely to be victimized in intimate relationships as adults as well as to become a perpetrator or victim of violence on the streets *(Widom, 1992)*.

Health Professional Presentation *(continued)*

Slide 9

Violence is learned by exposure to violent media

- By age 18, a child has seen 200,000 acts of violence on TV and other media.
- Studies suggest that children confronted incessantly by violent images may become immune to the horror of violence and may come to accept violence as a way to solve problems *(AMA, 1996; Donnerstein et al, 1994)*.

Slide 10

Alcohol and drugs are risk factors

- 50% of youth homicide victims have elevated blood alcohol levels *(Mann, et al, 1998; Adams et al, 1992; Prothrow-Stith, 1992)*.
- 50% of youth who perpetrate homicide have elevated blood alcohol levels *(Mann, et al, 1998; Adams et al, 1992; Prothrow-Stith, 1992)*.

Slide 11

Firearms

- Teenage boys are more likely to die from gunshot wounds than from all natural causes combined *(Coordinating Council on Juvenile Justice and Delinquency Prevention, 1996)*.
- Family and friends are the primary source of guns for young people *(Sheley & Wright, 1998)*.

Health Professional Presentation *(continued)*

Slide 12

A combination of factors

- Violence is not the result of a single factor.
- Violence is the result of the interaction of multiple individual, situational, contextual, and society influences *(National Youth Violence Prevention Resource Center, 2001)*.

Slide 13

What health care professionals can do:

- Educate youth about ways to reduce risk and increase protection.
- Screen youth for risk and exposure.
- Refer them to comprehensive support programs.

(Brandt, 1997; Sege et al, 2001; Cohn, 2001)

Slide 14

Three Phases of the Haddon Matrix

Pre-injury	Prenatal care
	Routine preventive care
	Acute care unrelated to injury from violence
Injury	
Post-injury	Acute
	Urgent
	Emergency care related to injury from violence

(National Committee for Injury Prevention and Control, 1989)

Post-injury: educate

- Educate parents on methods to help child avoid re-injury, and to cope with emotional trauma.
- Educate young people on the same topics.

Slide 15

Post-injury: assess

- Document injuries and surrounding events.
- Seek further psychiatric evaluation.
- Risk factors for re-injury:
  - Is conflict settled?
  - Does person feel safe leaving health setting?
  - Is he/she thinking about revenge?
  - Is there a safe place to go while things cool off?

Slide 16

Post-injury: refer

- Refer young people and families to mental health and crisis services.
- Refer to long-term comprehensive services.
- Notify authorities in case of abuse/neglect or when plans for revenge warrant.

Slide 17

Slide 18

Don't forget "invisible victims" of violence

- Child witnesses to domestic violence are victims—we often forget them.
- In a "cycle of violence," many young perpetrators have also been witness to and victims of violence.

(Widom, 1992).

Slide 19

Post-injury—"invisible injuries"

- Educate caregivers on emotional impact of witnessing violence and methods to help child cope.
- Screen young people for exposure.
- Refer to comprehensive programs with mental health services.

Slide 20

Three Phases of the Haddon Matrix

Pre-injury	Prenatal care
	Routine preventive care
	Acute care unrelated to injury from violence
Injury	
Post-injury	Acute
	Urgent
	Emergency care related to injury from violence

(National Committee for Injury Prevention and Control, 1989)

Health Professional Presentation *(continued)*

Slide 21

Pre-injury: educate

- Educate parents on strategies to build protective socio-emotional competencies.
- Educate on the effects of media violence and ways to reduce exposure.
- Educate on firearms and ways to reduce risk such as safe storage procedures.

Slide 22

Pre-injury: screen

- Age-appropriate screening for risk factors throughout child's development.
- Examples of tools for use with adolescents:
  - Fighting
  - Injuries
  - Sex
  - Threats
  - Self-defense

Slide 23

Pre-injury: refer

- Connect young people who show risk and their families to comprehensive and effective prevention programs.

Slide 24

Effective programs

- Early start
- Long-term
- Intense
- Strong connection with supportive adult
- Involve many sectors (health care, schools, police, community, business).

(Dryfoos, 1990; Burt and Resnick, 1992; US DHHS, 2001).

Slide 25

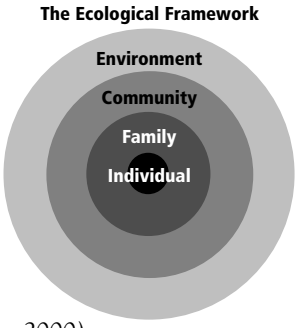
Galveston, Texas–
Island Youth Programs

Slide 26

Beyond the clinic

- Work with schools.
- Work with community coalitions.
- Advocate for effective policy.

(Commission for the Prevention of Youth Violence, 2000).



Youth and Community Presentation

Introduction

American Medical Association
Physicians dedicated to the health of America

Connecting the Dots to Prevent Youth Violence

A Training and Outreach Guide for Physicians and Other Health Professionals

Slide 1

Youth violence—What you can do

Name
Date
Institution
Youth and Community Outreach

Slide 2

The problem

- The United States has the highest youth homicide and suicide rate among the wealthiest developed nations *(CDC,1997)*.

Youth and Community Presentation *(continued)*

Slide 3

Magnitude and scope of violence

- Homicide is second leading cause of death for youth ages 15 to 19 and suicide is the third *(Cohen & Potter, 1999)*.
- Sixteen million adolescents in the United States have witnessed some type of violent assault in their lifetimes, including up to 95% of children in our inner cities *(US DHHS, 2001)*.

Slide 4

Impact on health

- Firearm injuries cost up to $2.3 billion annually in medical costs *(Cook, 1999)*.
- Recent research shows changes to brain structure and chemistry following exposure to extreme violence *(Niehoff, 1999)*.

Slide 5

Violence can be prevented

- Violence is not inevitable. Like polio and other public health threats, violence can be prevented.
- Numbers show that some progress is being made because youth violence has been in decline from 1994 to 1999 *(Snyder, 1999; FBI, 1997)*.

Slide 6

Discussion

Violence among young people is an output of their desire to create. They don't know how to use their energy creatively, so they do the opposite and destroy.

Slide 7

Violence is learned in the home

- More than 3 million children witness physical and verbal domestic abuse in their homes each year *(Horn, 2000; Carlson, 1984; Jaff, 1990)*.
- Effects of witnessing domestic violence can include traumatic stress reflected in higher levels of depression and anxiety, attention and learning problems, and greater likelihood of developing aggressive and anti-social behavior *(Hawley, 2000)*.

Slide 8

Violence is learned by being victimized by intimates

- 826,000 children in the United States were maltreated in 1999 *(US DHHS)*.
- Experiencing child abuse and neglect increases the likelihood of arrest as a juvenile by 53% and of committing a violent crime by 38% *(Widom, 1992)*.

Violence is learned from peers

- One in 7 school children is either a bully or has been the victim of a bully *(Brooks, et al, 2000; Batsche G, et al, 1998)*.
- Between 10% and 30% of teens experience violence while dating. This is not surprising in light of a survey of two Chicago high schools, in which 28% of boys responding believed that "girls needed to be punched or slapped sometimes" *(American Medical Association Alliance, 1999)*.

Slide 9

Violence is learned from media

- A child views about 25 acts of violence a day on television. By age 18, that child will view 16,000 simulated murders and some 200,000 acts of violence *(Commission for the Prevention of Youth Violence, 2000; Donnerstein et al, 1994)*.

Slide 10

Discussion questions

- What are examples of violent media that concern you? Why?

Slide 11

Youth and Community Presentation *(continued)*

Slide 12

Alcohol & drugs

- 50% of youth homicide victims have elevated blood alcohol, as do 50% of youth who commit homicide *(Adams et al, 1992; Prothrow-Stith et al, 1992; Mann et al, 1998)*.

Slide 13

Gangs

- Youth gangs are responsible for a disproportionate share of all criminal offenses, both violent and nonviolent *(Snyder et al, 2000)*.

Slide 14

Guns

- Teenage boys are more likely to die from gunshot wounds than from all natural causes combined *(Coordinating Council on Juvenile Justice and Delinquency Prevention, 1996)*.
- Family and friends are the primary source of guns for young people *(Sheley & Wright, 1998)*.

Slide 15

Discussion questions

- What risk factors do you see in your community and/or school?
- Which ones concern you the most?

Slide 16

Factors that "protect" youth

- Relationship with a responsible adult
- Positive school experiences
- Plans and dreams (future orientation)
- Ability to control impulses

(Search Institute, 2000)

Slide 17

A success story

- Galveston, Texas, and the Island Youth Programs *(Thomas, 2002)*.

Slide 18

Discussion questions

- What resources are there for violence prevention in your community?
- What can you do to prevent youth violence?

Slide 19

What you can do to prevent violence…

- Get involved.
- De-normalize violence—it's not normal.

(Commission for the Prevention of Youth Violence, 2000).

Slide 20

Media—

What you can do to prevent violence

- Watch what you and your family watch.
- Become media literate.

Slide 21

Media literacy skills

- Plan ahead what you are going to watch/hear.
- Ask yourself about the motivations of producers.
- Ask yourself how the problems depicted could be solved without the use of violence.
- Imagine what the real-life consequences of the violence you see in the show would be.

(American Academy of Pediatrics, 1999).

Slide 22

Firearms—

What you can do to prevent violence

- Walk away if you see a gun.
- Don't keep guns in the home.
- Use safe firearm storage procedures and know if parents in homes youth visit also do so.

Slide 23

Firearm safety procedures

- Store ammunition and guns separately.
- Keep both in locked containers.
- Adult keeps keys/access code secure on person at all times.
- Put trigger locks on firearms.

(American Academy of Pediatrics, 2000).

Slide 24

What you can do to prevent violence

- Talk to a trusted adult if you or one of your friends is being bullied.
- About problems with alcohol and drugs.
- About violence in the home or school.

Section 4

Case Studies

- Bullying
- Firearms
- Media violence

Case Studies

Bullying

Case: Antonio

Age: 10 years old

Grade: 5th grade

Problem: Bullying

Antonio is 10 years old and attends Main Elementary School just a few blocks from his home. He is in the 5th grade and is an average student. Antonio has always been a bit shy and somewhat anxious around his peers. He just moved to his new city 3 months ago and has not developed any close friends at his new school, although he does have a "best friend" who lives in a different city. Antonio is unusually tall and thin for his age and is very self-conscious about his appearance.

Over the past month Antonio has become increasingly withdrawn. Several weeks ago he came home with a tear in his favorite jacket. When his mother asked him what happened, he hurriedly said it was an "accident." He talks less and less to his peers at school, and when he comes home he goes straight to his room and shuts the door. When his mother tries to talk to him he says nothing is wrong and tells her to go away. She has noticed that recently he is more irritable and is often tearful. His mother worries about him but believes he is going through a phase and will "grow out of it." She also worries about making Antonio too dependent on her if she gets overly involved in his problems.

You hear through others that Antonio is being teased at school by some of his classmates. You also hear that this is not a one-time event, rather, that it happens several times a week. In particular, you hear that there are two children—a girl, Rebecca, and a boy, Jonathon—who make fun of the way he looks and have convinced most of his classmates to make him sit alone at lunch.

Discussion Questions:

Do you see a problem and, if so, what is it?

Why is bullying a serious problem?

How could you encourage Antonio to talk about what is going on?

What could you do to help Antonio?

Bullying *(continued)*

1. Do you see a problem and if so what is it?

Antonio is a victim of teasing or bullying by his peers.

Definition. Bullying is a serious problem and is a form of violence. Bullying involves repeated negative acts committed by one or more children against another.[1] Bullying includes verbal teasing and abuse by peers, pushing and shoving, or even psychological abuse through playing "tricks" or "practical jokes" on the victim. Approximately 10% to 15% of youth are bullied or are initiators of bullying behavior on a regular basis.[2, 3]

Risk factors. Children who are at risk for being bullied or teased often are shy and feel awkward with their peers. They may be described as "lacking social skills." They may have characteristics that make them different from their peers. For example, a child may have unusual physical features like Antonio's awkward height or a child may be of a different race or ethnic group or have a disability, such as a speech impediment, that sets him or her apart from peers.[4]

Children may be particularly at risk for bullying and other forms of violence during important transitions in their lives—times when they are going through important changes. Such changes may include a major family transformation such as a divorce or, as in Antonio's case, a recent move to a new city and a new school.

Warning signs. Children who are bullied frequently are isolated from others and may not have a social support system to turn to for assistance. They may withdraw from their peers and from the adults in their lives. Like Antonio, they may retreat to their room and refuse to answer family members' questions about what is happening in their life. They may also appear irritable, even angry, or they may cry frequently. They may come home with unexplained injuries or damaged property, like Antonio did with his jacket. Children who are bullied may try to avoid going to school in the morning, or may appear upset when they return home from school.

Common adult responses. Parents of children who are involved in bullying, either as a perpetrator or as the victim, are frequently unaware that their children are involved. In some instances, adults—teachers included—believe that bullying is a "rite of passage" in a child's maturation process. They believe that children must be left to sort it out on their own, or they will not be able to handle problems when they grow up. A common statement made about bullying is that "kids will be kids." Others may be uncomfortable with watching children engage in bullying, but not knowing how to respond, they do nothing.

2. Why is bullying a serious problem?

Impact on the victim. Bullying is a serious form of violence, and the effects of bullying can be life-long. Children who are bullied may be at increased risk for depression, anxiety, poor self-esteem, and other problems.[2] In extreme and unusual instances, bullied youngsters may resort to aggressive and violent acts to defend themselves, or may attempt to harm themselves through suicide.

Impact on the perpetrator. Children who do the bullying are also at increased risk for negative outcomes. Chronic bullies are several times more likely than their nonbullying peers to commit antisocial acts, including vandalism, fighting, and truancy, and to have an arrest by young adulthood.[2, 5, 6]

Impact on the school/community. Not only does bullying affect the victim and the bully, but allowing bullying to occur in a school or community can contribute to negative climate in the school or neighborhood, and contribute to all of the children feeling unsafe and anxious.

Bullying *(continued)*

3. How can you encourage Antonio to talk about what is going on?

You can tell Antonio that you care and are concerned about him. Ask him to tell you what is going on and give him opportunities to talk to you openly. Explain that telling is not tattling and that telling will help you help him. When he begins to talk, respond to him in an accepting and positive way, and tell him that it's not his fault and that he did the right thing by telling you.

4. What might you do to help Antonio?

Interventions that have proven to be effective in reducing bullying in schools and other settings are comprehensive and involve developing a culture of intolerance for bullying among young people and adults, and training in identifying and interrupting bullying behavior. While in the past most anti-bullying programs have emphasized building social and conflict management skills in the victimized child, more recently, research is suggesting that programs that target the peers of bullied children and teach them to intervene during episodes of bullying may be effective methods for reducing victimization.

As a health professional:[7, 8]

- Add a violence history to patient examinations that addresses exposure to violence, safety issues, stressors in school, family, and community. Gather this history on Antonio.
- Talk to Antonio's parents/caregivers about bullying and its seriousness. Address any myths they might hold about bullying being a normal part of childhood or rite of passage.
- Provide information to Antonio's parents about bullying and how to help their child respond to bullying. Give them materials such as the American Academy of Child and Adolescent Psychiatry's *Facts for Families No. 80 on Bullying*,[8] or *Bullying Prevention: Recommendations for Parents* from the Center for the Study and Prevention of Violence (CSPV).[9]
- Give Antonio a copy of information on bullying for young persons such as *Bullying Prevention: Recommendations for Kids* from the CSPV.[9]
- Work with Antonio's school to implement a comprehensive violence prevention plan that includes an anti-bullying component such as the promising program from the Blueprints series, *The Bullying Prevention Program*.[11]

As a parent or trusted adult:[9]

- Ask Antonio what he thinks should be done, what he's already tried, and whether it worked or not.
- Talk to Antonio's teacher, principal, or school counselor and ask for their help. Ask them to find out about programs other schools and communities have used, such as the promising program from the Blueprints series, *The Bullying Prevention Program*.[11]
- Encourage Antonio to try walking away to avoid the bully, or to ask for help from a nearby adult. Do not encourage him to fight the bully.
- Help Antonio practice what to say to the bully to defuse the situation.
- Help him practice being assertive—for example, insisting that the bully leave him alone.
- Suggest he stay with his friends as much as possible and avoid being alone, since bullies are less likely to pick on a child in a group.[10]

As a young person who is being bullied:[10]

- If you are being bullied, tell your parents or a trusted adult. Telling is not tattling. Your parents or another adult can help you figure out what to do.
- Tell your teacher or principal or school counselor. If you are uncomfortable, you can bring someone with you or you can have a trusted adult talk to them for you.
- Do not fight the bully. Try to walk away or defuse the situation or respond calmly and firmly. A bully likes to see you get upset.

Bullying *(continued)*

- To prevent being bullied, develop friendships with other young people. Bullies are less likely to bother you if you are in a group.
- Act confident; make eye contact and walk with your head up. Bullies are less likely to pick on you if you look sure of yourself.
- Avoid unsupervised areas of the school or neighborhood where you are isolated from your peers or adults.

As a young person who is the friend of someone being bullied:[10]

- To help a person who is being bullied, do not join in if you see that someone is being bullied, even if the bully tries to get you to participate.
- Get a teacher or responsible adult to come help. This is not tattling. This is you showing compassion for someone who is being hurt, and you saying that you think bullying is not acceptable and do not want anyone to get hurt.
- Try to get the person being bullied to tell his or her parents or a trusted adult. Go with the person if it makes him or her more comfortable.
- If your friend is unwilling to report the bullying, tell a trusted adult yourself. Do not let the bully know so that he or she does not become aggressive toward you.
- Encourage your school to start an anti-bullying program if they do not have one.

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Firearms

Case: Thomas

Age: 16 years old

Grade: 11th grade

Problem: Firearms and Violent Environment

This morning, Thomas, who is 16 years old, was caught carrying a gun onto his high school campus. The campus police were called and Thomas explained to them that he brought the gun from home and is carrying it for "protection." There has been an increase in violence in the community surrounding the school and Thomas looks nervous when describing his recent encounters with some gang members at the school. Until now, Thomas has been doing fairly well in school. He is making Bs and Cs in his classes and talks about enrolling at the local community college after he graduates to study computers. He is popular with his peers, but several of his teachers are concerned about his friendships with several youths whom they believe to be active in a local gang.

Thomas has a close relationship with his mom and younger brother. Thomas' father no longer lives with them. When he did, he was distant and occasionally was physically abusive to Thomas' mother. There have been several shooting incidents and robberies in Thomas' neighborhood in the past year, and because of this Thomas' mother keeps a loaded gun in the home for self-defense. She keeps the gun hidden under her sweaters in her closet and believes that, "Thomas will never find it there." To be certain, she has instructed Thomas never to touch a gun if he ever finds one.

Because Thomas has no previous criminal record and no gang affiliation, he spends minimal time in custody and is released to his mother. The school suspends him for a period of time. During his suspension, Thomas and his mother will begin a life skills training program at the local Boys Club. They will also see a trained counselor for family therapy, who will use a multisystemic therapy approach. At the end of the suspension period, Thomas will complete the school year at the Alternative Learning Center adjacent to the school.

Discussion Questions:

What factors place Thomas at risk for becoming involved in serious violence?

What elements in Thomas' life can help protect him against involvement in serious violence?

What can you do to help Thomas and his family?

Firearms *(continued)*

1. What factors place Thomas at risk for becoming involved in serious violence?

The presence of a firearm in the home and failure to store it properly. A major risk factor for Thomas and for his younger brother is the presence of a firearm in their home. Guns in the home are much more likely to be used in a suicide attempt or to intimidate family members than in self-defense against an intruder.[1, 2]

To increase the risk further, Thomas' mother does not use safe storage procedures. Instead of storing the ammunition and firearm in separate locked containers, having the only set of keys that she keeps inaccessible to others, or using a safety device such as a trigger lock to secure her gun, Thomas' mother keeps the gun loaded, unlocked, and believes her children will not touch it if they find it.

Young people often do not adhere to parental prohibitions to not touch a gun. In fact, these prohibitions may make a young person even more likely to handle a gun because of the attraction of the "forbidden." A recent study of young people's behavior around guns found that 76% handled a hidden gun they "discovered" despite prior instructions from their parents not to touch guns.[3]

It is interesting and disturbing to note that most young people caught with guns report they got the gun from their home or from friends.[4]

Exposure to violence in the home. There is a close relationship between violence in the home and youth violence, what one might describe as a "cycle of violence." From an early age, Thomas has watched the adults in his life use violence to "solve" their problems. Research suggests that violence is learned, learned early, and often learned in the home.[5] Children who witness violence in their homes may come to believe that it is acceptable and even necessary to use violence to solve problems with others.[6] In addition, Thomas' early exposure to violence and traumatic stress may have affected his brain chemistry, making him more susceptible to depression and problems with impulse control.[7]

Living in a distressed community. Thomas lives in a community that is distressed, a place where violence is common and gangs are evident. Young people who live in communities like Thomas' and who are involved with street gangs, whether voluntarily or involuntarily, are at greater risk both for becoming the victim of violence and for becoming a perpetrator.[8]

Peer group. During adolescence, young people are influenced by the behavior of their peers. In fact, many researchers believe that at this stage, young people are more influenced by their peers than by the adults in the their lives.[7] Young people whose friends are involved in gangs or other high-risk activities, are more likely to engage in these high-risk activities themselves.[9] Several of Thomas' friends are involved in gangs, which engage in high-risk behaviors that are frequently violent. His association with these individuals increases the risk that Thomas will become involved in the high-risk behaviors, including violence.

The influence of peers is also an important factor to consider when Thomas returns to school. Being placed in an alternative learning center may actually increase Thomas' exposure to peers who engage in high-risk behaviors and could increase his risk for involvement in serious violence. The pros and cons of such a placement, especially given the fact that this appears to be Thomas' first offense, should be carefully evaluated.

The role of younger siblings. It is important to note that many of the factors that place Thomas at risk increase risk for his younger brother as well. When addressing Thomas, it is also important to consider risk reduction for the younger brother.

Option: Insert a story from the local community about firearms and youth.

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2. What elements in Thomas' life may help protect him against involvement in serious violence?

While there are many risk factors for violence in Thomas' life, there are a number of important protective factors as well.

Positive experiences in school and future orientation. Thomas has dreams and plans for the future (a future orientation) and a commitment to education, both of which have been proven to protect young people against involvement in violence and other high-risk behaviors.[4]

This is a personal resource that Thomas, you, and others in Thomas' life can build on to reduce the chance he will become involved in serious violence.

Strong relationship with an adult figure. Thomas has a close and positive relationship with his mother. Young people who have a strong relationship with a parent or another responsible adult are significantly less likely to engage in high-risk behavior, including violence, than those who do not.[8] While it is unclear from the case description just how responsible Thomas' mother actually is, her presence at the school and obvious concern for Thomas are good signs.

Thomas' mother and his strong connection with her are resources you can build on to reduce the likelihood of his involvement in serious violence.

Access to effective violence prevention services. Finally, Thomas and his problems have come to the attention of his school and the local authorities. As a result, both he and his family have been referred to mental health and supportive services in the community. The recent Surgeon General's report on youth violence lists a number of interventions that have been proven to be effective in preventing violent behavior among youth. Life Skills Training programs and Multisystemic Therapy are included on the list of programs that are effective in preventing youth violence.[9] It is important to note that other popular types of interventions, including boot camp, residential treatment, and peer counseling, have not been found to be effective in reducing risk. It will be important to learn more about intervention methods used in the alternative learning center to ensure that they are consistent with "model" and "promising" programs described in the Surgeon General's report.[9]

Important note about his brother: Again, many of these resources and protective factors will apply to Thomas' younger brother too. Also, although it is unclear from the case study whether Thomas is close to his younger brother, encouraging him to be a good role model for his brother can be a strong motivator for change for older siblings.

3. What might you do to help Thomas and his family?

There are many things that a health professional, Thomas' mother, Thomas, and others can do to help:

For health professionals:[10, 11]

History and screen

- Take a violence history on Thomas and his family that addresses exposure to violence, safety/security issues, effects of trauma, attitudes toward weapon carrying, and stressors in the family and the community.
- Document history of family violence in the medical record.
- Screen Thomas and his family for access to firearms and use of safe storage procedures.

Patient education

- Encourage Thomas' mother to remove firearms from the home. If she insists on keeping a gun in the home, strongly encourage her to take a training course on the safe handling, storage, and use of this weapon.
- Educate Thomas and his family on firearm safety and work with them to develop a safety plan. Provide them with educational materials on safe firearm storage such as the American Academy of Pediatrics patient brochure, *Keeping Your Family Safe from Firearm Injury*.[12] Counsel Thomas' mother and the family to ask about gun possession and storage in

Firearms *(continued)*

other homes that Thomas and his brother visit, and ask the adults in these homes to consider removing the guns from their homes or using safe firearm storage procedures.

