

RECOGNIZING & PREVENTING

Youth Violence

**A Guide for Physicians &
Other Health Care Professionals**

MASSACHUSETTS MEDICAL SOCIETY
COMMITTEE ON VIOLENCE

PREFACE

This guidebook is the product of the Massachusetts Medical Society's Committee on Violence, Barbara Herbert, M.D., 2004–2005 chair, Elliot Pittel, M.D., vice-chair. Portions of this guidebook are based on the conference "Violence Prevention: New Approaches for Clinical Application," held at the Massachusetts Medical Society on May 1, 2000. The Committee would like to acknowledge Robert DuRant, Ph.D., Eli Newberger, M.D., John Rich, M.D., M.P.H., and Howard Spivak, M.D., who addressed the conference; Michael Cronin, M.P.H., Linda Grant, M.D., M.P.H., Barbara Herbert, M.D., Elliot Pittel, M.D., Stephen Porter, M.D., Nancy Rappaport, M.D., and Peter Stringham, M.D., who led the afternoon workshops; and many other professionals who contributed their thoughtful discussions at the conference. These discussions had the invaluable assistance of the following medical students who provided discussion guides and summaries for the participants: Jennifer Chen, Donna Greco, Jeffery Lazar, Ann Mullers, Rachel Salguero, Adam Saltzman, Serineh Voskanian, and Wei-Lien Wang.

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A special thank you to Peggy Lavigne, trustee chair/editor, and the Deaconess-Nashoba Valley, Ayer, MA, for permission to use illustrations and text from *The Voices of Children — Messages of Hope and Optimism for a Kinder World*. Messages from 450 fifth-graders are at the heart of this book that is based on the question, "How can kids create peace in their lives?" The book, published in May 1998, is the work of the hospital's Trustee Community Relations Committee. Additional illustrations on pages 17 and 18 were done in 1993 and 1994 by children in an inner city middle school and collected by Rosalind Hoey and James Coats.

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MASSACHUSETTS MEDICAL SOCIETY
COMMITTEE ON VIOLENCE

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Note to Readers:

This guidebook is intended as an informational resource. The guidelines and suggestions herein should not be construed as standards of care. Treatment decisions must be made on the basis of the facts and circumstances of each individual case. While care has been taken to accurately reflect current knowledge, medical standards are constantly evolving. Therefore, this guidebook should serve only as a starting point. The information contained herein does not constitute legal advice, and clinicians should seek the advice of their own counsel concerning the application of law to the facts they face.

INTRODUCTION

It has now been four years since the introduction of the first version of this guide. We have been very gratified to find that many health care providers have found the first edition useful, and have sought to update this guide with newer information. Unfortunately, although great reductions have been made in youth violence, violence is still among the leading causes of injury, death, and physical and mental disability for American children. Although physicians and other health care professionals have always been involved in treating the *results* of violence, recent research and practice suggests that we can also play a critical role in its *prevention*.

There are two different opportunities for intervention and prevention: during a routine health care visit and when caring for a youth who has been injured. On these occasions we can provide preventive education, help families raise resilient children, screen for risk, and develop linkages to community and medical resources.

This guide was written to:

- Provide basic information about youth violence
- Describe appropriate assessments of risk and resilience
- Suggest approaches to violence prevention and intervention
- Present ideas and resources for advocacy and research
- Introduce the Massachusetts Medical Society Committee on Violence's *Violence Prevention for Children and Youth Parent Education Cards* (Tip Cards).

The Medical Society's tip cards were developed through a process that included experts' and physicians' and other professionals' input at every stage, along with parent involvement through professionally run focus groups. Studies performed on prototype cards demonstrated their clinical effectiveness, and over 700,000 cards have been distributed throughout the United States and foreign countries. We hope that the dissemination of knowledge about the risk and protective factors and about available resources will make a difference in the lives of our patients.

This guide does not focus on determining who is a victim and who is a perpetrator, as these distinctions can become blurred when dealing with youth violence. Instead, this guide will focus on identifying known risk factors and predictors for violent behavior, in order to reduce injury for *all youths* at risk.

Each patient contact is an opportunity for us to listen, counsel, and teach. As health care professionals, we can make a significant impact in the prevention of youth violence.



Some Sobering Facts

- On average, 15 Americans between the ages of 15 and 24 were murdered each day in 2001. 80 percent of these deaths involved firearms.¹
- Teenagers 12 to 19 years of age have the highest rate of violent crime victimization of all age groups.²
- Violence-related injuries involving children and adolescents occur at a rate of 52.7 per 10,000 person-years, according to a four-year survey of Boston emergency departments.³
- Of all the head injuries reported to the National Pediatric Trauma Registry between September 1988 and January 1996, 49 percent were the result of assault, while many of the remaining head injuries were due to child abuse.⁴
- In the 2003 Youth Risk Behavior Surveillance Survey:⁵
 - 33 percent of high school students nationwide reported being in a physical fight in the past year, with 4.2 percent injured seriously enough to require medical attention.
 - 8.9 percent reported being hit, slapped, or physically hit on purpose by their boyfriend or girlfriend in the past year.
 - 17.1 percent carried a weapon, and 6 percent carried a gun at least once in the past month.
 - 5.4 percent skipped school at least once in the past month because they felt unsafe.
 - 17 percent seriously considered suicide and 8.5 percent attempted suicide in the past year.
- Children who are witnesses and victims of violence are at significantly higher risk for developmental and mental health problems including depression, conduct and anxiety disorders, and post-traumatic stress disorder. These children are more likely to become aggressive and violent than children not exposed to violence.⁶