- Discuss Thomas' concerns about his safety, and work with him to make a plan to increase his safety from gangs and other violence-related threats in his community and school.
- Educate Thomas' mother on resources for victims of domestic violence and provide her with the telephone numbers of a hotline or support center where she can discuss her experience and receive assistance.

Refer

- Provide referrals to Thomas and his family to youth programs in the surrounding community that provide comprehensive services for youth violence prevention.
- Provide referrals to Thomas' mother to a local battered women's shelter and hotline.

Work with schools and community

- Work with Thomas' school to develop a safety plan for Thomas and to address problems with violence in the school.
- Volunteer to work with the school as an epidemiologist or crisis team member and assist staff in violence prevention planning for the school.
- Volunteer to serve on community prevention initiatives.

Enhance resources in clinical practice setting

- Establish a network of referral services for youth and family violence prevention. Know how the programs in this network compare to the list of effective programs in the Surgeon General's report on youth violence.[9]
- Implement practice guidelines and practice protocols for firearm injury prevention such as the *Physician Firearm Safety Guide* available through the American Medical Association (312 464-5066).[13]
- Become knowledgeable of firearm training programs in your community. Information on training programs is available from organizations such as the *Brady Center to Prevent Gun Violence, Physicians for Social Responsibility,* and the *National Rifle Association*.[14-16]

For parents and a community audience:[10, 17]

- Do not keep firearms. If you must, make sure to keep them safely stored and locked up with ammunition stored separately. Make sure the parents of Thomas' friends do the same.
- Talk to Thomas about the dangers of firearms and work with him to find other methods to protect himself. Insist he not use firearms as a way to increase his feeling of safety.
- Develop a safety plan with Thomas. Encourage him to go to a reliable adult when he encounters problems at school or in the community.
- Supervise Thomas' activities and know his schedule and his friends.
- Maintain two-way communication with Thomas and talk to him about the violence he has witnessed and may be experiencing.
- Seek out a support group to increase parenting skills and effective and protective methods for responding to anger and aggression from others.
- Urge school and community organizations including police to implement a comprehensive violence prevention program in the community. Participate in this effort.
- Urge Thomas to participate in organized after-school activities provided by responsible groups.

For young people:[10, 18]

- Do not use or handle firearms. If one of your peers has one, walk away and notify a responsible adult.
- Talk to a responsible person—physician, teacher, clergy, counselor, parent, or friend—about violence you have witnessed or experienced.

- Report incidents of violence to school authorities, parents, or other responsible adults.
- Participate in organized and supervised recreational, educational, and cultural after-school activities.
- Act as a role model for children and other adolescents by refusing to have anything to do with firearms, alcohol, and illicit drugs.
- Become involved in or start a violence prevention program in your school or community.
- Promote television programs, movies, music, and video games that portray nonviolent alternatives to conflict resolution.
- Talk with friends and family members about concerns about violence and how it affects their lives.

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Media Violence

Case: Jonathan and Raquel

Age: 6 and 10

Grade: 1st and 5th

Problem: Media Violence

Jonathan and his sister, Raquel, live in a middle-income community near Los Angeles. Jonathan is 6 years old and began attending the local elementary school this year. Raquel is 10 and goes to the same school as Jonathan. They both like the school, are doing well academically, and get along well with their peers.

They live with their mother, who has a very demanding job that requires her to work long hours. Many times she does not return home until 8 or 9 at night. She is very conscientious about the care of her children and has arranged for in-home child care for her children.

When the children return home, the babysitter allows them to play until 6 PM, which is when they eat dinner. They then do homework and get ready for bed. Their favorite activities are to watch TV and play video games. They enjoy imitating the shows or games after they see them, switching off playing "good guy" and "bad guy."

Raquel is also becoming a fan of music videos and often watches them on the TV in her room after she has gone to bed. Last week Jonathan's teacher mentioned to the mother that he is overly aggressive with the other children, and the mother has been concerned about drawings her daughter brought home last month depicting her in a fist fight with a "bad guy."

Discussion Questions:

What elements of Jonathan and Raquel's lives may be contributing to their aggressive behavior?

What elements in Jonathan and Raquel's lives are protective against violence?

What can their mother do to address Jonathan's aggressive behavior and Rachel's depictions of violence in her drawings?

What can you do to help Jonathan and Raquel?

Media Violence *(continued)*

1. What elements of Jonathan and Raquel's lives may be contributing to their aggressive behavior?

Exposure to violence in the media. Jonathan and Raquel, like many children in the United States, are exposed to a great amount of media violence. This exposure occurs through television shows, movies, video games, the Internet, music and music videos, and print. On average, American children spend 28 hours a week watching television.[1]

The largest study of violent content on television, the National Television Violence Survey, found that 61% of television programs contain some violence, and that 58% depict no pain resulting from the violence, 47% depict no harm, and 40% depict harm unrealistically. Finally, 44% of violent interactions on TV are perpetrated by individuals who exhibit qualities that are attractive to youth.[1]

Evidence that violent media increases aggressive and violent behavior. There is strong evidence that exposure to violence in the media can increase children's aggressive behavior and emotions over the short-term, and some evidence (albeit contested), that there may also be long-term effects.[2]

A leading researcher in this subject stated in testimony to the US Congress, "There can no longer be any doubt that heavy exposure to televised violence is one of the causes of aggressive behavior, crime, and violence in society. The evidence comes from both the laboratory and real-life studies. Television violence affects youngsters of all ages, of both genders, at all socio-economic levels and all levels of intelligence." [3]

This position is supported by findings of the most comprehensive meta-analysis to date of the impact of violent media, which shows a clear link between brief exposure to violence on TV or movies and increases in aggressive and even physically violent behavior in young persons.[4] This is true even of cartoons.[5]

Specific effects on youth. While exposure to a single risk factor such as violent media typically does not lead to violent behavior in children, frequent exposure to violent media can: [6]

- Teach children aggressive behaviors and attitudes
- Desensitize them to the negative aspects of violence
- Cultivate fearful and pessimistic attitudes about the real world

Other caregivers. While Jonathan and Raquel's mother has arranged for childcare in the home, it is unclear how effective this care is. Lack of adequate adult monitoring is a risk factor for a wide range of behavioral and social problems.

Option: Insert a story on media violence from the local community.

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2. What elements in Jonathan and Raquel's lives are protective against violence?

Positive school climate and success in school. There are many factors that are protective against violence in Jonathan and Raquel's lives. First, Jonathan and Raquel feel welcome in their school and are both doing well academically. Positive school climate and academic mastery are both protective against violence and other high-risk behaviors, such as substance abuse, and are strong predictors of positive developmental outcomes for young people.

Good social skills. Jonathan and Raquel get along well with their peers. Good social skills with peers is one of five socioemotional competencies that research suggests can protect children against involvement in violence and in a wide range of other problem behaviors. The other four socioemotional competencies are the ability

to monitor and regulate feelings, thoughts, and actions (impulse control); the capacity to show empathic concern for others; the ability to cope with and solve interpersonal problems; and a positive identity and future orientation.[7]

Adult monitoring. Although their mother is often unavailable because of her demanding work schedule, she is concerned about her children and is attempting to provide them with a supportive adult in the home when she is not able to be there.

Finally, both Jonathan and Raquel have teachers who are attentive to early warning signs for violence, and there is good communication between the teacher and parents. Responsive adults can be an important source of protection for young people. Teachers, physicians, neighbors, and parents can identify red flags that may indicate problems and help the child and his or her family access help early on before the problem becomes severe.

3. What can you do to reduce Jonathan and Raquel's exposure to violent media?[6, 8-10]

A former US Commissioner of Education, Ernest Boyer, wrote, "It is no longer enough to simply read and write. Students must also become literate in the understanding of visual images." Children must learn to read and understand media messages for what they really are, rather than passively accepting them.[10]

As a health professional you can:[11]

Take a media history as part of the health care visit. Ask questions such as:

- How do you decide what shows to watch?
- What are the rules about watching shows or movies?
- How many hours a day do you watch TV and is there a limit?
- What are the most watched shows?
- Are there rules regarding music videos? Video games?
- Do you use Internet blocking software?

Inform parents and children old enough to understand about the effects of media violence and encourage them to increase their general media literacy. See "Media Matters" at the American Academy of Pediatrics Web site for a self-training brochure for teaching patients media literacy.[12]

Become involved in organizations that seek to decrease the use of violence. Speak at public meetings, join media watch and literacy groups, and help in advocacy efforts directed at the media industry, and state and federal legislators.

As a parent you can:[11, 12]

Become familiar with the media your children consume. Watch at least one episode of shows they watch regularly, listen to the lyrics of their music, and observe the computer and video games they play.

Teach your child to be informed and critical consumers of the media.

- Who created this (media product) and why?
- Is it real or make believe?
- Is this a good way to solve a problem? What are some alternate ways that do not involve violence?
- What would happen if someone in real life were to do the same thing that the character on the show, song, or video did? Injury? Prison? Upset and hurt family members? Other consequences?

Media Violence *(continued)*

Limit your children's access to violent content. To do this you can:

- Avoid using television, videos, or computers as babysitters. Instead plan other activities to engage and keep your children busy.
- Limit media viewing; allow only 1 to 2 hours a day.
- Keep televisions and video players out of children's bedrooms.
- Only turn on the TV when you have something specific to view.

Model healthy use of media for your children.

Advocate with policymakers and media industries for quality programming and reductions in violent media.

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Section 5

Issue Briefs

- Adolescent substance abuse
- Bullying in schools
- Child abuse
- Dating violence
- Firearm-related violence
- Firearm safety
- Media violence
- Risk and protective factors for youth violence
- School violence
- Youth development and violence prevention
- Youth gangs
- Youth suicide

Issue Brief

Adolescent Substance Abuse

Introduction

Adolescent substance abuse is a serious concern nationwide. From the 1980s to the 1990s, the percentage of American youth aged 14 to 18 years who required treatment for substance abuse doubled.[1] Furthermore, beginning in 1992, rates of substance use by teens rose steadily and have only recently leveled off or slightly decreased.[2]

Substance use by youth has serious health and social implications. For example, although most youth who use drugs do not commit violent crimes, there is a correlation between frequency and severity of juvenile delinquency and frequency and severity of drug use.[3] In addition, health issues such as the long-term physical effects of tobacco use and increased risk of childhood injuries are critical concerns related to substance abuse by adolescents.[4]

Scope of the problem

Illicit drugs

According to the National Household Survey on Drug Abuse (NHSDA), illicit drugs include marijuana (includes hashish), cocaine (includes crack), heroin, hallucinogens, inhalants, and non medical use of prescription-type pain relievers, sedatives, and stimulants.[5]

The rate of illicit drug use varies by age. The 2000 NHSDA indicated that 3% of 12- to 13-year-olds used illicit drugs within the past month; 6% of 18- to 20-year-olds used illicit drugs within the past month; and for those 20 years and older, the rates generally declined. However, after age 20, the rate of use declined only to age 40, when use increased among the 40 to 44 year-old age group and then dropped again at age 45. This is particularly interesting to note, since those in their early 40s in 2000 were teenagers in the 1970s when drug use was drastically on the rise.[5]

In the 1980s, 5% of adolescents aged 14 to 18 experienced drug-related problems that required treatment, and by 1991, the percentage rose to 10%.[1]

In 2000, although overall rates of illicit drug use remained stable, the rate for teens ages 12 to 17 dropped slightly to 9.7% from 9.8% in 1999.[5]

Alcohol

Alcohol use among 12- to 20-year-olds has remained constant for several years. In 2000, 9.7 million (27.5%) youth in this age group reported drinking alcohol in the past month. Of those, 6.6 million (18.7%) were binge drinkers, and 2.1 million (6%) were heavy drinkers.[5]

Rates of alcohol use by adolescents increase with age. For example, in 2000, prevalence at age 12 was 2.4% and reached a peak of 65.2% at age 21. In addition, college students ages 18 to 22 were more likely than non college students of the same age group to drink, binge drink, and drink heavily.[5]

Tobacco

Tobacco use includes cigarette smoking, cigar smoking, and use of smokeless (chewing) tobacco.

Unlike drug and alcohol use among adolescents, tobacco use among youth aged 12 to 17 declined significantly from 14.9% in 1999 to 13.4% in 2000. The decrease was attributed to a decline in tobacco use among boys, which declined significantly from 14.8% in 1999 to 12.8% in 2000. The rate of tobacco use among females also decreased in 2000, but not significantly.[5]

Tobacco use also varies greatly by age, increasing steadily up to age 20. For example, in 2000 the rates of tobacco use were 1.8% for 12-year-old youth, and 13.4% for 13- to 17-year-old youth, and rose to 41.4% by age 20.[5]

Smoking can lead to using other substances. Youth who smoke are 3 times more likely to use alcohol, 8 times more likely to use marijuana, and 22 times more likely to use cocaine.[4]

Risk factors

A variety of biological, psychosocial, and environmental factors act alone or in combination to place youth at risk for substance abuse.[3, 6]

Adolescent Substance Abuse *(continued)*

Genetics and biology

Studies of twins indicate that genes may account for some degree of risk in substance abuse. It is likely that a combination of genes, rather than one gene alone, contributes to drug and alcohol use.[6] Independent of the genetic factor, however, prenatal exposure to tobacco, alcohol, and drugs puts infants at risk to develop substance problems later. In addition, biological factors such as temperament (impulsivity, aggression, hyperactivity, sensation seeking, and rigidity) and brain chemistry (dopamine/drug interaction) are associated with substance abuse.[6]

Psychosocial influences

Some psychosocial factors have been associated with adolescent substance abuse. For example, childhood psychopathology such as conduct disorder and attention deficit hyperactivity disorder (ADHD), academic failure and learning difficulties, low self-esteem, and deficits in social competency have been linked to tobacco, alcohol, and drug use in teenagers. Adolescent antisocial behavior such as aggression, fighting, and truancy, as well as antisocial beliefs and values about substance use, are also considered to be risk factors.

Environment

Various aspects of family life, peer groups, school environment, and community contribute to adolescents' proclivity toward substance abuse. Risk factors within the family include a family history of substance abuse; access to tobacco, alcohol, or drugs in the home; poor family management, lack of discipline, and low parental monitoring; low levels of nurturing and attachment; and abuse in the home.[3]

Having peers who use drugs or hold positive beliefs about substance use increases adolescents' risk for substance abuse. The opposite is also true. That is, the likelihood of using drugs decreases among youth whose peers have positive values and anti-drug attitudes. In addition, school-related factors influence youth substance abuse. For example, lack of belonging or bonding to school and low achievement and poor academic performance are indicators of risk for drug use.[3]

Risk factors for substance abuse also are found in the community. Risks include low levels of community resources and opportunities, lack of community bonding, pro-drug attitudes within the community, pro-drug messages in the media, and lack of services and opportunities for youth.[3]

Promising strategies

Traditional intervention and prevention strategies such as incarceration, detoxification and rehabilitation, and public health education have not had much sustainable impact on reducing adolescent substance use and abuse. Some recent successes have been documented using the social influence approach and the competence enhancement approach. Botvin described these two approaches in detail.[7]

The social influence approach focuses on the social and psychological factors that contribute to onset of use. Two major components of this approach include normative education and resistance skills training. The purpose of normative education is to rid teenagers of the belief that "everybody does it." Resistance skills training teaches teens skills to resist pro-drug influences from peers, media, and society. Studies show social influence approaches to yield a 30% to 50% reduction in smoking prevalence, alcohol, and marijuana use.[7] In addition, follow-up studies show positive behavioral changes for up to 3 years. However, long-term follow-up studies indicate a decay of positive effects over time.

Life skills training (LST) represents a variation of the social influence approach known as competence enhancement. LST is based on social learning theory and problem behavior theory. The underlying assumption is that drug use is a learned behavior influenced by the interaction of social and personal factors. Thus, LST teaches youth social and personal management skills. Examples of skills taught are decision making and problem solving, cognitive skills for resisting social and media influences, personal control, goal setting, stress and anxiety management, assertiveness, and general

Adolescent Substance Abuse *(continued)*

social skills. Prevention efforts are generally aimed at 7th to 10th graders and typically vary in length from 7 to 20 sessions. Skills are taught by teachers and/or outside professionals such as project staff, graduate students, and social workers.

This approach has been empirically tested and demonstrated to reduce tobacco, alcohol, marijuana, and polydrug use in adolescents.[2] Furthermore, the effects seem to be stable over time. A long-term follow-up study with 6000 participants who received LST in the 7th grade showed lower drug use at the end of the 12th grade for LST youth than for controls.

Issue brief prepared by Roxie Alcaraz for the Southern California Center of Excellence on Youth Violence Prevention, University of California, Riverside, Winter 2002.

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Internet resources

Center for Substance Abuse Prevention
http://www.samhsa.gov/centers/csap/csap.html

Centers for Disease Control and Prevention
http://www.cdc.gov

National Clearinghouse for Alcohol and Drug Information
http://www.health.org

National Institutes of Health
http://www.nih.gov

National Institute on Alcohol Abuse and Alcoholism
http://www.niaaa.nih.gov

National Institute on Drug Abuse
http://www.nida.nih.gov

Office of National Drug Control Policy
http://www.whitehousedrugpolicy.gov/pubs/fastfind.html

US Department of Health and Human Services
http://www.dhhs.gov

Your Time, Their Future
http://www.health.org/yourtime

Issue Brief

Bullying in Schools

Introduction

Bullying in American schools and neighborhoods is not a new phenomenon. This form of aggression among children typically has been viewed as an acceptable and normal part of growing up. However, in recent years, bullying has come to the forefront of media and public scrutiny, particularly in the aftermath of school shootings in the late 1990s and early 2000s. In fact, bullying is cited as a major contributing factor in the Columbine High School incident.[1]

Educators, parents, communities, and policy makers have responded to bullying and its possible detrimental outcomes with increased attention to the causes and impact of bullying behavior and with implementation of innovative anti-bullying programs across the country.

Scope of the problem

Olweus defines bullying as follows: "A student is being bullied or victimized when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other students."[2] Such negative actions are generally aggressive in nature and may take three forms: physical (eg, hitting, kicking, pushing), verbal (eg, taunting, name calling), and psychological (eg, intimidation, spreading rumors, social exclusion).

Bullies

Boys are bullies more often than girls and they usually bully other boys. Regardless of the gender of the victim, boys tend to use physical force or threats. Likewise, girls typically bully other girls, but do so verbally and indirectly more often than physically.[3]

There are also long-term consequences for bullies. Children identified by age 8 as bullies are 6 times more likely to commit a crime by the time they are 24 and 5 times more likely by age 30 to have a serious criminal record.[4] Crimes linked to bullying behavior include vandalism, shoplifting, and drug-related offenses. Other behaviors such as truancy, dropping out of school,[5] and fighting are also related to bullying.[1]

Victims

Surveys show that 10% of school-age children are bullied on a regular basis and that half of all children are bullied at some time during their school years.[3] Victims of bullying tend to avoid going to school. In 1999, 7% of American 8th graders reported staying home from school at least once a month due to fear of bullies.[4]

Common characteristics among victims are isolation, depression, and low self-esteem. Victims are at higher risk for a range of problems, including impairment in psychological and social functioning and deficits in school performance. In the most extreme cases, victims may contemplate or attempt suicide as an alternative to harassment and terrorization by their peers.[1]

Bystanders

Most studies of bullying focus on identified bullies and victims. Such research often overlooks the effect of bullying on "bystanders" who witness bullying even though they do not participate directly. Among junior high and high school students, 88% report having observed bullying at some time.[5]

Bystanders are distracted from learning in school for a number of reasons. For example, they may be afraid to associate with victims for fear of becoming victims themselves, or they may fear reporting incidents of bullying for fear of gaining a reputation as a snitch. Additionally, they may develop feelings of guilt and helplessness from being unable to control incidents of bullying. In some cases, they may even succumb to peer pressure and become bullies themselves.[5]

Risk factors

Bullies

Several characteristics of children and families have been identified as risk factors for bullying behavior. In particular, children who thrive on power, need to be in control, and have little empathy for others are at risk of becoming bullies. Rather than displaying low self-esteem and anxiety, these children appear to have an over-inflated sense of self and high self-esteem.[4]

Bullying In Schools *(continued)*

This type of aggressive bravado may be linked to problems in other settings. Indeed, research on how families can contribute to bullying has shown that children at risk of becoming bullies often come from homes where physical discipline and punishment are common and parental warmth is lacking. In these settings, children learn that the best way to deal with their problems is by dominating and controlling others.[4]

Victims

Victim research has identified two types of victims: passive and provocative. The majority of victims of bullying typically are passive. These victims are often loners; younger than the bullies; and socially, emotionally, and physically weak. However, physical characteristics such as clothing, weight, and wearing eyeglasses, do not appear to be significant factors in victimization.[4] A smaller number, 10% to 15%, are identified as provocative victims. Provocative victims are both victims and bullies. They often tease bullies and are often easily aroused emotionally.[4]

Promising strategies

Most successful efforts to prevent or reduce bullying utilize an integrated and comprehensive approach.[2, 4-8] According to Olweus, anti-bullying efforts must incorporate schools, administrators, teachers, parents, and communities.[2] In addition, creating a safe school environment depends on early intervention efforts, strong leadership, ongoing commitment, ongoing staff development and training, cultural sensitivity, and parental and community involvement in planning and implementation.

A number of anti-bullying programs have shown positive effects. For example, an elementary school in Englewood, Colorado, reported that in a 2-year period, its bully-proofing integrative program had a positive impact on the school environment. Another comprehensive program at a middle school in Caruthersville, Missouri, resulted in a 16% reduction in physical fighting among students in the first year and a 25% reduction in the second year.

Another effective anti-bullying strategy is mixing age groups within programs.[4] Bullying behavior tends to be higher in same-age peer groups. However, mixing older and younger children in activities tends to foster nurturing and protective behavior by older children toward younger children and bullying is reduced. In addition, allowing bullies to take on protective roles, such as on a safety patrol, helps reduce bullying behavior.

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Bullying In Schools *(continued)*

Related publications on bullying

Fried S, Fried P. *Bullies & Victims: Helping Your Child Through the Schoolyard Battlefield*. New York, NY: M. Evans & Co; 1996.

Garrity C, Jens K, Porter W, Sager N, Short-Camilli C. *Bully-Proofing Your School: A Comprehensive Approach for Elementary Schools*. Longmont, CO: Sophris West; 2001.

Olweus D, Limber S. *Blueprints for Violence Prevention: Bullying Prevention Program*. Book Nine. Boulder, CO: Center for the Study and Prevention of Violence, University of Colorado; 1999.

Internet resources

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

Center for the Prevention of School Violence
http://www.ncsu.edu/cpsv

Center for the Study and Prevention of Violence
http://www.colorado.edu/cspv/

Children, Youth, and Families Education and Research Network
http://www.cyfernet.org/

Family Education Network
http://www.familyeducation.com

National Resource Center for Safe Schools
http://www.safetyzone.org

Office of Juvenile Justice and Delinquency Prevention
http://www.ojjdp.ncjrs.org

Issue Brief

Child Abuse

Introduction

Although the incidence of child abuse has declined within the United States during the last year, it continues to be a serious problem.[1] Children all over the country are neglected, beaten, and sexually and emotionally abused every day. Although some children may be more at risk for victimization, child abuse is often difficult to detect. Various programs have been implemented at the individual and family levels to prevent child abuse and to help victims and perpetrators of child abuse.

Child abuse is defined as harm inflicted on children by anyone, including other children, and encompasses physical abuse, sexual abuse, psychological abuse, and neglect.[2] Signs of physical abuse include unexplained injuries such as welts, bruises, burns, and injuries that are in the shape of objects such as belt buckles or electrical cords. Signs of emotional abuse may include aggressive or withdrawn behavior, shying away from physical contact with parents or other adults, and/or being afraid to go home. Physical signs of sexual abuse are often difficult to detect by anyone other than a physician,[3] but may include difficulty in walking or sitting; stained or bloody underwear; and genital or rectal itching, swelling, redness, or discharge. The child may also show behavioral or emotional signs such as difficulty in eating or sleeping, soiling or wetting pants or bed after being toilet trained, withdrawing from activities with others, and/or excessive crying or sadness. Victims of prolonged sexual abuse often develop low self-esteem, a feeling of worthlessness, and an abnormal or distorted view of sex.[3]

Scope of the problem

There were an estimated 826,000 victims of child maltreatment nationwide in 1999. This rate of victimization was 11.8 per 1000 children, a decrease from the 1998 rate of 12.6 per 1000 children. More children (58.4%) suffered from neglect than from any other form of maltreatment. One fifth (21.3%) suffered physical abuse, while 11.3% were sexually abused.[1] However, this number may be an underestimation because of the possible number of unreported cases. Children are often afraid to tell anyone about what has happened, and the legal procedures for validating instances of sexual abuse are difficult.[3] In addition, more than one third (35.9%) of all victims of child abuse were reported to be victims of other or additional types of maltreatment.

Rates of many types of maltreatment were similar for male and female children. However, the sexual abuse rate for female children was higher than that for male children (1.6 and 0.4 per 1000 in the population, respectively). The highest victimization rates were in the 0- to 3-year age group (13.9 per 1000 in the population) and declined as age increased.[1]

Children who were victimized before 1999 were almost 3 times more likely to experience recurrence during the 6 months after their first victimization in 1999 than children without a prior history of victimization.[1]

Risk factors

Although there is no specific abusive personality type, some families are at greater risk for experiencing child abuse.[4] Child abuse tends to happen more frequently in families that are isolated and have no friends or relatives, families with parents who were abused as children, families with parents who abuse drugs or alcohol, and families with parents who are under a lot of stress or are often in crisis (financial difficulties or move often).[5] Empirical research has also shown a concurrence of intimate partner violence against mothers and abuse of children in up to 50% of cases.[5] A study by McKibben and colleagues found that 40% to 60% of mothers of 32 abused children were also victimized, compared to 13% of mothers of 32 matched children with no record of abuse.[6] In a related study, McGuigan and Pratt found that among at-risk parents, domestic violence during the first 6 months of child-rearing tripled the likelihood of physical abuse occurring during the child's first 5 years.[7]

Reporting guidelines

In most states, reporting suspected child abuse or neglect is required by law. Federal agencies have no jurisdiction to intervene in child abuse and neglect cases; therefore, the state agency must be contacted. Guidelines require that if there is suspicion of child abuse, the child should be taken to a quiet area and encouraged to give

enough information to evaluate whether abuse may have occurred. The child should be told that the adult believes him/her, that the child isn't bad and that he or she has the right to tell about the abuse.

If abuse or neglect is suspected within the family, the state's Child Protection Agency should be contacted. If the abuse is outside of the family, it should be reported to the police or district attorney's office.[8] If there is no toll-free number available, the Childhelp National Child Abuse Hotline at 1-800-A-CHILD will provide assistance.

Promising strategies

Various preventive strategies have been used to combat child abuse. In an increased effort to reduce risk factors leading to child maltreatment, preventive services used include respite care, parenting education, housing assistance, substance abuse treatment, day care, home visits, individual and family counseling, and crisis and domestic violence services.[1]

Remedial services have also been made available to families who have already suffered child maltreatment. These include family-based services such as counseling and family support, foster care services, and court services such as proceedings to determine temporary custody of the victim.[1]

Prepared by Olivia Pillado for the Southern California Center of Excellence on Youth Violence Prevention, University of California, Riverside, Winter 2002.

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Related publications and Internet resources

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

Becker WJ. *Child Abuse*; 1991. Available at: http://www.cdc.gov/niosh/nasd/docs/as02600.html. Accessed: October 18, 2001.

National Center for Injury Prevention and Control Home Page
http://www.cdc.gov/ncipc

National Clearinghouse on Child Abuse and Neglect Information
http://www.calib.com

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US Department of Health and Human Services, The Administration for Children and Families
http://www.acf.dhhs.gov

Issue Brief

Dating Violence

Introduction

Violent behavior that occurs in the context of a dating relationship is not a rare event among adolescents in the United States. In fact, teens are the fastest growing population at risk for dating violence. It is estimated that 1 in 8 high school students and 1 in 5 college students will be involved in a violent relationship. Yet, despite these alarming statistics, many teens do not view dating violence as destructive or unhealthy, and some actually believe it can improve a relationship. This perception is worrisome, as it may prevent adolescents involved in dating violence from seeking help. Dating violence is not limited to a specific demographic; instead, teenagers are vulnerable regardless of race, gender, socioeconomic status, or sexual orientation. Dating violence can take many forms, including psychological, emotional, physical, and sexual abuse. In less severe forms, it includes jealousy, possessiveness, verbal put-downs, and coercive behavior. More extreme forms of dating violence involve punching, slapping, shoving, pulling hair, threats involving a weapon, and rape. While limited research exists on effective strategies for prevention, several programs show promise for reducing dating violence in national and local evaluations. Typically, these programs are multidimensional and focus on education and development of effective relationship and conflict resolution skills.[1-3]

Scope of the problem

Adolescent dating violence is a common occurrence, with estimates of incidence ranging from 28% to 96%.[4] Studies that include emotional and verbal abuse in their definition of dating violence report the highest incidence rates. Studies that limit definitions to overt physical or sexual violence report somewhat lower rates.

Both male and female adolescents can be victims of dating violence. In a recent survey of high school students, 36.4% of girls and 37.1% of boys reported experiencing physical violence in a dating relationship.[5] In this instance, while the rates of those reporting violence were similar, the nature of the violence was different. Girls were more likely to report more severe forms such as being punched or forced to engage in sexual activity; boys were more likely to report being pinched, slapped, scratched, and kicked.

In the Massachusetts Youth Risk Behavior Survey, 1 in 5 girls from grades 9 to 12 reported experiencing physical and/or sexual violence by a date, with 1 in 10 reporting physical abuse and 1 in 25 reporting sexual violence.[6] Males also report experiencing sexual violence. Eight percent to 16% of college males report being pressured and/or forced to have sexual intercourse with a dating partner.[7, 8] When young people are asked about their experiences with emotional and psychological abuse, 96% say they have experienced this in a dating relationship.[9]

In a review of the dating violence literature, 39.3% of females and 32.9% of males reported being a perpetrator of violence in their dating career.[10] Some studies indicate that more females than males report engaging in violent behavior in dating relationships. In one study, 51% of high school females reported behaving violently with their romantic partners, in contrast to 20% of males.[11] While rates of perpetration for males and females may appear similar and, in some instances, be even higher for females, males far exceed females in the use of severe violence in dating relationships. Males are 2 to 4 times more likely than females to use weapons against a dating partner and to use physical violence that results in serious injury.[10,12-14]

Risk factors

Adolescent dating violence is a complex phenomenon resulting from a combination of individual, familial, and societal factors.

Individual and peer influences. Low self-esteem, prior antisocial and aggressive behavior, and prior exposure to violence in the home have all been associated with an increased likelihood of being a victim or perpetrator of dating violence.[15,16] Alcohol and substance use are other risk factors.[17,18] In one study, 33% of the adolescents reported that both partners were drinking at the time of the violent incident, and 25% reported use of other controlled or illegal substances.[19] Negative gender identities

also increase the risk of dating violence. Adolescents who ascribe to stereotyped perceptions of males as dominant and aggressive, and females as submissive and passive, are more likely to be involved in violent dating relationships. Finally, peer group norms can be a powerful influence. Young people whose friends are in violent dating relationships are themselves more likely to be perpetrators or victims of dating violence. This is especially true for females.[20]

Family and community factors. Family plays a critical role in influencing adolescent dating behaviors. Parents model behaviors, values, and attitudes about the management of conflict in intimate relationships.[21] Children—especially males—who are exposed to family violence, are more likely to use aggression in their relationships with peers and romantic partners later in life.[22-24] Exposure to community violence has also been linked with increased risk for dating violence.[25]

Societal factors. Adolescents receive many messages from the media about how males and females should behave and how intimate relationships should be conducted. Much of the content in movies, videos, song lyrics, comic strips, and television programs is violent, and contains stereotyped and negative images not only of gender roles, but also of different racial and ethnic groups. On television alone, 57% of programming contains violence.[26] Many studies have linked depictions of violence and stereotyped gender roles in the media with increased rates of interpersonal aggression.[27-30]

Promising Strategies

Interventions that define violence as an unacceptable part of dating relationships, and provide education and training in effective relationship and conflict management strategies, show promise for reducing dating violence among adolescents.[31]

The Southside Teens About Respect (STAR) includes classroom-based education for students in grades 7 to 12, teacher workshops, parent workshops, peer leadership/activism training, a community-wide public awareness campaign, and community-based workshops for out-of-school youth.[32] Preliminary evaluation findings show an increase in youth knowledge about dating violence and an increase in intention to seek help for violence. Participants also demonstrated a decline in attitudes supportive of dating violence.

The Dating Violence Prevention Program focuses on promoting equity in dating relationships, challenging attitudes about violence as a means of conflict resolution, improving communications skills, supporting victims of dating violence, and seeking help for those involved in violent experiences. In 1998, the Annual Report on School Safety identified it as a model program based on evidence of attitude changes among youth about the use of violence in dating relationships and on the program's focus on developing positive relationship skills in participants.[33]

Boston's Dating Violence Intervention Project (DVIP) is recognized as an outstanding program by the Department of Health and Human Services and the US Department of Education. DVIP's programs include assemblies and performances built around the theme of respect, and 3-session courses in which former victims and abusers train students to identify abusive behaviors, engage in respectful communication, and manage conflict. Other initiatives include weekly counseling groups for male students who abuse or threaten a female peer, training for school staff and police officers, and a 24-hour hotline and counseling service. The curriculum has been used in other Massachusetts communities, as well as in Canada, New Zealand, and Australia.[34]

The Safe Dates Project targets eighth and ninth graders and is a combination of school (a 10-session curriculum, a play, and a poster contest) and community components (training for service providers, a crisis line, and a support group). Initial evaluations of the program show a 25% reduction in self-reported psychological abuse perpetration, 60% reduction in sexual violence perpetration, and 60% reduction in violence perpetrated against a current dating partner.[35]

Dating Violence *(continued)*

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Internet resources

Dating Violence: It is your business.com
http://www.itisyourbusiness.com/

Dating Violence (National Network for Family Resiliency)
http://www.nnfr.org/adolsex/fact/adolsex_viol.html

Dating Violence (CDC)
http://www.cdc.gov/ncipc/factsheets/datviol.htm

Dating Violence Among Adolescents (Advocates for Youth)
http://www.cyfernet.mes.umn.edu/youth/sexuality.html

Recognize the Early Warning Signs of a Violent Teen Relationship and What Parents Need to Know
http://ww2.mms.org/pages/violent_teen_relationships.asp

What You Need to Know About Dating Violence: A Teen's Handbook
http://www.lizclaiborne.com/lizinc/lizworks/women/pdf/teen_handbook.pdf

2001: A Parent's Guide to Teen Dating Violence: Questions to start the conversation
http://www.lizclaiborne.com/lizinc/lizworks/women/pdf/10questions_hand.pdf

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Issue Brief

Firearm-Related Violence

Introduction

The United States has the highest rate of youth violence in the industrialized world. Many premature deaths and injuries are related to youth gun violence. During the late 1980s and early 1990s, youth firearm-related violence increased dramatically in the United States. Juvenile gun arrests rose sharply as more teens began to carry guns, and the number of gun homicides committed by juveniles more than doubled. Youth suicides with handguns also increased rapidly during that time period. Since 1994, however, the tide has begun to turn. In recent years, we have seen significant decreases in youth suicides and in homicides involving a juvenile offender. However, much remains to be done. Each year in the United States, too many teens still illegally access firearms and harm others and themselves.

Firearm access

The Youth Handgun Safety Act of 1994 prohibits possession of handguns by anyone under the age of 18, and under the Gun Control Act of 1968 it is unlawful for federally licensed firearms dealers to sell handguns to persons under 21. Yet, youth appear to have little difficulty in obtaining handguns. In one survey of 7th and 10th graders in Milwaukee and Boston, 42% reported that they could get a gun if they wanted one, and 28% reported having handled a gun without adult knowledge or supervision.[1] How do teenagers acquire guns? When juvenile offenders in detention centers were interviewed about how they acquired their first gun, 42% indicated that they were given their first gun by a peer, an older youth, or a relative, while 38% purposely acquired their first gun by borrowing (17%), buying (11%), or stealing (10%). Of those who possessed guns, 84% said that they had obtained them before they were 15 years old.[2]

Many youth gain access to guns in their homes. A recent study found that 41% of households in the United States have at least one gun and 27% have a handgun. One in 3 firearm owners keep their guns loaded at least some of the time, and 1 in 5 keep them permanently loaded. This means that as many as 44 million firearms are kept loaded on any given day in the United States. Furthermore, 40% of American households with children under 18 have guns, and a quarter of those households keep their guns loaded and unlocked at least some of the time.[3] The Congressionally mandated, federally funded National Longitudinal Study of Adolescent Health found that almost one quarter (24%) of those adolescents surveyed reported having easy access to guns at home. The study also found that adolescents living in homes where guns are kept are more likely to behave violently, using a weapon in a fight or shooting or stabbing someone, and are also more likely to attempt or contemplate suicide with a weapon.[4]

Firearm carrying and use

Clearly, one factor that contributes significantly to adolescent gun violence is that gun possession and carrying have become common among adolescents, particularly in urban areas. Male teens, in particular, are likely to possess and carry firearms. In a nationwide survey of high school students in 1999, 9% of male students (and 4.9% of all students) reported carrying a gun at least once in the 30 days preceding the survey.[5] While still high, this represents a significant decrease since 1993, when 13.7% of male students (and 7.9% of all students) reported having carried a gun in the 30 days preceding the survey.[6] The main reason given by adolescents for obtaining or carrying guns is self-protection. Additional motivational factors include involvement in delinquent activities, such as drug dealing, and a propensity for aggressive behavior.[7] It is important to note that adolescent gun carrying has serious consequences even when it does not lead to physical injuries. It increases community members' exposure to intimidation and threats and creates an environment of fear and distrust in communities.

Juvenile arrests for weapons violations increased sharply during the late 1980s and early 1990s before declining in the mid-1990s.[8] A variety of factors may have contributed to the reduction in youth firearm carrying and use in recent years, including changes in legislation and law enforcement practices; improvements associated

with violence prevention programs; demographic changes; changes in the market for illegal drugs; and the broad economic expansion in the United States.[9] Still, it is important to note that even with the impressive declines, there were still more than 40,000 juvenile weapons arrests in the United States in 1999, accounting for 24% of all weapons arrests.[8]

Firearm-related suicide

More youth die from suicide attempts with firearms than any other method. This is true for both males and females, younger and older adolescents, and all races. More than 60% of youth suicide deaths in 1998 were firearm-related. The rate of youth suicides involving a firearm increased 38% between 1981 and 1994, and although firearm-involved suicides declined more than 20% from 1994 to 1998, these numbers are still much too high. Among young people 10 to 19 years old, there were 1240 suicides with guns in 1998—more than 3 on average every day of the year.[10] Youth in states with high levels of household gun ownership are more likely to commit suicide than youth in states with low levels of gun ownership–due entirely to firearm suicides; the number of non-firearm suicides are similar.[11] The most common location of firearm suicides by youth is in their homes, and there is a positive association between the accessibility and availability of firearms in the home and the risk for youth suicide. The risk conferred by guns in the home is proportional to the accessibility (eg, loaded and unsecured firearms) and the number of guns in the home.[12, 13] One study found that guns were twice as likely to be found in the homes of adolescent suicide victims as in the homes of those who attempted suicide and failed.[14] The use of guns in a suicide attempt leads to a fatal outcome 78% to 90% of the time.[13, 15]

Firearm-related homicide[16]

Along with the increase in the number of youth carrying firearms in the late 1980s and early 1990s came a sharp increase in gun-related homicides. Male teenagers have always tended to resort to violence to settle arguments, but the increased presence of guns means that disputes once settled by fistfights often escalates to shooting incidents. Youth in states with high levels of household gun ownership are more likely to be homicide victims than youth in states with low levels of gun ownership–due to their increased likelihood to be murdered with a gun.[11] Between 1985 and 1993, the number of gun-related homicides committed by juveniles nearly tripled (increasing from 909 to 3486), with little accompanying growth in non-gun homicides. By 1993, 81% of homicides committed by juveniles involved the use of a gun. In recent years, the number of killings committed by juveniles has decreased dramatically. From 1993 to 1999, the number of homicides by juveniles decreased by a remarkable 59%. This decline was attributable almost entirely to a decline in homicides by firearms, as gun homicides committed by juveniles declined 65% in that time period. The number of gun homicides committed by juveniles is still far too high, however, accounting for 11% of all gun homicides in 1999 for which the age of the offender is known.

Non-fatal firearm crime[17]

Firearm-related homicides are just the tip of the iceberg. From 1993 through 1997 there were 3.3 nonfatal gunshot injuries from assault treated in hospital emergency departments for every firearm-related homicide. Because suicide attempts with firearms seldom fail, nonfatal gunshot injuries from suicide attempts were much less likely, with only 0.3 firearm-related attempted suicides for every completed suicide. Just as homicides and suicides decreased from 1993 to 1997, nonfatal firearm injuries from crime declined 39% and firearm injuries from suicide attempts decreased by 45% in that same time period.

Other strategies to reduce firearm-related violence[18]

In recent years, federal, state, and local governments have had considerable success in reducing youth firearm violence. They have passed new laws and employed strategies to interrupt sources of illegal guns through gun tracing and monitoring of both licensed and illegal gun

Firearm-Related Violence *(continued)*

dealers and by aggressively prosecuting and sentencing those who sell guns to youth. They have worked to deter illegal possession and carrying of guns by those at risk for violence by using community allies to report illegal gun trafficking; targeting probationers, gang members, and drug traffickers; prosecuting those who possess illegal guns; and imposing strong sanctions on those who are involved in gun violence. They have implemented programs to educate youth, families, and community residents about the dangers and consequences of gun violence. They have also increased and coordinated services and resources for at-risk youth, providing positive opportunities such as tutoring, mentoring, job-training, and after-school activities, and educating them about peaceful conflict resolution. Finally, they have mobilized community residents and organizations to work together in their communities to respond to the problem of youth violence.

Developed by The National Youth Violence Prevention Resource Center. Accessed on-line at http://www.safeyouth.org/topics/firearm.htm on January 2002.

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Issue Brief

Firearm Safety

Introduction

Firearm-related injuries and deaths may be reduced through firearm safety education and training, regulation of firearm access and distribution, and design enhancements that reduce the risk of accidental discharge and unauthorized use. A combination of these factors will be required to produce meaningful reductions in firearm fatalities.[1]

Design and storage issues

Regardless of ownership patterns or the rationale for owning firearms, authorities agree on the need to store guns safely and securely and that guns that are not in use should be unloaded. For example, the National Rifle Association's *A Parents Guide to Gun Safety* outlines three fundamental safety rules:

- Always keep the gun pointed in a safe direction
- Always keep your finger off the trigger until ready to shoot
- Always keep the gun unloaded until ready to use

The same brochure also notes that one should "*store guns so that they are inaccessible to children and other unauthorized users*."[2]

Unfortunately, many gun owners violate these basic rules, particularly those on safe storage, securing, and loading practices. Multiple surveys have found that as many as half of firearm owners keep their guns loaded part of the time, and many of these firearms are accessible by children or others.[3] A national survey of gun owners found that 20% keep a firearm both loaded and unlocked at home; a significant number of these gun owners had children.[4]

Devices for storing and securing firearms

Safe Storage. A number of devices can help with the safe storage of firearms. These include safes or vaults designed to hold firearms and ammunition, protecting them from unauthorized users such as children or thieves. Firearms and ammunition should be stored in separate locked devices, with the keys or access codes kept secure at all times by a responsible adult. Safes and other locked storage devices may also prevent impulsive acts such as suicide that occur in the home, especially among adolescents. Somewhat less secure alternatives to safes include lock boxes designed specifically for firearms.

Trigger Locks. Trigger locks are also available to secure a firearm, particularly when more secure storage, such as a safe, is not available. The trigger lock simply fastens to the gun and prevents the trigger from being pulled. The lock must be removed before use and reattached to the gun after use, forcing the owner or shooter to take additional steps to ensure protection, steps that, if ignored, will decrease safety. Disabling the trigger is critical not only because the trigger allows the gun to fire but because most triggers can easily be operated by children. Other locks are made with cables that fit through the barrel and chamber, thereby preventing a cartridge from entering the chamber. Trigger and cable locks are relatively inexpensive and readily available, while gun safes are comparatively expensive. Groups such as the National Shooting Sports Foundation sponsor programs to distribute trigger locks.[5]

Design Enhancements. Built into many firearms are so-called manual safeties, mechanical devices that can be manipulated (up or down, in or out) to allow or prevent the firing of a gun. These safeties are manufacturer dependent, so there are no standards. A few handguns feature grip safeties, which are built into the weapon's handle. They allow the gun to fire only when the grip safety is depressed, as would be the case when the gun is properly held. Interlocking devices, which prevent the firing of a semiautomatic pistol when the magazine has been removed, serve a similar purpose. In a related vein, some guns feature load indicators, which tell a person that a round of ammunition is in the chamber. This is particularly valuable for a semiautomatic pistol from which the magazine has been removed but which still holds a cartridge in the chamber.

Firearm Safety *(continued)*

Other devices and technologies exist or are being developed to improve firearm safety. These include electromechanical locks, personalized firearms, and guns that fire only for an individual wearing or using the proper technology. These are not yet generally available but are under development; prototypes exist for some of these devices.

Contents excerpted from the American Medical Association's Physician Firearm Safety Guide. *(Chicago, IL; 1998) by Stacey Zapanta, BS. Additional content and updates were provided by Art Elster, MD of the American Medical Association. Information about the National Rifle Association's Gun Safety Rules is available at: http://www.nra.org/. Accessed: February 5, 2002.*

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Issue Brief

Media Violence

Introduction

Children and adolescents have access to and consume a variety of different media forms, including television, the Internet, music and music videos, film and video games, many of which contain high levels of violent content. The concern—and the controversy—lies in whether violent content in media affects a young person's beliefs and behaviors and, more specifically, if frequent exposure contributes to increased aggression and violence in young people.

Much of the research that has been conducted on the relationship between media exposure and aggression supports such a connection. Although critics have challenged the validity of these findings, suggesting that they focused only on short-term effects and were conducted in controlled laboratory settings, a recent study suggests that exposure to violent media in home environments has long-term implications.[1]

Promising strategies for reducing exposure to media violence are available and include limit setting by parents/guardians, technological innovations such as the v-chip (which blocks inappropriate shows or content from being viewed by children), and media literacy training.

Scope of the problem

Most American homes have a television set, which is in use for at least 7 hours each day.[2] The National Television Violence Study, a 3-year assessment of violent content on television, found that 57% of current television programming contains some form of violence.[3] Researchers found that the negative consequences of this violence were rarely portrayed. In 2,693 television programs reviewed, 73% of perpetrators were not held accountable for their violent acts and 47% of victims showed no evidence of harm; 67% of programming targeted at children not only contained violence, but consistently juxtaposed violence with humor.[3] By age 10, the average American child witnesses 108,000 acts of such violence, including 8,000 acts of murder.[4]

Movies, music videos, video games, and the Internet also contain high levels of violent content. For example, music videos targeting youth audiences (12 to 19 years of age) depict an average of 6.1 violent acts per video.[5]

Media as a risk factor

The relationship between exposure to violent media and aggression has been researched extensively over the past 20 years.[6] A review of 217 studies found that exposure to violent media was consistently correlated with increases in aggressive behavior in youth.[7] Exposure to media violence also has been correlated with changes in youth attitudes about the use of violence in interpersonal relationships.[8] While the evidence may be compelling, translation of these findings to the "real" world has been problematic.[9] Findings are criticized on the grounds that most studies were conducted under controlled laboratory conditions and focused on short-term changes in behavior. It is unclear whether violent media has similar effects when viewed in home or community settings and whether such exposure has long-term consequences.[8]

Recently, the Children in the Community Study addressed these limitations and demonstrated a relationship between consistent consumption of media (3 hours a day) in the home/community and an increased likelihood of aggression toward others.[1] Researchers followed 707 families for a 17-year period and examined the relationship between consumption of media and aggression, using youth self-report, parental report, and criminal arrest data. Forty-two percent of males who viewed television more than 3 hours per day at age 14 were reported to have been involved in aggressive acts that resulted in injury when they were 1 6 or 22 years old, this compared to 9% of males who viewed less than 1 hour of television per day. This relationship persisted even after controlling for other factors such as prior history of aggressive behavior, child neglect, neighborhood violence, family income, psychiatric disorders, and gender.