PRIMARY PREVENTION

Physicians and health care professionals can play a crucial role in the primary prevention of youth violence. Unfortunately, studies have shown that many physicians do not include violence prevention as a routine part of care.^{7,8} Lack of training, limited time for assessment, and lack of familiarity with community resources are often cited as barriers. Research has also shown that many parents believe violence prevention deserves a place in the care of their children. In the recent National Survey of Early Childhood Health, 56 percent of parents believed that pediatricians should discuss community violence during a routine office visit, but only 10 percent of pediatricians did so.⁹

The goal of primary prevention is to prevent violence before it occurs. From a clinical standpoint, this involves recognizing risk factors for violent behavior, assessing for resiliency, educating patients and their families about violence, and connecting them to appropriate intervention and follow-up services.

Risk Factors

Violent injury and death result from altercations between family members and acquaintances far more often than from robberies or other criminal activity.¹⁰ The same can be said for youth involved with violence ranging from minor conflicts to homicide; it results from arguments and conflicts between friends, acquaintances, parents, and siblings.¹¹ In addition, there are cultural and social factors that can influence risk-taking and subsequent involvement in violence.

Violence is a complicated group of behaviors, and there are numerous theories and studies concerning the neurobiology of violence. A complex interaction, or combination of factors, leads to an increased risk of involvement in violence. These factors include the following:¹²

- Previous aggressive or violent behavior
- Being the victim of physical abuse and/or sexual abuse
- Exposure to violence in the home and/or community
- Genetic or family heredity factors like temperament
- Exposure to violence in the media
- Use of drugs and/or alcohol
- Presence of firearms in the home
- Combination of stressful family and socioeconomic factors (poverty, severe deprivation, marital breakup, single parenting, ineffective parenting practices, unemployment, loss of support from extended family)
- Brain damage from a head injury

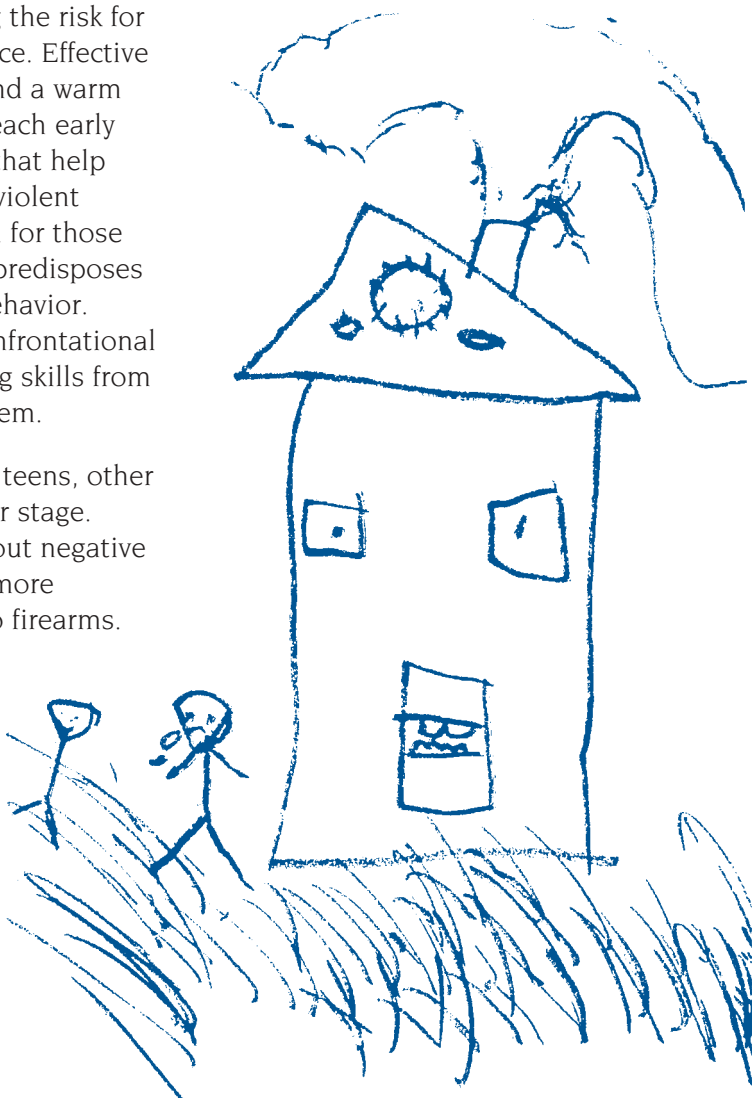


TIP CARD: When Children Witness Violence

Children see, hear, and remember more than adults think they do. When children witness violence in the home, they are often profoundly affected by it. This card describes various behavioral changes that can occur when children have been exposed to violence in the home. It provides some communication tools that adults can use to address the issue of violence with children.