Media Violence *(continued)*

Social learning theory provides an explanation for how violent media may influence childhood aggression. Social learning theory posits that a child learns how to act and forms his or her attitudes from observing important role models in his or her life. Characters portrayed in the media may become models who influence the child's attitudes, beliefs, and behavior. He or she may learn to see violence as a part of everyday life and an acceptable way to solve interpersonal problems. Because violence in the media is so frequently presented without negative consequences, youth may fail to accurately assess or even understand the real-life consequences of violent actions against others.[8]

While children of all ages can be affected by violent media content, young children are particularly vulnerable.[7] Developmentally, they are less able to discern reality from fantasy and are more likely to be emotionally and cognitively affected by the violence they observe.[8]

Finally, the effects of violent media appear to be race, class, and gender-blind. Violent media influences both males and females (although some data suggest that males may be slightly more affected), and while some studies suggest a connection between socioeconomic and community factors and vulnerability to the effects of media violence, most research shows that all groups can experience the effects of media violence on attitudes and behaviors.[8,10]

Promising strategies

At present, little research exists on the effectiveness of different interventions for reducing the effects of violent media on children. Some common sense approaches such as limiting children's access to violent media and teaching them to be informed media consumers have gained support from professional and legislative groups. Despite the lack of research, available interventions have both intuitive and theoretical appeal.

Limiting access to and consumption of violent media. Researchers have found that limiting media consumption, including television viewing and video game playing, can reduce short-term aggressiveness in children.[6] Since the majority of children's media exposure occurs in the home, parents/caretakers play a pivotal role in limiting consumption both by monitoring their child's viewing habits and by regulating what and how much media they consume. Parents/guardians should engage their children in discussion of this issue but realize that they may not share their children's opinions or interpretations of violent programming and content.[8]

In 1996 Congress passed the Telecommunications Act, which was intended to assist parents and caregivers in reducing children's exposure to violent media. The legislation calls for the inclusion of v-chips in all new televisions and for the development of a rating system to enable parents/caretakers to assess the violence content of specific shows.[11] Unfortunately, implementation has been slow to nonexistent. Organizations such as the American Civil Liberties Union are contesting the legislation on censorship grounds.[12] The networks have been slow in developing effective rating systems for their programming. To some extent, industry is responding with devices such as Weemote and TVGuardian, which can filter out certain television channels and even offensive language, thereby providing some level of parental control over children's viewing preferences.[13,14]

Developing media literacy in parents and youth. Another strategy to reduce the effects of violent media is media literacy training. Parents/caregivers and children are taught to critically appraise the media they consume and develop strategies for reducing exposure to violence. They are taught to distinguish between real and fantasy violence, identify the real-life consequences of violent acts that occur in the media, critically assess the motivations of the producers in making the media product, and describe nonviolent alternatives to the violent actions contained in the programming.

Media literacy training resources include The Just Think Foundation, which focuses on children by providing educational programs that can be utilized during or after school and on-line[15]; the Center for Media Literacy, which offers media literacy training for teachers and parents, and community, civic, and youth leaders through exercises and activities in small group settings[16];

Media Violence *(continued)*

and the American Academy of Pediatrics' Media Matters program, which provides training for health care professionals in media literacy and educational materials for use in the health care setting.[17]

Developed by Carmela Lomonaco for the Southern California Center of Academic Excellence on Youth Violence Prevention; Winter 2002. Appreciation is expressed to Dr. L. Rowell Huesmann for his insight and suggestions.

Internet resources

American Academy of Pediatrics Media Matters
http://www.aap.org/advocacy/mediamatters.htm

The Center for Media Literacy
http://www.medialit.org

Children Now
http://www.childrennow.org/media

The Just Think Foundation
http://www.justthink.org

Mediascope
http://www.mediascope.org/

New Mexico Media Literacy Project
http://www.nmmlp.org

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13 See http://www.tvguardian-online.com

14 See http://www.tvguardian-online.com/weemote

15 See http://www.justthink.org

16 See http://www.medialit.org

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Issue Brief

Risk and Protective Factors for Youth Violence

Introduction

Numerous factors can contribute to and influence the range of behaviors that are defined as youth violence. It is important to consider these factors in order to develop a comprehensive understanding of the nature of the problem. It is also necessary to understand those factors that build resiliency and potentially "protect" youth from engaging in violence.

Current research indicates that the presence of a single risk factor in an individual does not, by itself, cause antisocial or violent behavior.[1] Rather, it is now generally believed that multiple factors combine to contribute to and shape behavior over the course of adolescent development. Studies suggest it is the confluence of certain "risk" factors that contribute to violent behavior, and the existence of certain "protective" factors that create resiliency. The design of effective prevention and intervention strategies should take into consideration the dynamics and inter-relationship of both types of factors.

Overview

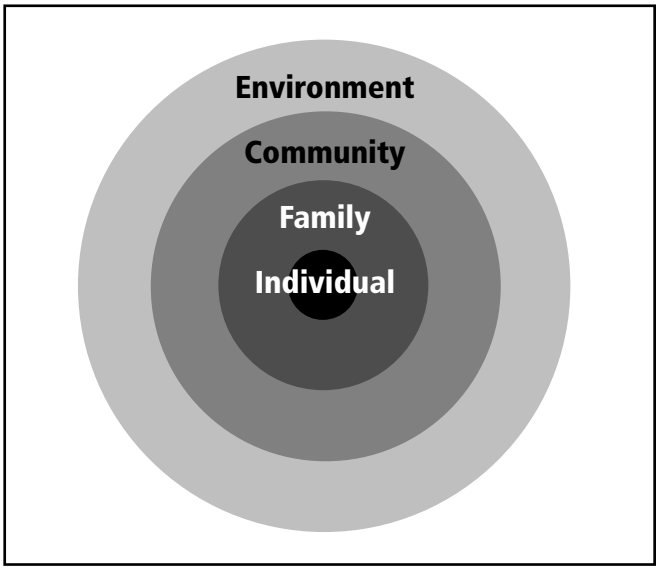
Risk factors are defined as scientifically established factors or determinants for which there is strong objective evidence of a causal relationship to a problem. Protective factors, on the other hand, are those that potentially decrease the likelihood of engaging in a risk behavior. These factors can influence the level of risk an individual experiences or can moderate the relationship between the risk and the outcome or behavior.[2]

One way to understand the dynamic between risk and protective factors is to view them within an ecological framework.[3-5] The ecological model recognizes that each person functions within a complex network of individual, family, community, and environmental contexts that affect their capacity to avoid risk.

The ecological framework is based on a public health perspective for reducing risks and preventing disease, illness, and injury. Instead of focusing just on the individual who is at risk for, or who engages in, a particular behavior such as violence, the public health approach considers the individual's relationship to his or her surroundings. Recently, other disciplines, including mental health and criminal justice, have begun to adopt this multi-level approach in their efforts to understand the nature of violence and identify potential points of intervention that reach beyond the individual.

Individual-level factors, for example, are identified as those behaviors or characteristics that affect one person's risk of, or resistance to, potentially engaging in violent behavior. *Family factors* are typically related to a family's structure, support, culture, and functioning and ultimately affect the behavior of the individual members. *Community factors* consider physical environment, available economic and recreational opportunities, existing social supports, and other issues that influence the successful functioning of the residents. Finally, *environmental factors* encompass larger issues such as social values and the impact of media, policy, or legal decisions.

The ecological model



Specific risk and protective factors

Violence prevention experts have identified a number of risk and protective factors that can be directly attributed to violent behavior.

Risk and Protective Factors for Youth Violence *(continued)*

Below is an overview of some of the specific factors that have been linked to youth violence. The factors are organized into categories that reflect their level of influence, though some may cut across the different levels. While many have been scientifically studied, others require more research. However, all have been identified as having some contributing connection to youth violence and delinquency. Given that individuals operate within the context of their surroundings, the section moves from the broader, environmental factors to the specific factors that relate directly to individual behavior.

Environmental-level factors

Environmental factors play an important role in creating conditions that can contribute to a culture of violence among a particular group of people or in a given community. Some of the factors at this level that have been linked to violence include poverty, media exposure to violence, and the general disenfranchisement of young people in our society.

Socioeconomic status has been consistently found to be an important contributing factor to violence in many studies. Depressed economic conditions coupled with individual cases of unemployment and limited economic opportunity contribute to higher levels of violence in a given community. Researchers have confirmed that youth living in poverty are more likely to engage in violent behavior.[6] These youth often also experience specific barriers when seeking employment, such as employers who would prefer not to hire them, limited job skills or vocational training, or physical obstacles, such as poor transportation.

Other research indicates that exposure to violence in the media, particularly prolonged exposure by children, may contribute to aggressive behavior and desensitization to violence.[7, 8] The media also may contribute to the perception of violence as a normative behavior, reinforcing and sensationalizing violence as an appropriate and justifiable problem-solving strategy.

Finally, many adults have a disregard and mistrust of young people, and our culture has largely failed to recognize youth as a valuable asset. As a result, many youth may find it difficult to engage in meaningful and substantive relationships with adults both individually and within the larger community. This lack of connection may contribute to youth's feelings of alienation and disassociation from mainstream society, thus increasing risk for delinquent or violent behavior.

Protective factors that can help build resiliency and reduce overall risk for violent behavior at the environmental level include national, state, and local policies that support child- and youth-oriented programs. Such programs can help adults build a base of understanding and commitment to working with and engaging young people. One of the most powerful protective factors emerging from resiliency studies is the presence of caring, supportive relationships.[9] Thus, the commitment of resources to programs that support meaningful opportunities for adult-youth interaction will help more adults understand youth perspectives and behaviors, and can contribute to a culture of caring instead of one that ignores youth or, worse, labels them as deviant or antagonistic.

Community-level factors

Some of the community-level factors that contribute to the risk for youth violence include the availability of drugs and firearms, community deterioration or disorganization, and access to quality educational and recreational opportunities.

Researchers have found that the prevalence of drugs and firearms in a community predicts a greater likelihood of violent behavior.[6] Legislation, enforcement, and community dynamics combine to influence the local accessibility of drugs and weapons. Within individual communities, the availability of drugs or weapons may vary, influenced by the presence of existing violence, gang activity, or an active firearm trade. These factors are clearly linked to existing socioeconomic conditions. For example, limited economic opportunities in a given community may legitimize a local drug trade, creating an underground secondary economy offering the potential of significant financial gain, status, and power.

Risk and Protective Factors for Youth Violence *(continued)*

Community disorganization is another predictor of violent activity.[6] This factor is defined as the presence of high crime rates, gang activity, poor housing, and general deterioration in a given community. These communities also may have a lack of appropriate institutions and services for young people, such as quality schools and recreational facilities, limiting youth access to positive and productive development experiences.

On the other hand, a strong community infrastructure has been identified as a protective factor against youth violence in the resiliency literature. Communities can create opportunities for youth to participate in activities where they have choices, decision-making power, and shared responsibility. Such experiences help them to develop new skills, increase self-confidence, and offer a chance to make a difference.

Family-level factors

Research demonstrates that family dynamics and parental or caregiver involvement are significantly correlated with an individual's propensity to engage in violent behavior. A lack of parental interaction and involvement increases the risk for violence, particularly among males.[10] Failure to set clear expectations, inadequate youth supervision and monitoring, and severe or inconsistent family discipline practices can also contribute to delinquency and violent behavior.

Child abuse and neglect are additional family-level risk factors. Research evidence suggests that children or youth who have been physically abused or neglected are more likely than others to commit violent crimes later in life.[11, 12] Exposure to high levels of marital and family discord or conflict also appears to increase risk, as does antisocial or delinquent behavior by siblings and peers.

Family members, especially parents or primary caregivers, can play a significant role in protecting youth from violence by emphasizing the importance of education and offering support and affection. Frequent, in-depth conversations and communication between parents and children help build resilience as does the existence of a non-kin support network that offers access to a variety of adult viewpoints and experiences. Other family-level protective factors include clear boundaries for behavior that enforce structure and rules within the household and reasonable disciplinary actions when rules are violated.

Individual-level factors

The majority of research related to risk factors has focused on individual-level characteristics or behaviors that predict or contribute to violence. It is important to be cautious in assessing these factors to avoid inappropriately labeling or stigmatizing individual young people because they possess certain characteristics or fit a specific profile. It is also necessary to view individual factors within a developmental framework, to understand what is appropriate behavior at certain ages, and to avoid misinterpretation of the signs. Finally, it is necessary to remember that violent behavior is a product of multiple factors operating on many levels in the absence of protective factors and that individual youth are acting largely within the context of their environment and experiences.

An analysis of findings from many studies conducted by the US Department of Justice found consistent evidence of a correlation between violent behavior and hyperactivity, concentration problems, restlessness, and risk taking. Further research appears to be necessary to understand causal pathways. Other research indicates strong evidence for the co-occurrence of mental health disorders, such as depression, among children or youth with antisocial or delinquent behavioral problems.

Aggressive behavior during childhood (from ages 6 to 13) appears to consistently predict later violence among males, although research results for aggressive females are less consistent.[13] Early onset of violence and delinquency is also associated with later acts of more serious and chronic violence,[14, 15] as is involvement in other forms of antisocial behavior, such as substance use, stealing, and destruction of property.[6]

Risk and Protective Factors for Youth Violence *(continued)*

Poor academic achievement and school failure are other individual-level factors that contribute to risk for violence. Some research indicates that this relationship is stronger for females than for males.[16] Young people who are consistently absent from school during early adolescence (ages 12-14) appear to be more likely to engage in violence as adolescents and adults. Leaving school before age 15 has been found to correlate with increased risk as well.

Individual-level traits and characteristics that have been identified as protective factors include a sense of purpose and belief in a positive future, a commitment to education and learning, and the ability to act independently and feel a sense of control over one's environment. The ability to be adaptable and flexible and have empathy and caring for others is also significant, as is the ability to solve problems, plan for the future, and be resourceful in seeking out sources of support. Conflict resolution and critical thinking skills are additional factors that help protect youth from violence, delinquency, and antisocial behavior.

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Issue Brief

School Violence

Introduction

In recent years a number of highly publicized school shootings have occurred. While this type of school violence has raised public awareness and concern, overall levels of school violence actually have declined in recent years. In fact, schools are safer today than they have been for several years[1]. Nonetheless, schools and communities still face many challenges in creating a safe and healthy learning environment for our nation's youth.

Scope of the problem

Fatal crime

School-related death is rare. In the 1998-1999 school year, less than 1% (50 total) of youth homicides in the United States occurred on school property, at school events, or on the way to or from school.[2] Of the 50 school-associated deaths, 34 were student homicides, 9 were attributed to suicide, and 1 to an unintentional shooting. Only 2 incidents involved multiple victims.

Nonfatal crime

Nonfatal crimes including theft, rape, sexual assault, robbery, aggravated assault, and simple assault declined from 1992 to 1998. In 1992, these types of crimes occurred at the rate of 144 per 1000 students and dropped to 101 per 1000 students in 1998. Students are less likely to be victims of serious violent crimes (eg, rape, robbery, and aggravated assault) at school than away from school. In 1998, 9 per 1000 students were victims of serious violent crimes at school or going to or from school, while 21 per 1000 students were victims of serious violent crimes away from school. Conversely, theft is more likely to occur at school than away from school. In 1998, there were 58 thefts per 1000 students at school and 48 per 1000 students away from school. These numbers decreased, however, from 95 per 1000 at school and 68 per 1000 away from school in 1992.[3]

Weapons and fighting

Carrying a weapon and fighting also declined in the late 1990s. From 1993 to 1999, the percentage of students who reported carrying weapons to school dropped by nearly half, from 12% to 7%. Self-report of fighting at school dropped from 16% to 14% during the same time period.[3]

Perception of safety

Students feel safer at school than in the past. In 1995, nearly 10% of students reported not feeling safe at school sometimes or most of the time. In 1999, this number dropped to 5%.[2] In addition, clear differences were seen among ethnic groups as to how safe students feel at school. Latinos and African Americans are the most fearful at school. Students who do not feel safe at school report avoiding one or more places at school, such as hallways, stairs, cafeterias, and restrooms.[3]

Crimes against teachers and classroom disruption

In general, violence in school has declined steadily since the early 1990s. However, from 1994 to 1998 crimes against teachers remained constant at about 31 violent crimes per 1000 teachers and 51 thefts per 1000 teachers. In addition, classroom disruption continues to be a problem. Although not considered violence, misbehavior in the classroom interferes with the learning environment. More than 85% of students report that their teachers stopped class to deal with disruptive students at least once a week. This number remained constant from 1992 to 1998.[3]

Risk factors

Because youth spend much of their day at school, the school is a likely context for violence to occur. Although studies have shown that certain characteristics of schools can increase risk of violent acts, most of the risk factors for school violence are, indeed, the same as those for youth violence. These include individual characteristics such as age, gender, and certain personality characteristics as well as socialization influences of those closest to the child, particularly family and peers. In addition, although a 2000 report of the US Secret Service stated that there is no accurate profile for school shooters, the specific set of risk factors for school shooters is somewhat distinct.[4,5]

School Violence *(continued)*

Age and gender

Youth are at highest risk of initiation of violent crime between 15 and 16 years of age and at highest risk for participation in violent crime from 16 to 17. After age 17, participation drops greatly and, by 21, participation in serious violent crime drops by 80%. Boys are much more likely than girls to use physical aggression and violence, although some studies indicate that girls are more likely to use indirect forms of aggression such as name-calling and social exclusion. Because aggression begins early and is relatively stable over time, it is likely that the 15 to 17 year-olds committing violent crimes in high school may have been among the more disruptive and aggressive children in elementary school.[6]

Personality

Characteristics such as hyperactivity, limited attention span, restlessness, impulsivity, and risk-taking have been linked to violent and delinquent behavior in school.[7,8]

Social environment

Many factors that normalize violence also lead to increased risk. Societal factors such as exposure to media violence, easy access to weapons, and gang and hate group affiliation can increase the likelihood of youth violence at school.[8]

Family and home environment

The most crucial influences in healthy youth development come from the family and home environment. Negative factors originating within the family, such as harsh physical discipline; alcohol and drug abuse; parental discord, domestic violence, and divorce; child abuse and neglect; incarceration of parents or other family members; or simply poor parenting practices, have profound implications for children. Children raised in problem home environments tend to be stressed, frustrated, alienated, confused, and violent.[6-8]

Peer group

Another area of risk for youth is the peer group. Children tend to choose friends who are like themselves, and they turn to friends and peers for support and guidance. Thus, already alienated children form peer groups where negative behavior is the norm and the violent or criminal behavior of one or more is likely to be followed by others.[8]

School environment

While violence in schools stems predominantly from sources outside the school, the school environment itself may exacerbate the problem.[9] For example, an unsafe school environment, in and of itself, may precipitate more aggressive behavior among students, resulting in a cyclic pattern of violence in the school. In addition, methods and policies implemented in schools to reduce school violence can make matters worse.[10] For example, already alienated students who crave attention may be encouraged by the presence of metal detectors and cameras to commit violent acts simply for the recognition. Furthermore, policies of zero tolerance and punitive or coercive punishment tend to further alienate and upset students. After 4 years of implementation, reports show that schools using zero-tolerance policies are less safe than schools that have not implemented such policies.[11]

School shooters

There is no typical profile of the school shooter. Some are loners and some have close friends. Some are from single-parent homes and some are from intact families. In fact, school shooters typically do not have behavior problems in school. In terms of academic performance, some may be failing and others may be honor students. School shooters do, however, share some similar behavior patterns. For example, although popular belief is that they "snap," this is generally not the case. Rather, they typically plan carefully and they do so for a long time, maybe months or years. In addition, they spend a long time gathering weapons, or considering which weapons to use. It is also common for school shooters to have told someone something about their plan or to talk about wanting to kill people. Frequently, they write their plans and feelings in diaries or poetry. Revenge generally surfaces as the primary motive for school shootings. Shooters, for example, may be victims of constant

bullying, may feel continuously rejected or ignored by teachers, or may feel that no one ever listens or cares. Lastly, school shooters have all been male.[4,5]

Promising strategies

Evidence indicates that successful school violence prevention and intervention strategies require integrative, proactive approaches. The literature abounds with evidence and discussion in favor of comprehensive multidimensional prevention efforts for school safety.[2, 7, 8, 12-17] Furthermore, because violence in the schools reflects violence in the community as well as other social and familial aspects of children's lives, collaboration among schools, parents, communities, social services, and law enforcement agencies is necessary for the efficacy of prevention programs.[2,8]

One such collaborative program is currently being piloted by the Riverside Unified School District (RUSD) in Riverside, California. RUSD's Healthy People, Healthy Places is an interagency Wellness Center program. RUSD, County Departments of Mental Health and Probation, the police department, and the University of California, Riverside, have come together to form Wellness Centers at several school sites that provide a variety of personal, mental health, law enforcement, and social services to students and their families. The objective of the Wellness Center model is to provide evidence-based activities to promote mental health and prevent violence and other problem behaviors in school.[18]

Other examples of successful school violence prevention programs are LIFT (Linking the Interests of Families and Teachers) and the Perry Preschool Program.[19] LIFT is a school-based program that targets first- through fifth-graders, the focus being reduction of conduct problems, association with delinquent peers, and drug and alcohol use. LIFT uses classroom and playground activities to role-play, problem solve, and build social skills. Parenting education is also part of the program. LIFT programs decreased physical aggression on the playground and increased positive social skills and classroom behavior in participating children. The Perry Preschool Program targets low socioeconomic status families and provides high-quality early childhood education in an effort to improve later school and life performance. Program outcomes for Perry Preschool children include less delinquent behavior and fewer arrests by age 19, less antisocial behavior and misconduct during elementary school, higher academic performance and commitment to school, and lower rates of school dropout. These and other validated violence prevention programs are described in detail on the Center for the Study of Prevention of Violence Web site under "Blueprints for Violence Prevention" (see Internet resources at the end of this paper).[19]

Regardless of the particular prevention or intervention selected for a safe school plan, program planners should understand risk and protective factors; know what research finds to be effective; determine the needs of their particular school and community, as well as identify individual students at risk and most in need of immediate intervention; develop school-wide policies and curriculum that support development of social skills and help students manage anger, solve problems, and treat others with respect; ensure that all aspects of prevention plans are developmentally and culturally appropriate; and include all collaborative partners in the planning and implementation of the program.[8, 12, 13, 16, 20] Clearly, issues of school and youth violence are complex. Furthermore, the solutions appear to be as multifaceted as the problems. The major components of successful prevention of school violence are proactive, comprehensive, and collaborative, and each of these holds within it a number of essential elements. Intensive planning that takes into consideration research-based evidence for effectiveness will increase the possibilities for successfully reducing violence in America's schools.

Prepared by Roxie Alcaraz for the Southern California Center of Excellence on Youth Violence Prevention, University of Southern California, Riverside, Winter 2002.

School Violence *(continued)*

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School Violence *(continued)*

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http://www.aacap.org

Center for the Prevention of School Violence
http://www.ncsu.edu/cpsv

Center for the Study and Prevention of Violence
http://www.colorado.edu/cspv/

Comer School Development Program
http://info.med.yale.edu/comer/index.html

Family Education Network
http://www.familyeducation.com

National Resource Center for Safe Schools
http://www.safetyzone.org

National Youth Violence Prevention Resource Center
http://www.safeyouth.org

Issue Brief

Youth Development and Violence Prevention: Core Competencies

Introduction

Many youth violence prevention programs seek to identify "risk" factors that increase risk for violence and "protective" factors that moderate that risk. Indeed, there is a large body of literature on risk and protective factors related to youth violence[1]. Efforts are therefore aimed at reducing specific risk factors and enhancing protective factors. In some cases, programs are directed towards entire populations believed to be at risk, such as inner-city, low-income youth. In other cases, certain youth are identified for participation in a variety of programs based on the presence of selected risk factors, such as early aggressive behavior, low self-control, poor social problem-solving skills, or significant family problems. A number of federal agencies such as the Office of Juvenile Justice and Delinquency Prevention and the Centers for Disease Control and Prevention have rallied around this public health perspective that emphasizes reduction of risk for youth violence.

A slightly different approach to violence prevention emphasizes the importance of positive youth development. Rather than focus on selected risk factors and how to reduce them, a youth development approach emphasizes strengthening the capacity of youth to become healthy and successful adolescents and adults through skill building and development of opportunities for engagement and support. Youth development programs are typically broad-based and include all youth rather than targeting those deemed to be at risk. Terms such as *positive development, social competence,* and *asset-building* are used. The overall goal of the youth development approach is to maximize positive outcomes.

Core competencies for healthy youth development

Despite the existence of a number of taxonomies of positive developmental outcomes,[2,3] most youth development and prevention efforts select certain competencies (eg, problem-solving skills) or contextual supports (eg, family functioning) that are not connected systematically. In many cases these are mixed together in long lists of "good things." For example, a large number of communities have embraced the 40 assets of healthy youth development promoted by the Search Institute.[4] Many of these assets reflect ways to build individual competencies (eg, family support), rather than delineating what these competencies are and how they are linked to youth violence.

Rather than providing a listing of assets or protective factors that often do not differentiate clearly between individual outcomes (eg, self-control) and supports that facilitate those outcomes (eg, effective parenting), a focus on *core competencies* provides a specific guide for youth development programming by emphasizing measurable outcomes. Development of core competencies begins at birth or before and extends through adolescence and beyond. A number of different programs and supports can facilitate the development of these competencies at different ages.

Five core competencies are important for healthy social and emotional development and are important for youth violence prevention.[5,6] In other words, youth who are skilled in these five areas should be less likely to engage in violence and other problem behaviors. These are described in the following table.

Youth Development and Violence Prevention: Core Competencies *(continued)*

Core competency	Related terms	Links to youth violence
Positive identity	Positive self-concept, hopefulness, future goals	Violence associated with negative identity
Personal agency	Self-efficacy, effective coping, attributional style	Violence associated with hostile attributional bias
Self-regulation	Affective, behavioral, and cognitive self-regulation	Violence associated with poor impulse control
Social relationship skills	Social problem-solving skills, empathy, conflict resolution skills, capacity for intimacy	Violence associated with poor social problem-solving skills and lack of empathy
System of belief	Attitudes, norms, values, moral engagement	Violence associated with aggressive norms and moral disengagement

A youth development approach to violence prevention that highlights core competencies emphasizes understanding and attending to the specific developmental needs of youth. It integrates a risk-focused approach by recasting many risk and protective factors in terms of these core competencies. However, developmental issues alone are not the only predictors of youth violence. It is also important to identify problem-specific factors that are not directly related to development. For example, easy access to firearms can increase the risk of violence, while community policing can decrease that risk. The impact on risk of these community factors is not directly related to the mastery of specific competencies; rather, it is through other mechanisms such as opportunities and deterrence. An integrated approach to violence prevention should build on youth development but also recognize other violence-specific risk factors and how they can be addressed.

Promising strategies

Healthy youth development begins early and can be fostered in many ways. A major emphasis is on the creation of supportive environments in families, schools, and communities. Most youth development efforts also emphasize integrated services within communities rather than disconnected and fragmented programs.

The development of the five core competencies begins at birth or before. Thus, programming to foster this development must begin early and continue throughout childhood and adolescence. This programming should involve specific instruction and opportunities to practice discrete skills as well as promotion of contextual supports for development. Clearly, some strategies are more appropriate for selected age groups. Examples of positive strategies to foster healthy development include the following:

Youth Development and Violence Prevention: Core Competencies *(continued)*

Promoting a positive identity in children and youth

- Opportunities for engagement and involvement in school and community activities that are available to children regardless of academic achievement, income, or other prerequisites that exclude some children
- Parent and teacher training programs that emphasize positive reinforcement and acknowledgement of positive behaviors
- Opportunities to explore various skill and career options and to build on individual strengths and talents
- Youth employment training programs that prepare youth for meaningful and rewarding careers
- Mentoring programs that provide positive role models and encouragement

Developing a sense of personal agency

- Youth involvement in decision making and governance at school and in the community
- Attribution retraining programs that encourage youth to accurately attend to and interpret social cues and decrease hostile attributional biases
- Providing children and youth with safe and supportive environments that minimize exposure to stressors
- Training families and children in effective coping skills

Building self-regulation skills

- Direct instruction (eg, individual, classroom, small group) in self-regulation skills such as anger management and cognitive self-control
- Parent training programs that emphasize de-escalation rather than escalation of aggressive behavior
- Opportunities for engagement in group activities that provide structure as well as short-term and longer-term reinforcements
- Availability of mental health counseling and services, including diagnoses of children with problems such as attention deficit hyperactivity disorder

Promoting social relationship skills

- Opportunities for safe and structured play (eg, community playgrounds)
- After-school recreation and social development programs
- Direct instruction (eg, individual, classroom, small group) in social relationship skills
- Conflict resolution and peer mediation programs
- Mentoring programs that provide positive role models and teach children how to engage others successfully
- Community service opportunities that involve children and youth in the lives of others, including those most in need

Helping youth develop a prosocial system of belief

- School- and community-wide campaigns to promote prosocial norms and discourage aggressive and antisocial norms
- Media campaigns that encourage prosocial and responsible behavior
- Rules and laws that set guidelines for acceptable and appropriate behavior
- Social development, moral reasoning, and character education programs that emphasize social responsibility

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Youth Development and Violence Prevention: Core Competencies *(continued)*

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Internet resources

Youth Learn
http://www.youthlearn.org

National Youth Development Information Center
http://www.nydic.org

Institute for Youth Development
http://www.youthdevelopment.org

Positive Youth Development in the United States
http://www.aspe.hhs.gov

Reconnecting Youth and Community
http://www.ncfy.com

Issue Brief

Youth Gangs

Introduction

Gang members represent a relatively small proportion of the adolescent population. However, they commit the majority of serious youth violence.[1, 2] Along with the rapid proliferation of gangs since 1980, there have been growing concerns among lawmakers, law enforcement, educators, practitioners, and parents about gang behavior and gang violence. Researchers have studied the gang phenomenon since the early 1900s but have yet to delineate clearly the reasons why some youth join gangs.[1,2] Little is also known about the effectiveness of many of the intervention programs that exist to combat the gang problem.[1] Overall, the dynamics of gang behavior and its persistence in the United States are not well understood.[3]

Scope of the problem

Results from the 1999 National Youth Gang Survey suggest that the youth gang problem continues to be widespread and substantial across the United States.[4] On the basis of 3,911 police and sheriff's departments that responded to the survey, there were an estimated 26,000 gangs and 840,500 gang members across the nation. The majority of these gang members reside in large cities. For example, Chicago has an estimated 30,000 to 50,000 gang members. However, Los Angeles ranks first in the United States in gang-involved youth, with more than 58,000 gang members. California continues to have the most gangs and gang-related problems compared to any other state in the country, with more than 200 communities seriously affected by gang-related problems.

Most gangs are formed along racial or ethnic lines. In California, these include Latino gangs, African-American gangs, Asian gangs, and white gangs. There are also further ethnic distinctions within these larger groups, such as Chicano, Central American, and Puerto Rican gangs, all considered Latino. In California, Latino gangs compose the majority of the gang population, although Asian gangs are on the rise. Most (but not all) Latino and African-American gangs are divided by neighborhoods or location. Rivalries tend to stem from these neighborhood divisions. Asian gangs tend to be motivated more by profit than by neighborhood rivalries. Violence between ethnic gangs is normally intra-ethnic (eg, one Latino gang vs another Latino gang), based on neighborhood or location-based affiliation, rather than inter-ethnic (eg, Latino gang vs African-American gang).

Gang members commit more serious and violent offenses than adolescents who are non-gang members.[1,2] They are not only more involved in committing delinquent acts, they are responsible for the majority of all delinquent acts that are committed.[2,4] Respondents to the 1999 National Youth Gang Survey reported that the most prevalent offenses committed among gang members were larceny/theft, aggravated assault, and burglary/breaking and entering.[4]

Gangs tend to be composed of young males, ranging in age from 12 to 25 years, but there have been instances of gang members much younger and much older than this range. Some gangs are loosely knit and lack structure, while others are highly organized and regimented. Indeed, gangs are organizations that develop strategies to optimize the chances of organizational survival, some more successfully than others. In many cases, gangs engage in a range of entrepreneurial activities designed to provide money, power, and prestige to members.

Risk factors

Many of the risk factors for youth violence and delinquency also predict increased risk of gang involvement. In particular, researchers emphasize the importance of neighborhood, family, school, and peer influences.

Neighborhood

The majority of research on neighborhood influences on gangs has focused on the role of social disorganization. The basic idea is that poverty has caused a disintegration of social organization and social control that, in turn, has led to the emergence of gangs as alternate mechanisms that provide order, safety, and economic opportunities.

Thus, youth growing up in these communities are enticed by gang life because it provides something to do, material possessions, and protection from the existing violence on the streets. Indeed, studies have shown that the probability of joining a gang is higher in neighborhoods with low resources and high levels of community social disorganization.[2,5]

Family

Family disorganization is another salient influence in joining a gang. Poor family management strategies increase the risk of gang membership.[2] Poor strategies include low family involvement, inappropriate parental discipline, low parental control or monitoring, poor affective relationships, and parental conflict. Facing poor family relationships, a youth may be lured by a gang because it provides a "family" that is lacking at home. In some cases, parents who are themselves gang members may model and encourage the gang involvement of their children.

School

Educational variables have also been assessed as risk factors for gang membership. Studies have found that youth who have a low educational expectation have a higher risk of joining a gang. It is also a risk factor if a youth's parent(s) have low educational expectations for their child. Poor school performance and low commitment and involvement are also correlated with gang membership. Essentially, a high commitment to school indicates an attachment to conventional institutions. The less a youth bonds to these conventional institutions the more likely he/she will participate in gangs.

Peers

One of the most robust findings in the literature is the link between having deviant peers and joining a gang. Having peers who are gang members greatly increases the likelihood of joining a gang. Peers who are engaged in this type of behavior may construe gang behavior as attractive and fun. Gangs also provide a sense of comradship and expectations of safety and protection that can be appealing to youth. In many cases, older gang members recruit younger children for a variety of tasks, essentially creating a cadre of "trainees" who are socialized into gang life from an early age.

Promising strategies

Because of the complex interplay of factors that lead to gang membership, various types of intervention programs have been developed. These programs mainly focus on prevention, intervention, or suppression.[6] Prevention strategies aim to prevent youth from joining gangs through education-type programs. Intervention programs aim to divert youth from crime by providing alternatives such as after-school programs, counseling, and job training. Suppression strategies use enforcement tactics that identify, isolate, and punish criminal offenders. A mixture of approaches is currently being tried across the United States, with considerable efforts directed towards police suppression programs.[6] Although there are many programs representing a variety of approaches, very few of these programs have been carefully evaluated.

An exception is the Bureau of Alcohol, Tobacco, and Firearms' Gang Resistance Education and Training Program (GREAT). This prevention program utilizes law enforcement officers to teach a 9-week curriculum to elementary and junior high school students on resisting gang involvement and avoiding the use of violence. A number of evaluations of this program have been conducted. For example, a survey of 5935 eighth-grade students in 11 sites found that students who participated in the program reported more prosocial attitudes and lower rates of some types of delinquent behavior than students who did not participate in the program.[7] These results suggest that large school-based preventive programs may be effective in curtailing the gang problem, or at least in influencing attitudes and behaviors associated with gang involvement.

Interventions should include multiple components, incorporating prevention, social intervention, treatment, suppression, and community mobilization approaches.[6] One such program began in the Little Village area of

Youth Gangs *(continued)*

Chicago and has been extended to other sites across the United States. The Little Village program targeted the older members of two of the most violent Latino gangs via two coordinated strategies: (1) increased probation department and police supervision and suppression to control violent or potentially hard-core violent youth; and (2) efforts to encourage at-risk youth to engage in conventional activities through education, jobs, job training, family support, and brief counseling. Preliminary evaluation results (after 4 years of program operation) point to a reduction in the rate of increase in gang violence in the Little Village area compared to the control area.

Still, effective prevention of gang involvement and gang activity remains a pressing challenge. In contrast to individual acts of violence that can be addressed by programs designed to reduce individual risk, gangs are also social organizations that provide an alternative option for youth competing for scarce resources in low-income neighborhoods. Social interventions that provide entry-level skills and low-paying jobs may simply not be able to compete with the social and economic opportunities provided by gangs. Similarly, harsher sentencing seems to exacerbate rather than prevent the problem, as gang members continue and escalate their gang activity in prison. A sustainable reduction in gang problems may require a focus on the multiple functions they serve and on programs that can provide reasonable and viable options for youth.

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Internet resources

Center for the Study and Prevention of Violence
http://www.colorado.edu/cspv

National Alliance of Gang Investigators Associations
http://www.nagia.org

National Criminal Justice Reference Service
http://www.ncjrs.org

National Institute of Justice
http://www.ojp.usdoj.gov/nij/

National Youth Gang Center
http://www.iir.com/nygc

Office of Juvenile Justice and Delinquency Prevention
http://www.ojjdp.ncjrs.org

US Department of Justice
http://www.usdoj.gov

Issue Brief

Youth Suicide

Introduction

Youth suicide is a major public health problem in the United States today. It is the third leading cause of death for youth between the ages of 15 and 24 years.[1] As such, the reduction of adolescent suicide is one of the major objectives of the Healthy People 2010 Initiative.[2]

Scope of the problem

Age and gender differences

Suicide is not a common phenomenon during childhood and early teens.[3] Suicide mortality increases considerably in the late teens, and the increase continues into the early 20s regardless of gender. Youth suicide is marked by a distinct gender difference; although females are more likely than males to attempt suicide, males are roughly five times as likely to commit suicide.

Differences by ethnicity

Generally, European-American youth have a higher prevalence of suicide than African-American, Latino, and Asian-American/Pacific Islander youth, except for American Indian/Alaska Native youth, who have the highest prevalence of suicide across all age groups. In particular, American Indian/Alaska Native males have the highest youth suicide rate in the United States, with substantial variation by factors such as tribal affiliation and geographical area.[4] Whereas research suggests that Latino youth are not overrepresented among completed suicides,[5] they are overrepresented among attempted suicides.[6]

Methods of youth suicide

In 1998, firearm death was the most prevalent method of suicide, regardless of age and ethnicity. In fact, firearm-related suicide accounted for more than 60% of all youth suicides. Moreover, firearm suicides more than tripled between 1981 and 1994. Although firearm-related suicide rates among youth have declined more than 20% between 1994 and 1998, the rates have still been high. The second and third most prevalent methods of youth suicide are hanging and poisoning, respectively. The gender difference in the rates of completed suicide is most likely accounted for by the differences in suicide methods. A greater proportion of female suicides is accounted for by poisoning than male suicides among youth, whereas firearms, which have higher lethality, account for a greater proportion of male suicides compared to females.

Secular trends

Although the overall suicide rate has declined during the past two decades, from 12.1 per 100,000 in 1979 to 11.3 per 100,000 in 1998, among male youth aged 15 to 19 years, the suicide rate increased during that period. However, more recently (1994 to 2001), there has been a decline in suicide rates among adolescent and young adult males. One speculation is that the decline is a consequence of more effective antidepressant medications for youth and a decrease in substance abuse,[7] but the exact reasons remain unknown.

Geographical distribution

In general, youth suicide mortality is highest in the Mountain states of the United States and lowest in the Middle Atlantic states.[8] The rate for 1996-1998 ranges from the lowest of 4.4 per 100,000 population (New Jersey) to the highest of 22.0 per 100,000 per population (Alaska). The differential youth suicide rates by geographical location may be related to differential ethnic diversity of the population and/or the availability of firearms by states.

Nonlethal suicide behaviors

The significance of youth suicide as a major public health problem is even more evident when considering the high rates of nonlethal suicidal behaviors such as attempted suicides and suicidal ideation. For example, it has been documented that 1 in 5 high school students report expressing suicidal ideation and 8% report having attempted suicide, of whom approximately 3% need medical attention.[3, 6, 9] It is noteworthy that these responses are not with regard to the entire lifespan of the responding high school student but, rather, within the last year. Whereas male youth have a higher

prevalence of completed suicide than female youth, female youth have a higher prevalence of suicidal ideation and attempts than their male counterparts.

Risk factors

Suicidal behaviors are complex. Past research has identified multiple risk factors associated with these behaviors.

Psychopathology

The majority of youth who have completed suicide had significant psychiatric problems, including depressive disorders and substance abuse disorders. Major depression has been the most prevalent condition.[10] Female youth suicide victims have a higher prevalence of an affective disorder than male suicide victims. Substance abuse is also a significant risk factor, especially for older adolescent male victims.[10] Substance abuse has consistently been a significant psychiatric risk factor when it is co-occurring with an affective disorder.[11]

Previous suicide attempts

One quarter to one third of youth suicide victims had made suicide attempts before the completed suicide. Moreover, the risk of completed suicide after suicide attempts is also higher. For male adolescents the risk is 30 times higher, whereas for female adolescents the risk is 3 times higher.[11]

Access to lethal methods

Firearms are the most common method of suicide among youth, and the youth's own home is the single most common location for firearm suicides to take place.[12] Associations have been found between the accessibility and availability of firearms in the home and the risk for youth suicide.[12, 13] Moreover, the availability of loaded guns has been associated with an elevated risk of youth suicide, regardless of presence of diagnosable psychiatric disorder(s).[12]

Maladaptive coping skills

Maladaptive coping skills and poor interpersonal problem-solving ability may limit the adolescent's ability to generate solutions to a problem, resulting in considering suicide as the only solution.[14] Suicidal youth experience a greater number of stressful life events compared with their nonsuicidal peers. Consequently, when negative stressors are compounded by other multiple negative events, problem-solving difficulties may become paramount.

Stressful life events

Multiple negative life events are typically experienced by adolescents who attempt and/or complete suicide.[15] These stressors are likely to overtax the adolescent's coping skills because of inexperience with such life situations.[16] Completed suicide among youth is associated with experiencing life stressors such as interpersonal losses (eg, breaking up with a boyfriend/girlfriend) and legal or disciplinary problems (eg, getting into trouble at schools or with a law enforcement agency).

Suicide contagion

A significant increase in the number of suicides occurs after the appearance of suicide stories in the mass media, including newspaper articles, television news reports, and fictional and non-fictional dramatization.[3] In particular, the influence of suicide stories on subsequent completed suicides is greatest for adolescents.[17] However, the linking of the media's report of suicide and prospective suicide rates dissipates for those beyond the age of 24.[18]

Family history

Although it is unknown exactly how familial psychopathology increases the suicide risk among youth, a family history of suicidal behaviors is known to elevate the risk of completed suicide in youth.[19] Additionally, parental psychopathology (depression and substance abuse) is associated with suicidal behaviors,[20] and completed suicide among youth.[19] Some suggest that the association between parental and youth suicide

may reflect a genetic factor rather than family dysfunction per se.[21]

Socioeconomic status

Little is known about the association between socioeconomic status (SES) and youth suicide. Gould and colleagues found a differential effect of ethnicity in comparing adolescent suicide victims with community controls.[19] These researchers found that only African-American suicide victims had a higher SES than their general population controls. Psychopathology such as untreated depression and substance abuse disorders is one of the major causes of adolescent suicide. However, a variety of barriers to seeking treatment exist especially among those with the low SES, thus elevating the risk for suicidal behaviors among youth. Some of these health disparities are accounted for by differences of gender, ethnicity, education level, income, disability, geographic location, or sexual orientation.

Acculturative stress

One feasible explanation for the higher risk of non-lethal suicidal attempts among Latino youth is that the risk is associated with the unique life experience of immigration. The association between psychopathology and suicidal behavior depends on the degree of acculturative stress. A higher level of suicide attempts has been associated with drug use among Latino youth who were experiencing greater acculturative stress, perceived discrimination, poor opportunities, and language difficulties.[22]

Sexual orientation

Research suggests that gay, lesbian, and bisexual (GLB) youth are at an elevated risk for attempting suicide.[20, 23] More GLB students report suicide attempts compared with their heterosexual counterparts. Research also suggests that GLB youth are at high risk for associated maladaptive risk behaviors, including fighting, victimization, and frequent use of alcohol and drugs.[24] These mental health problems and substance abuse disorders are crucial predisposing factors for suicide in GLB youth.

Biological risk factors

Research suggests that abnormalities in the serotonergic system are associated with suicidal behaviors, as well as impulsivity and aggression. For example, it has been found that low levels of serotonin among suicide attempters were predictive of future completion of suicide.[25]

Promising prevention strategies

Whereas advances in knowledge have led to increased understanding of the risk factors for child and adolescent suicide, applying this knowledge to the design of prevention strategies and program evaluation to examine effectiveness of suicide prevention programs has just begun. According to the Centers for Disease Control and Prevention, the main goal of youth suicide prevention strategies is twofold: risk factor reduction strategies and case-finding strategies.[9, 26]

Risk factor reduction strategies are primarily targeted at suicide prevention for youth and at the community. They include: (a) promoting overall mental health among school-aged youth by reducing early risk factors for depression, substance abuse, and aggression, and building resiliency (eg, self-esteem and stress management); (b) providing crisis counseling; and (c) restricting access to lethal means, especially handguns.

Promotion of mental health among school-aged youth is typically achieved by general suicide education and peer support programs. General suicide education is designed to develop healthy peer relationship and social skills among high-risk adolescents.[9] It provides youth with information about suicide, including its warning signs, and how to seek professional help for themselves or others. Crisis counseling through crisis centers and hotlines involves trained volunteers and paid staff providing counseling via phone or drop-by services for suicidal youth. "Postventions" are interventions after an incidence of both successful and unsuccessful suicide attempts. These programs aim at preventing suicide contagion and helping youth and family cope effectively with an interpersonal loss after a suicide. Restrictions

of access to lethal means are interventions designed to reduce a person's access to lethal means of completing suicide. Disposing of medications and removing and/or locking up firearms from the home of a suicidal adolescent are types of means restrictions.[9]

Case-finding strategies aim at detecting suicidal youth by referral to mental health care.[9] There are two general types of prevention strategies, active and passive. An example of an active strategy is the administering of screening programs (general screening or a targeted screening after a suicide). An example of a passive strategy is providing gatekeeper training for schoolteachers and community adults, providing general suicide education in schools, and offering crisis counseling. General education strategies often aim at reducing the stigma associated with accessing mental health care to increase self-referral and/or referrals by persons who recognize suicidality in someone they know.[9]

In screening programs, self-reports and individual interviews are administered to identify depression, alcohol or substance abuse problems, recent suicidal ideation, and past suicide attempts. Further detailed assessment and treatment are provided where necessary. Gatekeeper training involves educating and training adults in contact with suicidal youth such as school staff (eg, teachers, counselors, and coaches) and community members (eg, physicians, clergy, and police) to identify and refer children and adolescents at risk for suicide.[3] General suicide education is also categorized as a case-finding strategy because of its emphasis on gaining knowledge about suicide and its warning signs, including information about how and where to get professional help.

Overall, there is a shortage of evaluation studies on many ongoing prevention strategies. Restrictions of access to lethal means are considered the most promising. The findings for general suicide education curriculum in schools are equivocal. One ethical concern of general suicide education is that, while some programs reported shifts in desirable attitudes, other programs may increase maladaptive coping responses with a possibility of suicide contagion. Screening programs have been found to be effective in identifying high-risk students. There is a severe shortage of evaluation research for crisis centers and hotlines.

An evaluation of C-CARE and CAST

Suicide prevention programs often incorporate both case-finding and risk factor reduction strategies. For instance, Thompson and colleagues evaluated the efficacy of two indicated suicide prevention programs targeted at potential high school dropouts.[27] In this study, high school students who were identified as "at risk" for suicide participated in 1 of 3 interventions randomly assigned to schools: (1) counselors CARE (C-CARE), a comprehensive assessment of risk and protective factors followed by a brief intervention to improve a youth's personal resources and social network; (2) Coping and Support Training (CAST), a 12-session small-group skill-training (eg, problem-solving coping, personal control) and social support intervention added to the C-CARE; and (3) regular care control.

Questionnaire instruments were administered before the intervention, after C-CARE (4 weeks), after CAST (10 weeks), and at a 9-month follow-up. A significant decline occurred in attitudes toward suicide and suicidal ideation among students who received interventions. C-CARE and CAST were effective in reducing depression and hopelessness compared with regular care. Female students had a greater reduction than male students in anxiety and anger in response to these programs. CAST was most effective in enhancing and maintaining personal control and problem-solving coping strategy. Overall, the study demonstrated the feasibility and effectiveness of school-based prevention programs in reducing suicidal behaviors and associated distress and for enhancing resiliency among youth at risk for suicide.

Clearly, additional prevention efforts to reduce youth suicide need to be designed, implemented, and evaluated. Because of the enormous effort and financial cost involved in launching and maintaining programs, their efficacy and safety should be guaranteed before they

Youth Suicide *(continued)*

are promoted. The Centers for Disease Control and Prevention's recommendations include ensuring that prevention programs are matched with access to mental health resources in the community; incorporating several prevention strategies in developing programs; and incorporating rigorous scientific evaluation of studies, including planning, process, and outcome evaluations.[9]

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Internet resources

American Association of Suicidology
http://www.suicidology.org/index.html

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

US Department of Health and Human Services
http://www.dhhs.gov/

The Surgeon General's Call to Action to Prevent Suicide
http://www.surgeongeneral.gov/library/calltoaction/default.htm

Center for Disease Control and Prevention National Center for Injury Prevention and Control
http://www.cdc.gov/ncipc/

CDC's SafeUSA Guide to Preventing Suicide
http://www.cdc.gov/safeusa/suicide.htm

Suicide Statistics from CDC's National Center for Health Statistics
http://www.cdc.gov/nchs/fastats/suicide.htm

National Institute of Mental Health Suicide Fact Sheet
http://www.nimh.nih.gov/research/suifact.htm

NIMH Frequently Asked Questions About Suicide
http://www.nimh.nih.gov/research/suicidefaq.cfm

Selected Bibliography on Suicide Research—1999
http://www.nimh.nih.gov/research/suibib99.cfm

Depression in Children and Adolescents: A Fact Sheet for Physicians
http://www.nimh.nih.gov/publicat/depchildresfact.cfm

Section 6

Act Now Handouts

- What health professionals can do
- What families can do
- What youth can do
- What schools can do
- What law enforcement can do
- What the media can do
- What legislators can do
- What business and civic leaders can do
- What faith-based organizations can do

What Health Professionals Can Do to Prevent Youth Violence

- Become educated in firearms injury prevention, including adolescent assault, homicide, and suicide.
- Encourage training programs to provide undergraduate, graduate, and continuing education in the causes and prevention of violence and competencies in understanding and working with communities.
- Routinely screen for and counsel patients about firearm safety.
- Regularly screen for and treat or refer patients for help for alcohol and other drug abuse problems.
- Participate in practice-based violence research and advocate for resources to support research, including ongoing public health data collection and surveillance.
- Advocate for and adhere to practice guidelines or protocols for assessing high-risk violence situations and behaviors, appropriate treatment and referrals, and counseling and screening from the prenatal period through adulthood.
- Disseminate information about the root causes and risk factors for violence.
- Add to patient examinations a violence history that addresses exposure to violence; safety/security issues; effects of trauma; attitudes toward weapon carrying, aggression, and fighting; and stressors in the family and community.
- Strengthen the documentation of abuse and histories of family violence in both individual and group records.
- Volunteer to serve local schools as epidemiologists, health care providers, and crisis team members and local community prevention initiatives as mentors, supervisors, and advocates.
- Establish a network of referral services to make it easier for youth and their parents or caretakers to access resources.
- Advocate for public policies and resources to address the sources of violence.
- Promote the use of family-based strategies such as multisystemic therapy and functional family therapy for troubled youth.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago, IL: American Medical Association; 2000:28.

Where to go to get started:

Visit the National Youth Violence Prevention Center on-line at
http://www.safeyouth.org/home.htm

Or a regional Center of Excellence on Youth Violence Prevention at
http://www.stopyouthviolence.ucr.edu/resource_agencies/cdc.html

What Families Can Do to Prevent Youth Violence

- Act as role models, settle conflicts nonviolently.
- Take an active role in their children's school; talk regularly with teachers; volunteer.
- Maintain two-way communication with their children; talk with them about violence they may have witnessed.
- Do not keep firearms or keep them safely stored and locked up with ammunition stored separately.
- Initiate or participate in community or school violence prevention groups.
- Monitor/supervise their children's use of the Internet, television, reading material, movies, music, and video games.
- Seek out support groups to improve parenting skills and manage anger, if needed.
- Establish and enforce household rules and reward positive behavior.
- Demand involvement in violence prevention programs initiated by schools and communities and in disciplinary actions imposed on their own children.
- Supervise the activities of their children; know their schedule and their friends.
- Urge their children to participate in organized after-school activities provided by responsible groups.
- Practice zero tolerance for bullying in the family and take proactive steps to eliminate bullying in schools.
- Provide foster homes and safe havens for abused children.
- Encourage community service.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago, IL: American Medical Association; 2000:30.

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What Youth Can Do to Prevent Youth Violence

- Speak out against bullying at home and at school.
- Report all incidents of bullying to school authorities, parents, or other responsible adults.
- Mentor younger students.
- Participate in organized and supervised recreational, educational, and cultural after-school programs.
- Talk to a responsible person—physician, teacher, clergy, counselor, parent, or friend—about violence they witness or experience.
- Act as a role model for other children and adolescents in refusing to have anything to do with firearms, alcohol, and illicit drugs.
- Promote television programs, movies, music, and video games that portray nonviolent alternatives to conflict resolution.
- Become involved in violence prevention programs offered by the community, church, or school.
- Encourage friends who seem depressed or angry to seek help from a parent, physician, teacher, counselor, or member of the clergy.
- Talk with friends and family members about concerns about violence and its effects in their lives.
- Seek opportunities for community service.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago, IL: American Medical Association; 2000:32.

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What Schools Can Do to Prevent Youth Violence

- Create a school-wide ethos that fosters positive discipline, academic success, and mental and emotional wellness.
- Intervene early with the 10% to 15% of students at risk for severe academic or behavioral problems.
- Directly provide or arrange for immediate and intensive intervention for problem students in the form of coordinated, comprehensive, sustained, and family-focused services.
- Eliminate bullying and promote tolerance.
- Improve awareness and communication, so that children are knowledgeable about the signs of mental illness and violence and the importance of telling a responsible adult when they see troubling behavior in classmates.
- Appoint multidisciplinary teams to design and implement comprehensive violence prevention and response plans.
- Be active participants in community discussions and decisions on violence prevention.
- Enlist law enforcement professionals in the development of a school safety plan that addresses weapons and drug search policies; visitor protocols; use of screened and trained parents as volunteer monitors; positive incentives for good school citizenship; suspension and expulsion policies; and codes of student conduct.
- Involve parents in all school activities.
- Encourage participation in on-site after-school programs by offering such programs free or providing scholarships and transportation and by partnering with external program sponsors.
- Implement a school health program that features comprehensive health education; provide counseling and social services; ensure a safe physical and psychosocial environment; and promote family and community involvement.
- Advocate for smaller schools that counter competitive pressures and social isolation.
- Promote on-site screening and intervention, including mental health care services for trauma, loss, use of alcohol and other drugs, and abuse.
- Integrate violence prevention into all curriculum levels; teach conflict resolution; and encourage community service.
- Make parenting classes mandatory.
- Ensure that all students, including those who violate disciplinary codes, are in either regular or alternative classrooms rather than on the street.
- Expand access to alcohol and drug dependency treatment programs.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago, IL: American Medical Association; 2000:28.

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What Law Enforcement and the Justice Community Can Do to Prevent Youth Violence

- Actively enforce laws that reduce youth access and exposure to firearms, alcohol, and illicit drugs.
- Work with schools and parents to promote the removal of firearms from environments in which children live and play.
- Help school personnel perform security surveys of their facilities.
- Consult with schools about security on an ongoing basis.
- Train the entire school community in personal safety.
- Develop partnerships with area schools.
- Work with schools and parents to lower truancy rates.
- Serve on school disciplinary action assessment teams.
- Provide comprehensive information about the consequences of violence.
- Provide comprehensive screening for youth entering the juvenile justice system in order to facilitate early intervention for problems.
- Provide intake officers with tools to distinguish between serious/less serious and occasional/frequent juvenile offenders.
- Promote the use of unified family courts that handle the full range of family-related cases, including family violence, mental health, delinquency, and dependency.
- Institute Court Appointed Special Advocate Programs (CASAs), which use trained volunteers (guardians *ad litem*) to stabilize the lives of victimized children.
- Enhance local efforts to investigate and prosecute child abuse and neglect cases and strengthen child protective services.
- Include alcohol and mental health assessment and mandatory treatment in all criminal justice responses to children and youth.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago: The American Medical Association. 2000;29.

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What the Media Can Do to Prevent Youth Violence

- Minimize the sensationalist aspects of coverage of school crime; place such crimes in statistical context.
- Reinforce anti-violence messages and ideas provided by schools and communities.
- Portray the consequences of violence realistically.
- Provide parents and other adult caretakers of children with guidelines to help them supervise and monitor their children's use of the media.
- Promote and participate in community coalitions for the prevention of youth violence.
- Promote and publicize anti-violence programs, policies, and community efforts.
- Facilitate community discussion forums about violence prevention.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago: American Medical Association. 2000;30.

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What Legislators Can Do to Prevent Youth Violence

- Enact meaningful gun control legislation designed to limit children's access to firearms.
- Mandate full health and mental health care coverage for all children.
- Enact legislation mandating parity for coverage of comprehensive mental health care services.
- Fully fund early intervention and prevention programs, including early childhood development.
- Encourage collaboration and coordination among education, mental health, social service, and juvenile justice agencies.
- Support comprehensive and coordinated school health care services, including mental health care.
- Enact legislation to address the physical and mental health care needs of detained and incarcerated youth.
- Ensure access to and availability of long-term programs in prevention, education, screening, and treatment of alcohol and other drug abuse.
- Support public education on media influences on violence.
- Ensure screening and appropriate intervention and treatment for abuse, neglect, and alcohol and other drug abuse for all youth entering the juvenile justice system, for all children of violent adult offenders, and for siblings of youth offenders.
- Support improved access to and availability of community mental health care services, including education, screening, and early intervention for victims, perpetrators, and witnesses of violence.
- Support the inclusion of violence reduction criteria in the education and training of teachers, administrators, and school staff.
- Re-establish and strengthen the mandate of juvenile judges to use discretion and creativity in sentencing children and adolescents.
- Support access to and availability of after-school programs to create safe places for elementary and secondary school children.
- Ban the use of corporal punishment in schools, juvenile facilities, child care facilities, and all other institutions where children are cared for and educated.
- Establish a comprehensive national, state, and local data collection and surveillance system for tracking intentional and unintentional injuries.
- Urge congressional support for a national violence prevention campaign involving all media.
- Urge federal support for violence prevention research.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago: American Medical Association. 2000;31.

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What Business and Civic Leaders Can Do to Prevent Youth Violence

- Promote and participate in community efforts to prevent youth violence. Assign responsibility for prevention education, screening, and early intervention to an existing agency or coalition or establish a new public entity for this purpose.
- Adopt a school and become involved in its programs and activities.
- Develop creative arts and media competitions with an anti-violence theme.
- Help students access job skill development, part-time employment, and internships.
- Advocate for violence prevention and intervention program funding.
- Ensure that all parents have access to affordable parenting skills programs.
- Promote firearm safety to prevent firearm-related injuries to young people. This includes safe storage and handling as well as the removal of firearms from homes of children with mental health problems.
- Develop scholarship programs to promote and reward academic success.
- Encourage employees to become involved in school activities and provide the flexibility for them to do so.
- Provide services, facilities, and equipment to enhance violence prevention and youth development programs in schools.
- Serve as mentors for youth at risk for or involved in violence in the community.
- Support Head Start programs for all children.
- Ensure proper training and technical assistance for agencies serving children and families.
- Promote a reduction in the amount of alcohol consumption in the community through environmental interventions such as limiting alcohol at sports events and increasing the cost of alcohol.
- Provide foster homes and safe havens for abused children.
- Provide local youth with opportunities for community service.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago: American Medical Association. 2000;29.

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What Faith-Based Organizations Can Do to Prevent Youth Violence

- Promote and participate with other groups in community coalitions for the prevention of youth violence.
- Encourage children and adolescents to talk openly with responsible adults about their concerns about violence.
- Provide or support parenting classes and programs that promote parent-child interaction.
- Teach social tolerance, model ethical behavior, and promote empathy among children.
- Establish a mentoring program to foster supportive relationships between youth and responsible adults.
- Provide recreational services and after-school programs for children and adolescents.
- Work with local law enforcement to provide creative alternatives to detention for young offenders.
- Hold meetings and symposia where concerned adults and children can come together to address violence-related issues in the community.
- Provide foster homes and safe havens for abused children.

Excerpted from The Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing and Public Health: Connecting the Dots to Prevent Violence.* Chicago: American Medical Association. 2000;31.

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Section 7

Resources: Professional and Patient/Family

Professional:

- Resources for Health Professionals
- Patient Assessment Tool

Patient/Family:

- Myths and facts about violence and how you can help prevent it
- Teaching the basics of violence prevention
- When children witness violence in the home
- Violence prevention in the home
- Time-out
- Key education points on firearm injury and death
- Pulling the plug on TV violence
- You are the experts on raising "violence-free" children: a guide for parents

Resources: Professional

Resources for Health Professionals

Recommended publications for health professionals:

Commission for the Prevention of Youth Violence. *Youth and Violence: Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence.* Chicago, IL: American Medical Association; 2000. The report can be accessed online at: http://www.ama-assn.org/violence. Hard copies are available at no cost from the American Medical Association by calling 312 464-4526.

Sege R, Licenziato V, eds. *Recognizing & Preventing Youth Violence: A Guide for Physicians & Other Health Care Professionals.* Waltham, MA: Massachusetts Medical Society;2001. The full guide can be accessed online at: http://www2.mms.org/pages/youthviolence.asp. Hard copies are available for $7.00 each by calling 800 843-6356.

US Department of Health and Human Services. *Youth Violence: A Report of the Surgeon General.* Rockville, MD: Department of Health and Human Services; 2001. This report can be accessed online at: http://www.surgeongeneral.gov/library/youthviolence/default.htm.

Resources for screening and risk identification

Sege R, Stringham P, Short S, Griffith J. Ten years after: examination of adolescent screening questions that predict future violence-related injury. *J Adolesc Health.* 1999;24: 395-402. This article describes the validation of a three-item questionnaire to identify risk for violence among young persons.

FISTS (Fighting, Injuries, Sex, Threats, and Self-Defense) - This mnemonic is used to identify a young person's level of risk for involvement in violence. Alpert E, Sege R, Bradshaw YS. Interpersonal violence and the education of physicians. *Acad Med.* 1997;72:S41-S50.

HEADS (Home, Education, Activities/ Abuse, Drugs, Sex, and Suicide) - A commonly used mnemonic that includes assessment of a youth's risk for involvement in serious violence. More information can be found in: Schubiner H. Preventive health screening in adolescent patients. *Prim Care.* 1989;16:211-230.

Resources for patient education

American Academy of Child and Adolescent Psychiatry (AACAP) - The AACAP has launched a Violence Initiative to assure that child and adolescent psychiatrists join the effort to prevent violence. The AACAP's Web site provides youth violence-related *Facts for Families,* which can be accessed at http://www.aacap.org/clinical/violence.htm.

American Academy of Pediatrics (AAP) has many violence prevention resources for health care professionals including resources on media literacy training for physicians and patients. Information can be found at http://www.aap.org/advocacy/mediamatters.htm and http://www.aap.org/advocacy/violence.htm.

American Medical Association (AMA) - Physician guidelines developed by the AMA on media violence, firearm violence, and family violence can be accessed online at http://www.ama-assn.org/ama/pub/category/3242.html.

American Psychological Association (APA) - The APA has developed a number of violence prevention resources. Parent information material titled *Raising Children to Resist Violence* can be accessed at http://www.apa.org/pi/pii/raisingchildren.html.

The Children's Safety Network (CSN) - Funded by the Health Resources and Services Administration (HRSA) and administered through the Maternal and Child Health Bureau, the CSN has produced a series of violence prevention information resources for parents and health professionals. Parent education material can be accessed at http://www.edc.org/HHD/csn/PDF/Parents0.pdf.

Resources for Health Professionals *(continued)*

Referral resources

Center for the Study and Prevention of Violence (University of Colorado at Boulder) - "Blueprints" is a national violence prevention initiative to identify and replicate effective violence prevention programs. More information can be found at http://www.colorado.edu/cspv/blueprints/Default.htm.

National Center for Injury Prevention and Control - Thornton T, Craft C, Dahlberg LL, Lynch B, Baer K. *Best Practices of Youth Violence Prevention: A Sourcebook for Community Action*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2000. One free copy can be obtained by calling 888 252-7751; the sourcebook also can be downloaded from http://www.cdc.gov/ncipc/dvp/bestpractices.htm.

Partnerships Against Violence Network (PAVNET) - PAVNET has a "virtual library" of information about violence and youth-at-risk, representing data from 7 different federal agencies. It provides a searchable database for promising programs and curricula on violence prevention. For more information on PAVNET, visit them at http://www.pavnet.org/.

For more information and training

Academic Centers of Excellence in Youth Violence Prevention. In 2000, the Centers for Disease Control and Prevention funded 10 Academic Centers of Excellence in Youth Violence Prevention. Each Center is developing resources for health professional training in youth violence prevention. Contact information is available at http://www.stopyouthviolence.ucr.edu.

Knox L. *Youth Violence and the Health Professions: Core Competencies for Effective Practice*. Riverside, CA: Southern California Developing Center for Youth Violence Prevention; 2001.

This report outlines the recommendations of an expert panel on the training needs of health professional training in youth violence prevention. It can be accessed online at http://www.stopyouthviolence.ucr.edu/health_care/articles.html.

National Youth Violence Prevention Resource Center (NYVPRC) - The NYVPRC is the national clearinghouse for information on youth violence and its prevention. Information is available online at http://www.safeyouth.org or call the center at 866-SAFEYOUTH (723-3968).

Patient Assessment Tool

Screening tools and mnemonics are being developed for use in the health care setting to identify youth at risk for or involved in violence and to help make appropriate referral decisions. Most tools are still being validated and are limited for use with adolescents. As resources become available for risk identification in younger children, consider incorporating these into your practice as well.

FISTS

FISTS is a mnemonic that has been successfully adapted for clinical practice. It is a practical screening tool that can be used to ask youth about fighting, injuries, sex, threats, and self-defense. Based on a risk determination, the physician can choose an intervention strategy and make appropriate referrals. Use of this tool provides an opportunity to discuss nonviolent solutions for problem solving and conflict resolution with young patients and their families.

Fighting

- How many fights have you been in during the past year?
- When was your last fight?

Try to get a detailed account of the fight once the adolescent discloses such information. Ask if a weapon was involved and how the fight was started, and explore with the adolescent if there was a nonviolent way to resolve the conflict.

Injuries

- Have you ever been injured in a fight?
- Have you ever injured someone else in a fight?

By asking these two questions, physicians can assess the severity of any previous fights. Patients who have been injured in a fight are more likely to have unresolved conflicts and be re-injured in the future.

Sex

- Has your partner ever tried to hit you?
- Have you ever hit or hurt your partner?
- Have you ever been forced to have sex against your will?
- Do you think that couples stay in love when one partner makes the other one afraid?

Sometimes adolescents are hesitant to talk about violent relationships. They may be embarrassed or may not have had experience with healthy relationships; they may not even be aware that a relationship is unhealthy.

Threats

- Has someone carrying a weapon ever threatened you?
- What happened?
- Has anything changed since then to make you feel safer?

Use these questions to assess how a youth reacts to a threatening situation, and the likelihood that he or she will be a perpetrator or victim of future violence. The more explosively youth act in these situations, the more likely they are to be involved in violence.

Self-defense

- What do you do if someone tries to pick a fight with you?
- Have you ever carried a weapon in self-defense?

When you ask about weapons in the context of self-defense, you will receive more candid responses. A youth who carries a firearm should be considered at high risk for lethal violence. Carrying a knife, especially a small pocketknife, is not as clearly identified with violent behavior.

Patient Assessment Tool *(continued)*

Assessing the level of risk

After obtaining the violence history, the physician can estimate the adolescent's risk for involvement in violence as low, moderate, or high. This information can be used to select interventions and make appropriate referrals for the youth and his or her family.

Low-risk youth:

- Have not been in a fight in the past year.
- Do not report the use of drugs.
- Are passing courses in school.
- Do not carry weapons.

Reinforce low-risk behavior, and ask how the young person avoids a fight when resolving a conflict.

Moderate-Risk Youth:

- Talk about recent fights.
- Are struggling with school work.
- Report other behavior that the health care professional identifies as risky.

Discuss the most recent fight and ideas to defuse future situations, such as anger management. Consider referring this adolescent to a counselor to discuss risk issues and behavior. Ask the teen for his or her consent to discuss intervention ideas with parents or caretakers.

High-risk youth:

- Are in more than four physical fights.
- Are failing or dropping out of school.
- Carry a weapon.
- Report illicit drug use.

Discuss recent incidents of fighting with the youth and with his or her family. Discuss different ways to avoid future confrontations such as walking away and anger management. High-risk adolescents may require interventions that are beyond the scope of the primary provider, including referral for more specialized mental health and social services.

Information on the FISTS mnemonic was adapted and reproduced with permission of the Association of American Medical Colleges. Alpert EJ, Bradshaw YS, Sege, RD. Interpersonal violence and the education of physicians. *Acad Med*. 1997;42:546.

Some Myths and Facts about Violence and Tips on How You Can Help Prevent It

Myth: Most homicides result from drug dealing-related crimes.

Fact: According to the FBI, less than 40% of violent deaths are associated with another crime. Most violence, including homicide, results from arguments or conflicts between friends, acquaintances, or lovers.

Myth: Most violence is racially motivated.

Fact: Most assaults and murders involve two people of the same race.

Myth: Carrying a gun gives protection.

Fact: Carrying a weapon can result in a sense of boldness that leads to foolish behaviors. If another person sees the gun, he or she may draw and shoot first. Carrying a gun can give a false sense of protection; it may actually make a person less safe!

Myth: "I would be safer with a gun in my home because there is so much violence."

Fact: A person with a gun at home is nearly 3 times more likely to be killed than a neighbor who doesn't have a gun. Shootings at home often occur when a friend or family member is mistaken for an intruder, when a fight between a husband and wife or boyfriend or girlfriend gets out of control, or when a child finds a gun. All have potentially deadly consequences.

Myth: Young children don't use guns.

Fact: Young children may not know the difference between toy guns and real guns. Their curiosity is stronger than their awareness of danger; they need protection from guns. Even young children are strong enough to pull the trigger.

Myth: Adolescent violence is an inner-city problem.

Fact: Violence occurs throughout America. Firearm injuries are the number one cause of injury-related death in 7 states and the District of Columbia. The federal government estimates that by the year 2003, they will be the leading cause of injury-related death in all states.

Violence is associated with poverty. Since half of all African-American teenagers live in poverty, violence rates among black adolescents are high, but they are also high among poor white Americans.

Myth: Kids who fight well—the ones who are good with their hands—are safest.

Fact: The safest, most popular kids are problem solvers. They know how to use their minds and mouths to solve problems, rather than their fists. Kids who fight a lot—even if they're good at it—eventually run into someone who is armed.

Myth: In order to gain respect from peers, boys have to be willing to fight.

Fact: Youths who are neither bullies nor aggressors—who are called problem solvers by peers—are the most successful and popular kids in school.

To change behavior, it is important to identify the risk factor(s) that apply to that child. The following are some specific tips for counseling youth at risk for violence.

Tip: When a youth gets into a fight, always ask how the fight started, not how it ended. Help youth think about what led up to and caused the fight and help them find alternative words or actions that could have prevented the fight. In the long run, a youth will be safer by avoiding fights through problem solving than by winning them. Teach children how to resolve their differences and conflicts in nonviolent ways.

Some Myths and Facts about Violence and Tips on How You Can Help Prevent It *(continued)*

Tip: The safest home for the children is a home without handguns. If a gun is in the home, it must be kept unloaded and locked with the ammunition stored and locked separately.

Tip: Encourage youth to develop other skills and interests in order to reduce the amount of time spent watching violence on television and in the movies.

Tip: Support initiatives to get guns off the streets and out of the hands of children.

Tip: Get involved in your neighborhood.

Tip: Encourage schools to teach youth about conflict resolution, to set up peer mediators, and to teach youths the truth about violence.

Tip: Be aware of warning signs for post traumatic stress disorder (PTSD). Previously associated with war veterans, PTSD is now evident among children and youth who have experienced or witnessed violence. Some of the warning signs are reliving the event, avoiding behaviors, decreased interest in usual activities, trouble sleeping, outbursts of anger, nightmares, numbing of feelings, and difficulty concentrating. Anyone experiencing symptoms of PTSD can get help by contacting a health care provider or a violence prevention counselor.

Reproduced with permission of the Massachusetts Medical Society, "Some Myths and Facts About Violence and Tips on How You Can Help." Sege R, ed. *Violence Prevention for Children and Youth: Parent Education Cards*. Waltham, MA; Massachusetts Medical Society; 2000. To order copies of this tip card, contact the Massachusetts Medical Society, Public Health and Education, 860 Winter Street, Waltham, MA 02451-1411; phone: 800-322-2303; e-mail: dph@mms.org

Teaching the Basics of Violence Prevention

Violence is becoming a more frequent occurrence in today's society. Children are being exposed to more violence in their communities and schools. Conflict resolution and violence prevention are important subjects to discuss with your children. This information can help guide these discussions and offers practical advice that you and your child can use in everyday situations.

It is important that you and your children learn to take precautions against becoming the victims of a violent crime. Here are some important steps that you can take to keep yourself and your children safe:

- Teach your children safe routes for walking in your neighborhood.
- Encourage them to walk with a friend at all times and only in well-lighted, busy areas.
- Stress how important it is for them to report any crimes or suspicious activities they see to you, a teacher, another trustworthy adult, or the police. Show them how to call 911 or the emergency service in your area.
- Make sure they know what to do if anyone tries to hurt them: Say "no," run away, and tell a reliable adult.
- Stress the dangers of talking to strangers. Tell them never to open the door to or go anywhere with someone they don't know and trust.

It is important to support your children in standing up against violence. Teach them to respond with calm but firm words when others insult, threaten, or hit another person. Help them understand that it takes more courage and leadership to resist violence than to go along with it.

Help your children accept and get along with others from various racial and ethnic backgrounds. Teach them that criticizing people because they are different is hurtful, and that name-calling is unacceptable. Make sure they understand that using words to start or encourage violence—or quietly accepting violent behavior—is harmful. Warn your child that bullying and threats can be a setup for violence.

In addition to offer guidance about conflict resolution, parents should act as role models for healthy problem solving. Keep in mind that children often learn by example. The behavior, values, and attitudes of parents and siblings have a strong influence on children. Values of respect, honesty, and pride in your family and heritage can be important sources of strength for children, especially if they are confronted with negative peer pressure, live in a violent neighborhood, or attend a rough school.

Most children act aggressively sometimes and may hit another person. Be firm with your children about the possible dangers of violent behavior. Remember also to praise your children when they solve problems constructively without violence. Children are more likely to repeat good behaviors when they are rewarded with attention and praise. You can teach your children non-aggressive ways to solve problems by:

- Discussing problems with them
- Asking them to consider what might happen if they use violence to solve problems
- Talking about what might happen if they solve problems without violence

This kind of "thinking out loud" together will help children see that violence is not a helpful solution. Parents sometimes encourage aggressive behavior without knowing it. For example, some parents think it is good for a boy to learn to fight. Teach your children that it is better to settle arguments with calm words, not fists, threats, or weapons.

Help your children learn constructive, nonviolent ways to enjoy their free time. Teach them your favorite games, hobbies, or sports, and help them develop their own talents and skills. Read stories to younger children, take older children to the library, or tell family stories about admired relatives who have made the world a better place.

Teaching the Basics of Violence Prevention *(continued)*

Hitting, slapping, or spanking children as punishment shows them that it's okay to hit others to solve problems and can train them to punish others in the same way they were punished. Physical punishments stop unwanted behavior only for a short time. Even with very harsh punishment, children may adapt so that it has little or no effect. Using even more punishment is equally ineffective.

Nonphysical methods of discipline help children deal with their emotions and teach them nonviolent ways to solve problems. Here are some suggestions:

- Give children a "time out"—making them sit quietly, usually 1 minute for each year of age (this is not appropriate for very young children).
- Take away certain privileges or treats.
- "Ground" them and don't allow children to play with friends or take part in school or community activities (this is only appropriate for older children or adolescents).

Punishment that involves taking away privileges or "grounding" should be consistently applied for realistic, brief periods.

Children need to feel that if they make mistakes, they can correct them. Show them how to learn from their errors. Help them figure out what they did wrong and how they can avoid making similar mistakes in the future. It is especially important not to embarrass or humiliate your children at these times. Children always need to feel your love and respect.

A positive approach to changing behaviors is to emphasize rewards for good behavior instead of punishments for bad behavior. Remember that praise and affection are the best rewards.

It's also helpful to stay involved in your community. A network of friends, neighbors, and family can offer fun, practical help, and support when you have difficult times. Reducing stress and social isolation can help in raising your children.

Get involved in your community and get to know your neighbors. Try to make sure guns are not available in your area as well. Volunteer to help in your neighborhood's anti-crime efforts or in programs to make schools safer for children. If there are no programs like this nearby, help start one!

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When Children Witness Violence In the Home

Helping children cope

Children can be deeply affected by violence in the community and at home. They see violence on TV and in video games, and hear it in music. Children may also witness fights that involve yelling, screaming or hitting. Sometimes these fights end with someone getting hurt, badly beaten, or even shot. But witnessing violence at home is especially troubling for children.

Did you know that:

- Children see, hear, and remember more than adults think they do. Parents may think that their children are asleep or watching TV, but children often know when their parents are fighting.
- Children react differently at different ages, but ALL children—even infants and toddlers—can be affected by witnessing violence.

How children react when they see or hear violence

Children may react immediately to the violence they witness; however, some will have a delayed response. Symptoms vary by age and personality, but these are some of the common reactions children might have:

- Difficulty with sleeping, poor appetite, stomachaches, nightmares, and bed-wetting
- Becoming fearful or moody
- Worrying about the safety of loved ones
- Finding it hard to concentrate, learn, and behave in school
- Trouble making or keeping friends
- Running away
- Involvement with drugs and alcohol

How you can help

Help children talk about violence with a trusted adult. When children can share their worries and fears with a parent, relative, teacher, school counselor, clergy member, or family friend, they will feel less frightened and alone. It may be hard for children to begin talking about the violence they have witnessed. Sometimes children blame themselves for the violence they see and hear. Tell the child: "The violence is not your fault."

Remember:

- Children who witness violence can become frightened. They should have a chance to talk to someone about what they are thinking and feeling.
- Doctors and other health professionals can help parents learn how to raise children in a home without violence.
- The goal is for everyone—children and adults—to live in a world without violence.

For additional information or help when you know someone is being hurt or feels afraid, contact your doctor or call: Parental Stress Line: 800 632-8188; National Domestic Violence Hotline: 800 799-SAFE (7233); and/or Massachusetts Society for the Prevention of Cruelty of Children (MSPCC): 617 587-1500.

Reproduced with permission of the Massachusetts Medical Society, "When Children Witness Violence in the Home: Helping Children Cope." Sege R, ed. *Violence Prevention for Children and Youth: Parent Education Cards*. Waltham, MA: Massachusetts Medical Society, 2000. To order copies of this tip card, contact the Massachusetts Medical Society, Public Health and Education, 860 Winter Street, Waltham, MA 02451-1411; phone: 800 322-2303; e-mail: dph@mms.org

Violence Prevention in the Home

Introduction

- Guns and children can be a deadly combination. Teach your children about the dangers of firearms or other weapons if you own and use them. If you keep a gun in your home, unload it and lock it up separately from the bullets. Never store firearms, even if unloaded, in places where children can find them.
- Don't carry a gun or a weapon. If you do, this tells your children that using guns solves problems.
- Violence in the home can be frightening and harmful to children. Children need a safe and loving home where they do not have to grow up in fear. Children who have seen violence at home do not always become violent, but they may be more likely to try to resolve conflicts with violence.
- Work toward making home a safe, nonviolent place and always discourage violent behavior between brothers and sisters. Keep in mind as well that hostile, aggressive arguments between parents frighten children and set a bad example for them.
- If the people in your home physically or verbally hurt and abuse each other, get help from a psychologist or counselor in your community. He or she will help you and your family understand why violence at home occurs and how to stop it.
- Sometimes children cannot avoid seeing violence in the street, at school, or at home, and they may need help in dealing with these frightening experiences. A psychologist, counselors at school, and a religious leader are among those who can help them cope with their feelings.
- Seeing a lot of violence on television, in the movies, and in video games can lead children to behave aggressively. As a parent, you should control the amount of violence your children see in the media.

Here are some ideas to prevent violence in the home:

- Limit television viewing time to 1 to 2 hours a day.
- Make sure you know what television shows your children watch, which movies they see, and what kinds of video games they play.
- Talk to your children about the violence that they see on television shows, in the movies, and in video games. Help them understand how painful it would be in real life and the serious consequences for violent behaviors.
- Discuss with your children ways to solve problems without violence.

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Time-Out

How do I use a time-out?

When your child does something good, be sure to offer praise: "I'm proud of you!" or "Good job!" However, every child occasionally needs to be disciplined. A time-out is a form of discipline that can be used when your child does something wrong on purpose. So, every time your child breaks an important rule make him or her take a time out. Make sure all other adults (parents, grandparents, baby-sitter) use the same rules.

To use a time-out:

- Warn your child: "If you don't stop, you'll have a time out!"
- When your child ignores the warning, have your child go to a quiet place (like a corner of a room) and start the timer.
- Explain the reason for the time-out: "You hit your sister. That's not allowed. Now you must have a time-out."

How long does a time-out last?

It lasts 1 minute for each year of age:

Two-year-old.....2 minutes

Three-year-old.....3 minutes

Four-year-old.....4 minutes

Five-year-old..... 5 minutes

If it's too long, young children forget why they are there!

If your child leaves the time-out area, have your child go back. You need to restart the timer and explain the need to stay put until the time-out is over.

Why use time-outs?

- Young children respond best to praise for good behavior. However, sometimes they need to have limits set for them. Time-outs let you do this safely and effectively.
- Sometimes, children misbehave just to get your attention. A time-out teaches your child that misbehaving is not a good way to get attention.
- A time-out stops the situation that led your child to misbehave in the first place.
- Children copy their parents. For example, if parents spank their child for hitting a brother or sister, the child gets a mixed message: "Mommy and Daddy can hit, but I can't."

Reproduced with permission of the Massachusetts Medical Society, "Time-Out!" Sege R, ed. *Violence Prevention for Children and Youth: Parent Education Cards*. Waltham, MA: Massachusetts Medical Society; 2000. To order copies of this tip card, contact the Massachusetts Medical Society, Public Health and Education, 860 Winter Street, Waltham, MA 02451-1411; phone: 800-322-2303; e-mail: dph@mms.org.

Resources: Patient/Family

Key Educational Points on Firearm Injury and Death

- A firearm in the home is more likely to result in a death during a household quarrel, a suicide attempt, or an unintentional shooting than in protecting members of the household.
- Firearms are especially dangerous in homes where children are living, someone in the household abuses alcohol or other drugs, there is a person with depression, or there is any family violence.
- If a firearm is kept in the home, it should be kept unloaded and securely stored locked up, with ammunition stored separately.
- Children should be taught never to play with firearms anywhere and to seek an adult immediately if they encounter one.
- Parents should ask about the presence and accessibility of firearms in homes their children will be visiting and restrict visits to homes that are not safe.
- Firearms that are no longer desired should be turned in to local law enforcement authorities or made unusable, but only by a professional properly trained to render the firearm inoperative and safe.
- Children and adolescent should be taught to resolve conflicts nonviolently.
- Parents should monitor children's use of television and other media and block access to messages that glorify firearm use or justify irresponsible firearm use. If children are exposed to such messages, parents should draw attention to the behaviors as undesirable and/or maladaptive and highlight the suffering caused to victims and their loved ones.
- Family members should remove firearms from the home when a member becomes depressed, develops a major mental illness, has a drug or alcohol problem, or is exhibiting memory problems.
- Family members should remove firearms from the home if there is an escalating pattern of family violence.
- Patients should discuss firearm safety and health-related issues with their doctors and other health care providers.
- If the decision is made to own a firearm, be sure to learn all about handling, storing, securing, cleaning, carrying, and firing the weapon safely.

Pulling the Plug on TV Violence

Facts and tips for parents

Some disturbing facts regarding TV violence

- Did you know that television teaches your child about violence? As adults, we know that real violence causes pain and sadness, but on TV, violence is often painless, and sometimes funny. American children see over 12,000 violent acts per year on TV. And some of the most violent shows are children's shows!
- TV characters often use violence to solve problems. Children need to learn how to solve problems in a nonviolent way.
- Just as children learn from brothers and sisters, they also learn from their TV heroes—both good and bad habits. According to experts in the field:
  - – Some children learn to fight by watching violence on TV
  - – Other children learn to become victims
  - – Many learn that violence is fun to watch and, as a result, friends encourage friends to fight

Helpful tips for parents and caregivers

- Limit your child's TV watching to 2 hours a day or less.
- Know what your child is watching. Help your child choose programs that are less violent.
- Don't put a TV in your child's room. You won't know what programs your child is watching or how much time is spent in front of the TV.
- When you're watching a program that has violence, don't allow your child to watch it with you.
- Stop unauthorized viewing with a blocking device if necessary.
- Watch programs with your child. If a program contains violence, talk about it with your child and ask:
  - – Is this real or pretend?
  - – Is this the way to solve a problem
  - – What would happen if you did that?
- Tell your child how you feel about violence.
- Tell your child that real violence is painful and makes people sad and angry.

"Pulling the Plug on TV Violence: Facts and Tips for Parents" is reproduced with permission of the Massachusetts Medical Society. Sege R, ed. *Violence Prevention for Children and Youth: Parent Education Cards*. Waltham, MA: Massachusetts Medical Society; 2000. To order copies of this tip card, contact the Massachusetts Medical Society, Public Health and Education, 860 Winter Street, Waltham, MA 02451-1411; phone: 800-322-2303; e-mail: dph@mms.org

Resources: Patient/Family

You are the experts on raising violence-free children

A guide for parents

You have the most power to keep your child free from violence when you spend time, show love, and communicate well with your child about:

- Respect
- Education and personal achievement
- Substance abuse
- Gangs
- Guns
- Bullying
- Dealing with emotions
- Peaceful solutions
- Witnessing violence

Do you know these facts about violence?

- Homicide is the second leading cause of death for teenagers.
- It is the No. 1 cause of death for black teens.
- Most homicides occur because of an argument.
- Alcohol is involved in most cases of violence.
- Every year, 32,000 people die from gunshot wounds.

Here is what we can all do for our children:

- Be a role model.
- Talk to them and listen to them.
- Spend valuable time with them that includes fun activities.
- Find out who their friends are and if they are a positive influence.
- Find out where they hang out and make sure it's safe.
- Have them set short-term and long-term goals and help them plan to reach their dreams.
- Be involved with their education.
- Review their homework, meet teachers, and participate in school activities.
- Let them know you disapprove of fighting.
- Keep your children "drug-free."
- Review this information and other safety tips with them.

Show concern and love

Warm family relationships protect children from violence and many other risky behaviors.

To show love and concern:

- Every day, tell your child you love him or her.
- Show affection daily with a hug, a kiss, or a touch.
- Make time for your family to spend playing and going out.
- Meet your child's friends to ensure he or she has positive influences.
- Reward your child for good behavior or a job well done.
- Set clear rules for behavior and monitor your child.

Communication is a two-way street

Children who have good communication with their parents are more likely to ask for their advice than turn to peers.

When talking to your child, always keep this in mind:

- Listen to your child.
- Find out what your child knows about violence and its prevention before you start talking.
- Let your child know he or she can always talk to you about anything.

R-E-S-P-E-C-T
Find out what it means to me

Many youth fight because they feel "dissed" and as a result feel angry, humiliated, or embarrassed.

To stay violence-free with respect means:

- Give respect so you may get respect.
- Stand up for yourself without putting yourself in danger.
- Discuss ways to solve problems without fighting.

You are the experts *(continued)*

- Respect is not gained by physical force or intimidation, but by the quality of your character.
- Fighting doesn't solve a problem or get you respect.
- It takes more guts to walk away from a fight than to fight.

Education/personal achievement

Children who have an interest in and plans for education and personal growth don't use drugs and don't fight. Household chores or employment teaches them responsibility, time management, and the value of money.

Show interest in your child's education and growth:

- Read to your child and encourage your child to read.
- Meet with your child's teachers periodically to discuss expectations and learn about your child's progress.
- Review homework and tests.
- Set short- and long-term educational goals.
- Have your child participate in an after-school program.
- Give your child household responsibilities.

Substance abuse

Alcohol is involved in most homicides. Children who aren't interested in school, who have friends who use drugs, and who are not bound by rules, are more likely to use drugs.

Keep your child "drug-free":

- Let your child know you disapprove of drug use, including alcohol.
- Let your child know why you disapprove of drugs.
- Be a role model—either refrain from drinking or do it in moderation.
- Don't let your child associate with friends who use drugs, including alcohol.

Gangs: the dangerous "family"

Many youth join gangs looking for affection.

Gangs are not family:

- Gangs only look out for their own interests and easily turn against their members if they fall out of line.
- Gangs are violent. They intimidate, hurt, and kill people.
- Gangs lead to self-destruction.
- Join nonviolent groups/peers for support.

Guns are not for protection!

The presence of guns turns conflicts into violent confrontations resulting in serious injury or death. Guns are more likely to kill a friend or a family member (unintentionally or through suicide) than an enemy.

Tips for gun safety:

- Parents—don't own a gun. If you must, store it unloaded and locked in a secure place.
- Children should be taught not to touch or play with firearms or hang out with peers who do.
- If threatened by someone holding a gun, cooperate immediately.
- Don't get into a conflict with someone who owns a gun.

Bullying

Prevent your child from becoming a victim:

- Instill self-confidence in your child.
- Assist your child in establishing good social skills.
- Teach your child to speak out for him or herself.
- If harassed, teach your child to seek help from you, teachers, and the principal.
- Try to meet with the bully to work things out; if the problem continues, call or meet with the parent of the bully.

You are the experts *(continued)*

Prevent your child from becoming a bully:

- Teach your child to respect him- or herself and others.
- Clearly state that violence is not acceptable.
- Assist your child in finding nonviolent strategies for anger management and conflict resolution.
- Present yourself as a model of nonviolent behavior.
- Seek help from school counselors for bullying and aggressive behavior.

Dealing with emotions

Children who don't know how to control their anger are more likely to fight. Teach children how to calm down and talk over their problems.

Tips for keeping cool and solving a problem:

- Keep in mind that anger is a temporary emotion and it will pass.
- To calm down, think about or do things you enjoy.
- Once you have calmed down, think about the problem with a clear head.
- Take steps to solve the problem.

Peaceful solutions: getting your way without fighting

Talk—clearly and calmly, state the problem and your desire to solve it without fighting.

Humor—make fun of the problem.

Compromise—both give up something and get something in return.

Avoid/ignore—sometimes it's not worth the bother. Let the other person have what he or she wants.

Way out—look for a reason not to fight (eg, "My parents will ground me").

Remember, it takes more guts and self-respect to walk away from a fight than to fight, risk your life, and hurt your family.

Witnessing violence

Children who have seen violence are more likely to become involved in violence as victims or perpetrators. Children who witness violence at home or in the community may suffer from emotional and mental disorders.

You can:

- Minimize your child's exposure to violence.
- Talk to your child about the violence he or she witnessed
- Tell your child that media violence is not real—it is glamorized, misleading, and fails to depict the real pain and suffering of the victims.

If your child's behavior changes after witnessing violence:

Talk to school counselors or your child's pediatrician; some warning signs of emotional or mental disorders related to witnessing violence include sleeplessness, lack of appetite, lack of attention, anxiety, and frequent thoughts or flashbacks of the event.

Adapted from a brochure of the Children's Safety Network National Injury and Violence Prevention Resource Center; Education Development Center, Inc., 55 Chapel Street, Newton, MA; 617 969-7100, ext. 2207. The Resource Center is funded by the US Department of Health and Human Services Health Resources and Services Administration (HRSA). Reprinted with permission of HRSA. A color version of this brochure with graphics is available for reproduction on the electronic version of this guide, located at http://www.ama-assn.org/violence.

Section 8

Additional Information

Additional Information

Child abuse

Child Abuse Prevention Network
http://www.child-abuse.com
This site provides several resources such as free subscriptions to e-mail lists for professionals in the area of child abuse, an annotated Prevention Bookmarks index, daily press reports about child abuse, and several downloadable documents as well as multimedia resources.

Childhelp USA
http://www.childhelpusa.org
Childhelp USA focuses on many facets of child abuse, from personal suffering to legal issues. Childhelp USA incorporates research, prevention, and treatment into one organization dealing with the problem of child abuse in our country.

National Clearinghouse on Child Abuse and Neglect
http://www.calib.com/nccanch/
The Clearinghouse provides resources on child abuse, neglect, and child welfare. Links to statistics, sources of funding, calendar of events, and publications, among others, can be found on its Web site.

National Resource Center on Child Maltreatment (NRCCM)
http://www.gocwi.org/nrccm/
NRCCM provides consultation, training, and technical assistance services to maltreated children and their families. Their program was created to enhance the expansion, development, and strengthening of service delivery to these families.

Prevent Child Abuse America
http://www.preventchildabuse.org/
Prevent Child Abuse America is an organization dedicated to preventing child abuse and neglect through chapters in 39 states and the District of Columbia.

Child advocacy and protection

Child Welfare League of America (CWLA)
http://www.cwla.org/
CWLA, which is dedicated to improving lives of endangered youths and their families, provides various services that deal with the prevention and treatment of child abuse.

Children's Defense Fund
http://www.childrensdefense.org/
The Children's Defense Fund provides a voice for the children of America who are unable to vote or lobby for themselves, with an emphasis on the needs of those with disabilities and poor or minority children.

National Association of Child Advocates (NACA)
http://www.childadvocacy.org/
Child advocacy leaders from across the country are able to share ideas and increase the impact of the child advocacy movement through the existence of the NACA.

Children, youth, and family resources

Adolescent Directory On-Line
http://www.educ.indiana.edu/cas/adol/adol.html
Adolescence Directory On-Line (ADOL) is an electronic service of the Center for Adolescent Studies at Indiana University. Web resources on adolescent issues can be accessed by teens, parents, counselors, researchers, health practitioners, and educators on ADOL.

Community Justice Exchange
http://www.communityjustice.org/
Provides a National Programs Database that you can search by city/state or program type.

Additional Information *(continued)*

Connect for Kids
http://www.connectforkids.org/
This site addresses various issues on crime and violence.

Drug Treatment Finder—SAMHSA
http://findtreatment.samhsa.gov/
This directory provides the location of drug and alcohol treatment programs around the country.

Family Education Network
http://fen.com/aboutfen/
Provides information that enables parents to help their children cope with school violence.

Family Resource Coalition of America
http://www.familysupportamerica.org/content/home.htm
The Family Resource Coalition of America is an alliance of those who believe that to do the best for America's children, we need to strengthen and support our nation's families.

Family Web Talk
http://www.familywebtalk.com/
This is a forum for parents and children to discuss pertinent family and school issues, such as violence and abuse.

Injury Prevention Web—
State by State Resources
http://www.edc.org/HHD/csn/StateResources/state.htm

KidsPeace
http://www.KidsPeace.org/
KidsPeace is a private, non-profit organization that provides families with comprehensive programs dealing with mental health treatment, intervention services, and public education initiatives.

National Association of Child Advocates
http://www.childadvocacy.org/
This association advocates for the safety and well-being of all children.

National Clearinghouse on Families and Youth
http://www.ncfy.com/ydorgs2.htm
Provides a small list of national resource programs that focus on developing youth.

National Parent Information Network
http://npin.org/
The mission of the National Parent Information Network's is to provide research-based information about parenting family involvement in education.

SafeCities
http://www.SafeCities.gov/
This community of people work together to significantly decrease gun violence in 11 cities/regions across the country.

State and Local Government on the Web
http://www.statelocalgov.net/index.cfm
Created by Piper Resources, this directory provides links to government sponsored and controlled resources.

State Resources
http://ojjdp.ncjrs.org/resources/asp/search_states.asp
This database can be used to find resources for a specific state.

The Bureau for At-Risk Youth
http://www.at-risk.com/
The Bureau for At-Risk Youth is an educational publisher/distributor of products, programs, videos, and publications for youth at-risk and their families.

United Way of America
http://www.unitedway.org/uwsearch/
United Way of America provides you with resources in your community.

Additional Information *(continued)*

Criminal justice

Center on Juvenile and Criminal Justice
http://www.cjcj.org/
The center's mission is to reduce the use of institutionalization as a solution to many social problems. This site provides information on the Center's Justice Policy Institute, which encourages effective approaches to the justice system.

Federal Bureau of Investigation
http://www.fbi.gov/
The FBI is the principal investigative arm of the US Department of Justice.

Data search

Ambulatory Health Care Data—CDC
http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm
Provides national data on emergency department and physician visits.

Ambulatory Medical Care Survey—CDC
http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm
Database that includes information about the provision and use of ambulatory medical care services in the United States.

American Society of Suicidology
http://www.suicidology.org/index.html
Devoted to the understanding and prevention of suicide, this non-profit organization is a resource for anyone concerned about suicide.

Annie E. Casey Foundation—Kids Count Data Book
http://www.aecf.org/kidscount/kc2001/
This on-line database allows you to generate custom state-by-state profiles, graphs, maps, and ranked lists.

Bureau of Justice Statistics (BJS)
http://www.ojp.usdoj.gov/bjs/welcome.html
BJS collects and analyzes data on crime. It also provides support to state agencies to help them improve their crime databases and reporting systems.

Crime Mapping
http://www.ojp.usdoj.gov/cmrc/weblinks/welcome.html
Provides simple maps that identify locations where crimes have occurred—only available for some communities.

Federal Justice Statistics Program (FJSP)
http://fjsrc.urban.org/
The FJSP describes the details of juvenile offenses processed in the federal criminal justice system.

Hamilton Fish Institute
http://www.hamfish.org/index.html
The Hamilton Fish Institute on School and Community Violence at George Washington University is a national resource on effective programs that can be replicated to reduce violence in America's schools and communities.

Monitoring the Future (MTF)—National Institute on Drug Abuse
http://monitoringthefuture.org/
This is a comprehensive national survey composed of a sample of 8th, 10th, and 12th graders. A longitudinal follow-up of a subset of students also exists. The survey reveals data about drug use (by type of drug), tobacco use, alcohol use, related attitudes, and use of weapons.

National Archive of Criminal Justice Data (NACJD)
http://www.icpsr.umich.edu/NACJD/index.html
The NACJD facilitates and encourages research of criminal justice issues by preserving and sharing important data resources.

Additional Information *(continued)*

National Crime Victimization Survey (NCVS)
http://www.ojp.usdoj.gov/bjs/cvict.htm#ncvs
The NCVS serves as America's primary source of information on criminal victimization. It provides annual statistics on sexual assaults, rapes, robberies, thefts, household burglaries, and motor vehicle thefts experienced by residents aged 12 years or older.

National Electronic Injury Surveillance System—Consumer Product Safety Commission (CPSC)
http://www.cpsc.gov/cpscpub/pubs/3002.html
NEISS identifies and assesses the risks of injury associated with consumer products. Injury data are abstracted from a sample of emergency department records. The Centers for Disease Control and Prevention works with the CPSC to collect data on all types and causes of nonfatal injuries, including firearm-related injuries, treated in emergency departments.

National Incident-Based Reporting System (NIBRS)
http://www.ojp.usdoj.gov/bjs/nibrs.htm
Provides national reports on offense arrests and crimes according to demographic information about those involved.

National Mortality Followback Survey
http://www.cdc.gov/nchs/about/major/nmfs/nmfs.htm
This is a survey of all resident deaths in the United States of people aged 15 years or older. This survey investigates socioeconomic differentials in mortality, possible prevention of premature death, and associated risk factors.

National Vital Statistics System—Mortality Data
http://www.cdc.gov/nchs/about/major/dvs/mortdata.htm
Through the National Vital Statistics System, the National Center for Health Statistics gathers and releases data on deaths in the nation.

National Youth Gang Survey
http://ojjdp.ncjrs.org/pubs/gangsum.html#183109
This annual gang survey was conducted by OJJDP's National Youth Gang Center. A sample of police and sheriff's departments throughout the United States provides information about youth gang activity in their jurisdictions.

Office of Juvenile Justice Statistical Briefing Book
http://www.ojjdp.ncjrs.org/ojstatbb/index.html
Provides basic information on crime for youth involved in the juvenile justice system. Provides reliable statistical data to common questions asked by policymakers, media, and the general public.

School Crime Supplement to the National Crime Victimization Survey
http://www.nces.ed.gov/pubs2001/crime2000/
These organizations periodically collect data on school crime by using a supplement to the NCVS. The survey asked youth aged 12 years or older, who attended school, questions about availability of drugs at school, street gangs, gang fights, presence of guns at school, victimizations, and fear of being attacked or harmed.

Sourcebook of Criminal Justice Data
http://www.albany.edu/sourcebook/index.html
This sourcebook incorporates data from more than 100 sources regarding all aspects of criminal justice in America.

Uniform Crime Reports
http://fisher.lib.virginia.edu/crime/
The crime rates for juveniles in states and counties, are provided at this site.

White House Drug Policy Center
http://www.whitehousedrugpolicy.gov/drugfact/index.html
Provides comprehensive data on major drug categories and special populations along with source materials.

Additional Information *(continued)*

WISQARS (Web-based Injury Statistics Query and Reporting System)
http://www.cdc.gov/ncipc/osp/data.htm
Provides customized injury-related mortality data that enables informed public health decision-making.

Youth Risk Behavior Surveillance System (YRBSS)
http://www.cdc.gov/nccdphp/dash/yrbs/
Monitors risk behaviors associated with the leading causes of death by providing various surveys for different age ranges. The survey includes race, ethnicity, age, and sex; tobacco and alcohol use, and well as other drug use; sexual behaviors (including sexually transmitted disease and HIV risk); dietary behaviors; physical activity; and injury risk behavior (motorcycle and bicycle helmet use, seat belt use, drinking and driving, fighting, weapon carrying, suicide attempt).

Dating violence

American Psychological Association- Love Doesn't Have to Hurt Teens

http://www.apa.org/pi/pii/teen/homepage.html

Provides a packet of information with warning signs, statistics, risk factors, resources and ideas for stopping the violence for friends and/or family members.

Dating Violence Fact Sheet

http://www.cdc.gov/ncipc/factsheets/datviol.htm

Concise summary of dating violence statistics and risk factors from the Centers for Disease Control and Prevention.

Massachusetts Medical Society

http://www2.mms.org/pages/tip_teendating.asp

Provides two articles on teen dating violence. One is geared towards recognizing the signs of a violent relationship and the other is for parents.

National Parent Information Network

http://npin.org/pnews/2000/pnew700/int700c.html

Provides an article on dating violence that describes how it fits into the cycle of violence, with risk factors and web resources.

National Youth Violence Prevention Resource Center

http://www.safeyouth.org/teens/topics/teen_dating.htm

The "Hot Topics" section provides a fact sheet on teen dating violence with statistics, warning signs and more.

Rhode Island Coalition Against Domestic Violence (RICADV)

http://www.ricadv.org/violence.html

RICADV developed resources for educators and teens, which address teen dating violence. Two main projects include "Dating Violence: It is Your Business," which is part of a public education campaign and a Resource Guide for Educators.

Transform Communities—Tools for Youth Relationship Violence

http://transformcommunities.org/tctatsite/ttools_yrv.html

Provides a list of teen dating violence prevention curriculum and programs.

Family violence

Minnesota Center Against Violence and Abuse (MINCAVA)
http://www.mincava.umn.edu
MINCAVA, which is housed at the School of Social Work at the University of Minnesota, supports education, research, and access to information about violence. MINCAVA promotes this mission through thefollowing projects: MINCAVA Electronic Clearinghouse, The Link Research Project, Violence Against Women Online Resources, Child Abuse Prevention Studies Program (CAPS), and the applied research section of the Violence Against Women Web site.

Additional Information *(continued)*

Center for the Prevention of Sexual and Domestic Violence
http://www.cpsdv.org/
This interreligious educational resource concentrates on topics relating to sexual and domestic violence, with an emphasis on education and prevention.

Family and Intimate Violence
http://www.cdc.gov/ncipc/dvp/fivpt/fivpt.htm

This division addresses many issues related to family and intimate partner violence, including tracking the problem and research and evaluation of programs.

Family Violence Department—National Council of Juvenile and Family Law Judges
http://www.nationalcouncilfvd.org/
In 1987, the National Council of Juvenile and Family Court Judges launched a Family Violence Project. Since then, it has grown into the Family Violence Department, and it serves as a major force in addressing family violence in the United States.

Family Violence Prevention Fund
http://www.endabuse.org
The Family Violence Prevention Fund works to end domestic violence and help women and children whose lives are affected by violence and abuse. Resources are available to help health professionals and employers identify and aid victims of abuse.

National Crime Victims Research and Treatment Center—Medical University of South Carolina
http://www.musc.edu/cvc/
The NCVC conducts important scientific research projects on different aspects of child abuse and criminal victimization. Recently, its research efforts include the analysis of the mental health impact of urban violence and natural disasters.

National Coalition Against Domestic Violence (NCADV)
http://www.ncadv.org/
NCADV goals are to empower battered women and children. The program "Remember My Name" is an ongoing project dedicated to compiling the names of women killed due to domestic violence. The NCADV provides information and referral services, as well as educational publications. The Give Back a Smile, FACE TO FACE, and SCORES programs help remove the scars of abuse and help address national public policy issues.

Firearms and substance abuse

Bureau of Alcohol, Tobacco and Firearms (ATF)
http://www.atf.treas.gov/
This law enforcement organization is dedicated to reducing violent crime and protecting the public. The ATF's National Tracing Center coordinates the Youth Crime Gun Interdiction Initiative, which is a national program that monitors the illegal supply of firearms to youth by tracing the guns used in crimes.

Center on Addiction and Substance Abuse at Columbia University (CASA)
http://www.casacolumbia.org
This organization focuses on informing Americans of the costs of substance abuse, such as the economic, social, and personal impacts. It encourages them to take action on combating substance abuse.

Join Together Online
http://www.jointogether.org
Join Together's searchable gun violence site provides information about issues related to gun possession and violence.

National Clearinghouse for Alcohol and Drug Information (NCADI)
http://www.health.org
The world's largest resource provides information and materials about substance abuse. NCADI is the information service of the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration in the US Department of Health and Human Services.

Additional Information *(continued)*

National Youth Anti-Drug Media Campaign
http://www.mediacampaign.org
The National Youth Anti-Drug Media Campaign is designed to educate and empower youth to avoid illicit drugs. A variety of media, including TV ads and school-based educational materials, are used to reach parents and youth.

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samsha.org
SAMHSA's mission is to improve the quality and availability of treatment, prevention, and rehabilitation services in order to reduce illness, disability, death, substance abuse and mental illnesses.

White House Office of National Drug Control Policy (ONDCP)
http://www.whitehousedrugpolicy.gov/
The goals of the ONDCP are to reduce the use of illicit drugs, manufacture of these substances, and drug-related health consequences and issues.

Sites for Identifying Funding for Youth Violence Prevention Programs:

Children's Safety Network

http://www.edc.org/HHD/csn/

The CSN is sponsored by the Health Resources and Services Administration of the federal government. It provides information on violence and injury prevention including information on funding.

Foundation Center

http://fdncenter.org

The Foundation Center provides an on-line searchable directory of funding sources for a broad range of issues including youth violence prevention.

Join Together On-Line

http://www.jointogether.org

JTO provides daily updates on topics in the news on violence prevention including information on funders.

National Resource Directory of Victim Assistance Funding Opportunities for 2000

http://www.ojp.usdoj.gov/ovc/fund/nrd/

National Youth Violence Prevention Resource Center

http://www.safeyouth.org/home.htm

The Center provides links to a broad range of information on youth violence prevention including funders.

Office of Juvenile Justice and Delinquency Prevention

http://ojjdp.ncjrs.org/

The OJJDP is a federal agency that works with states and local communities to develop, implement and evaluate violence prevention programs. They provide technical assistance, funding, and materials to those wishing to start programs.

Additional Information *(continued)*

Health care professional resources

ACT-Adults and Children Together—Against Violence
http://www.actagainstviolence.org/

This violence-prevention campaign involves community-based training programs and a national multimedia campaign. The campaign focuses on adults who interact with children ages zero to 8 years of age, emphasizing the importance of a positive role model in the health and mental well-being of youth.

Allina Health Systems Foundation
http://www.unitedhospital.com/ahs/foundation.nsf/page/AF_vp_HCCV

This is a statewide coalition of health care, health plans, and community organizations that work to implement violence prevention strategies in the health care system. This foundation also provides training, curriculum, resources, and publications for use by all health care providers.

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

The AACAP has multiple resources for families, health care professionals, and communities that address the issue of youth violence. To motivate child and adolescent psychiatrists to join the fight to prevent violence, it recently launched a violence initiative.

American Academy of Family Physicians
http://www.aafp.org/

Provides position papers on the role of family physicians and patient information on violence-related issues.

American Academy of Pediatrics (AAP)
http://www.aap.org

The AAP works to prevent violence by and against children and adolescents, with particular focus on the prevention of firearm injuries. The AAP has developed many resources on this issue, including the Firearm Injury Prevention Resource Guide for community leaders and health professionals and the STOP Firearm Injury Kit.

American College of Obstetricians and Gynecologists
http://www.acog.org/

This organization has developed educational bulletins and policies on violence topics, with an emphasis on sexual assault. Downloadable brochures and publications are available on its Web site.

American College of Physicians/American Society of Internal Medicine (ACP/ASIM)
http://www.acponline.org/home/policy.htm

The goal of the ACP/ASIM is to foster excellence and professionalism in the area of medicine in order to enhance the quality of care. A list of advocacy issues can be viewed online at their Legislative Action Center.

American Medical Association
http://www.ama-assn.org/violence

The AMA addresses the issue of youth violence in two major ways. First, it convened the Commission for the Prevention of Youth Violence. The Commission included a multidisciplinary group of organizations that explored the causes of violence among youth and issued recommendations on how health professionals and communities could make a positive impact on the prevention of youth violence. The AMA also addresses violence among youth through organizational policy and its National Advisory Council on Violence and Abuse. The AMA Alliance, a grass roots organization composed of spouses of AMA members, is very active in bringing anti-violence messages to communities nationwide. Information about the Alliance can be found at http://www.ama-assn.org/ama/pub/category/2141.html.

Additional Information *(continued)*

American Medical Association and Health Resources and Services Administration (HRSA)
http://www.ama-assn.org/ama/upload/mm/39/parentinfo.pdf

The AMA and HRSA developed and released "The Parent Package" in 2001. "The Parent Package" is designed to help physicians share important information about adolescents with parents. The sheets provide useful tips on violence, alcohol, drugs, depression, sex, parenting, making responsible choices, and growth and development issues, among many others. These sheets can be reproduced for widespread distribution.

American Medical Student Association (AMSA)
http://www.ama-assn.org/resource/pgres.cfm

The AMSA Foundation's Generalist Physicians in Training project, funded by the Robert Wood Johnson Foundation, has created Projects in a Box. Some of the topics included are: child abuse and neglect, guns and violence, preventing adolescent violence, substance abuse prevention, teen mentor programs, and more.

American Nurses Association (ANA)
http://www.nursingworld.org/rnkids/index.htm

The ANA addresses the issue of youth violence through its campaign: Kids in the Crosshairs: RNs Confront the Causes and Consequences of School Violence. This campaign explores the role of nurses in reducing youth violence.

American Psychiatric Association
http://www.psych.org

The American Psychiatric Association has position statements on many violence issues, and it is involved in three major projects related to youth violence prevention: (1) organizing the Youth Violence Prevention Project; (2) creating the National Prevention Coalition; and (3) being part of the Commission on Youth and School Violence, which is studying the problem of youth violence in schools.

American Psychological Association (APA)
http://www.apa.org

The APA has many divisions that address youth violence. It has a Commission on Violence and Youth, which has created and published many reports; the APA Presidential Task Force on Violence and the Family; and it has also teamed up with MTV to provide information on the warning signs of violent behavior to youth and steps to getting help when they recognize these signs.

American Public Health Association
http://www.apha.org

The American Public Health Association's journal provides access to many articles and publications on youth violence and prevention.

Center for Injury Prevention and Control—CDC
http://www.cdc.gov/ncipc/default.htm

The National Center for Injury Prevention and Control (NCIPC) works to reduce disability morbidity, mortality, and costs associated with injuries.

> **Division of Violence Prevention**
> http://www.cdc.gov/ncipc/dvp/dvp.htm
>
> The Division has four major areas for violence prevention: suicide, youth violence, family and intimate violence, and firearm injuries.
>
> **Youth Violence and Suicide Prevention Team**
> http://www.cdc.gov/ncipc/dvp/youth/youth.htm

Center for Mental Health Services (CMHS)
http://www.mentalhealth.org/cmhs/

Provides general mental health information, information about services, and information from the School Violence Prevention Initiative, the Emergency Services and Disaster Relief Branch, and the Child, Adolescent, and Family Branch.

Additional Information *(continued)*

Children's Safety Network—Maternal and Child Health Bureau
http://www.edc.org/HHD/csn/

The Children's Safety Network is located at Education Development Center, Inc. and is part of the National Injury and Violence Prevention Resource Center. The network provides resources and technical assistance to maternal and child health agencies and other organizations looking to decrease unintentional injuries and violence to children and youth.

Doctors Against Handgun Injury (DAHI)
http://www.doctorsagainsthandguninjury.org/

DAHI works to bring collective experiences and expertise from physicians about the danger of handgun injury in order to reduce the level of injuries and deaths.

Family Violence Prevention Fund
http://endabuse.org/

Health care providers and employers are able to identify and aid victims of abuse with the assistance of the Family Violence Prevention Fund. The group also works to enable all Americans to end abuse.

National Institutes of Health
http://www.nih.gov/

The NIH supports research on new ideas and programs that will aid in overall better health of the public.

National Institute of Child Health and Human Development (NICHD)
http://www.nichd.nih.gov/

The NICHD explores the developmental issues and related health of infants, children, youth, and families.

National Institute of Mental Health (NIMH)
http://www.nimh.org

The NIMH has supported programs that address the related issues of mental health: Families and Schools Together (FAST) Track Program and Linking the Interests of Families and Teachers (LIFT) Program, and the Promoting Alternative Thinking Strategies (PATHS) curriculum, which teaches children about problem solving, understanding emotions, and self-control.

Pacific Center for Violence Prevention
http://www.pcvp.org

The Pacific Center for Violence Prevention is the policy center of the California Wellness Foundation's statewide Violence Prevention Initiative, established in 1993. Policy goals are to reduce consumption and advertising of alcohol to youths, reduce access to firearms, and shift society's definition of youth violence from a law enforcement model only, to include a public health model.

Physicians for a Violence-Free Society
http://www.pvs.org/main/index.html

Physicians for a Violence-Free Society helps to develop leadership and advocacy in the health care community in order to promote violence prevention. It recently created the California Physician's Network.

Physicians for Social Responsibility
http://www.psr.org/violence.html

Its Violence Prevention Program is a national network of public health professionals and physicians. Information on gun violence training and related issues is available on its Web site.

PubMed—National Library of Medicine
http://www.ncbi.nlm.nih.gov/PubMed

This database allows for searches of international literature on the topic of violence.

The HELP Network (Handgun Epidemic Lowering Plan)
http://www.helpnetwork.org/main.html

The HELP Network is dedicated to reducing firearm-related injuries and deaths. HELP is an international organization that promotes public health science strategies and is also a clearinghouse for information on the growing trend of firearm casualties.

Additional Information *(continued)*

Key reports on youth violence prevention

Best Practices of Youth Violence Prevention: A Sourcebook—CDC (2000)
http://www.cdc.gov/ncipc/dvp/bestpractices.htm#

Blueprints for Violence Prevention
http://www.colorado.edu/cspv/blueprints/

Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence—Institute of Medicine (2001)
http://www.nap.edu/catalog/10127.html

Creating Safe and Drug Free Schools (1996)
http://www.ncjrs.org/pdffiles/safescho.pdf

Early Warning, Timely Response: A Guide to Safe Schools—Department of Education
http://www.air.org/cecp/guide/pdf.htm

Healthy People 2010—Department of Health and Human Services (2000)

http://www.health.gov/healthypeople/

Indicators of School Crime and Safety, 2001 — Department of Justice (2001)
http://www.ojp.usdoj.gov/bjs/pub/pdf/iscs01.pdf

Juvenile Offenders and Victims, 1999 National Report
http://www.ncjrs.org/html/ojjdp/publist2000/violence.html

Never Too Early, Never Too Late...To Prevent Youth Crime & Violence—Little Hoover Commission
http://www.lhc.ca.gov/lhcdir/report159.html

New Directions from the Field: Victims' Rights and Services for the 21st Century—Office for Victims of Crimes (2000)
http://www.ojp.usdoj.gov/ovc/new/directions/pdftxt/direct.pdf

Preventing Crime: What Works, What Doesn't, What's Promising: A Report to the US Congress—
http://www.ncjrs.org/works/wholedoc.htm

Preventing Youth Hate Crime: A Manual for Schools and Communities
http://www.ed.gov/offices/OESE/SDFS/encl26.pdf

Safeguarding Our Children: An Action Guide—US Department of Justice and US Department of Education (2000)
http://www.air.dc.org/cpcp/guide/act:onguide.html

The School Shooter: A Threat Assessment Perspective—FBI (2000)
http://www.fbi.gov/publications/school/school2.pdf

Toolkit to End Violence Against Women—

National Advisory Council on Violence Against Women and the Violence Against Women Office.
http://toolkit.ncjrs.org

Violence Prevention: A Vision of Hope—California Attorney General Dan Lungren (1995)
http://www.lapdonline.org/

Youth and Violence: Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence—Commission for the Prevention of Youth Violence (2000)
http://www.ama-assn.org/violence

Youth Violence: A Report of the Surgeon General—Surgeon General David Satcher (2001)
http://www.surgeongeneral.gov/library/youthviolence/default.htm

Additional Information *(continued)*

Media violence

Kids-In-Mind
http://www.kids-in-mind.com/

Kids-In-Mind is primarily addressed to parents, and it deals with assessing objectionable material in movies and other media with a non-critical approach.

KIDSNET
http://www.kidsnet.org

KIDSNET, a national computerized non-profit clearinghouse dedicated to children's video programming, audio, and television, promotes the quality of children's media.

Mediascope
http://www.mediascope.org/

This national, not-for-profit research and policy organization was founded in 1992. Since its roots, it has worked to promote the responsible portrayal of content and images in film, television, advertising, music, and other forms of mass media.

School violence and safety

Center for the Prevention of School Violence
http://www.ncsu.edu/cpsv/

The Center is dedicated to getting violence out of our schools, and it is currently working on special projects to attain this goal.

Division of Adolescent and School Health (DASH)—CDC
http://www.cdc.gov/nccdphp/dash/

DASH coordinates the Youth Risk Behavior Surveillance System, conducts the School Health Policies and Programs Study (SHPPS), and has developed a library of federal activities that address violence in schools.

National Alliance for Safe Schools
http://www.safeschools.org/

The alliance's main goal is to make and keep schools a safe learning environment for children and youth. Its Web site provides information on current anti-violence programs and provides training links.

National Mental Health and Education Center for Children and Families
http://www.naspcenter.org/index2.html

The National Association of School Psychologists created this public service program to provide information on current issues and programs as well as provide resources for crisis response and safe school programs.

National Parent-Teacher's Association
http://www.pta.org/

The National Parent-Teacher's Association develops community violence prevention kits to help combat school violence, and provides other information on prevention and education.

National School Safety Center
http://www.nssc1.org/

The Center provides information and resources to train school educators, parents, law enforcement, and other youth serving individuals on the topic of school violence prevention.

Safe and Drug Free Schools Program (SDFS)—Department of Education
http://www.ed.gov/offices/OESE/SDFS/

This program is the federal government's primary vehicle for reducing alcohol, drug, and tobacco use, as well as preventing violence in and around schools. With the help of federal, state, and community efforts and resources, they are able to help strengthen programs that promote these topics.

Additional Information *(continued)*

Safe Schools/Healthy Students Initiative—Center for Mental Health Services
http://www.mentalhealth.org/schoolviolence/default.asp

This grant program is designed to evaluate what works best to reduce the incidence school violence. School districts use the funds to assist communities with the implementation of many comprehensive educational services for youth. The goal is to prevent youth violence, foster resilience, and healthy childhood development.

Youth violence—an overview

Academic Centers of Excellence on the Prevention of Youth Violence

Asian/Pacific Islander Youth Violence Prevention Center (API)
http://www.api-center.org/

The University of Alabama at Birmingham, Comprehensive Center on Youth Violence Prevention. For more information, contact: Kurt Denninghoff, MD, 205 975-7387 or kdenning@uabmc.edu, and Frank Romanowicz 205 975-0520.

Columbia University's Comprehensive Center on Youth Violence Prevention
For more information, contact Karen Rose 212 305-8213.

The Developing Center on Hispanic Youth Violence Prevention
For more information, contact Brenda Mirabel-Colon, MD 787 758-2525 or at nlin@tld.net.

Harvard Youth Violence Prevention Center
http://www.hsph.harvard.edu/hicrc/prevention.html

The Johns Hopkins Comprehensive Center on Youth Violence Prevention
For more information, contact Philip Leaf, PhD 410 955-3962 or at Pleaf@jhsph.edu

The October Center for the Study and Prevention of Youth Violence
http://www.octobercenter.vcu.edu/

Southern California Center on Youth Violence Prevention
http://www.stopyouthviolence.ucr.edu/

University of California at San Diego Center on Youth Violence Prevention
http://www.sdhealth.org/yvp/yvp.html

The University of Hawaii at Manoa's Comprehensive Center on Youth Violence Prevention
http://www.api-center.org/

The University of Michigan, Developing Center on Youth Violence Prevention
http://www.sph.umich.edu/prc/projects/yvpc.html

Center for the Study and Prevention of Violence
http://patch.Colorado.edu/cspv

The Center provides information about many issues related to violence, spanning from bibliographical information to national violence prevention programs.

National Youth Violence Prevention Resource Center
http://www.safeyouth.org

This Resource Center is a collaboration between the Centers for Disease Control and Prevention and other federal agencies, and it serves as a central source of information on statistics, research, programs, and publications about violence and youth.

Partnerships Against Violence
http://www.pavnet.org/

This "virtual library" provides information from multiple federal agencies on violence-related issues, and it is the basis for the Pavnet mailgroup in which violence prevention professionals can share ideas and resources.