A child's overall environment provides the most important information regarding the risk for involvement in violence. Effective parenting practices and a warm family environment teach early childhood behaviors that help children become nonviolent problem solvers, even for those whose temperament predisposes them to aggressive behavior. Children learn nonconfrontational social problem-solving skills from adults who display them.

As children grow into teens, other risk factors take center stage. Clinicians can ask about negative peer influences, and more importantly, access to firearms. While this guide centers on the issue of interpersonal violence, the availability of a handgun in the home is a significant risk factor for teen suicide.



Resiliency Factors

Even when confronted with the risk factors listed on page 3, most exposed children do not become involved in violent activities. Many young people have traits, characteristics, and environmental influences that interact with risk factors and allow them to cope positively with adversity, therefore reducing the probability of negative outcomes. These characteristics are protective qualities or *resiliency factors*. These resiliency factors allow children to recover from adverse or disabling events. Recent research has demonstrated the extraordinary power of psychological resilience in the face of adversity, and increasingly, community-based organizations set their sights on increasing youth resilience rather than directly addressing known risks.¹³

Individual traits associated with resiliency include the following:¹⁴

- Social competence — impulse control, communication skills, empathy, humor, and most importantly, not planning retaliation or revenge after experiencing violence
- Problem-solving skills — ability to avoid violent conflict altogether or de-escalate a violent situation
- Autonomy — self-control, taking responsibility for one's actions, and establishing a distinct identity
- Sense of purpose/future — motivation, persistence and hardiness, goal-directedness

Family factors have been found to have a significant positive association with resiliency in children exposed to community violence. These include caring and supportive relationships among family members, high parental expectations of pro-social behavior, parental monitoring of children, household structure with clear rules and regulations, and active participation of children in meaningful family activities.

Community-level influences on resiliency include the connections a youth has to the larger community. This includes involvement with athletic teams, adult mentoring, church and other religious groups, and neighborhood organizations. These activities promote meaningful connections with adults and friendships with peers who have positive, pro-social personal values. Both organizational and individual connections promote resiliency. Studies have also found that school support may be protective against the negative outcomes of witnessing violence, especially when a child is able to form positive attachments in school, is offered consistent support from teachers, and is academically motivated.¹⁵



A Developmental Approach

Since violent behavior patterns are often learned at an early age, it's never too early to help parents and children develop skills for nonviolent behavior that will serve them throughout their lives. In fact, many of these topics are already addressed in a routine office visit: disciplinary methods, television viewing, exposure to domestic violence/child abuse, and gun ownership. Good parenting skills can decrease violence-related risk factors and increase resiliency factors in children. More specifically, providers can use the information gained from a detailed history to determine particular areas of risk, and therefore educate patients and caregivers on ways to curtail the cycle of violence.

Children as young as preschool age can begin to show violent behavior. This includes a wide range of behaviors: explosive temper tantrums, physical aggression, fighting, threats or attempts to hurt others (including homicidal thoughts), use of weapons, cruelty toward animals, fire setting, intentional destruction of property, and vandalism. Frequently, parents and other adults who witness the behavior may be concerned; however, they often hope that the young child will "grow out of it." Involvement in violence at any age needs to be taken seriously and addressed directly. Follow-up studies of aggressive preschool children suggest that violent behaviors are likely to persist in the absence of an intervention.

Adolescents can be screened for behaviors that place them at risk for mental health problems and future involvement in violence. An assessment by a health care provider begins with obtaining information from a number of sources: the adolescent, parent(s), significant other(s), and school personnel. The role of the pediatrician should be to maintain the child's physical health while keeping the adolescent connected to support systems; the latter includes keeping parents hopeful and involved, encouraging teachers to work with the student, and supporting therapists in their efforts to treat.



Clinical Signs of High Risk for Involvement With Violence

- Signs of mental health deterioration, including suicidal ideation or attempt, psychosis, homicidality
- History of witnessed or experienced physical or sexual abuse
- Emotional neglect
- History of running away from home
- Marked change in physical health
- Dramatic behavior change (e.g., withdrawal, aggression, petty theft, drunk driving, truancy, sleep patterns, lax personal hygiene, or agitation)
- Poor school performance or attendance
- Impaired or absent family relationships
- Alcohol or substance abuse by the family or by the patient

Infants & Preschool Children

Violence-related risk factors begin early in life. Psychological researchers conducting longitudinal surveys have identified important risk factors for aggression that begin before a child starts school. In particular, ineffective parenting styles, child abuse, and corporal punishment have been implicated in the development of physical aggression among boys. Explosive temperaments and hyperactivity, which may be predictors of school failure, can be diagnosed in school children. Because health care providers see children often during these early years, we have an opportunity to establish an alliance with families that can be used to teach important parenting skills. In fact, many parents rely on their child's medical provider for advice on many issues of typical child development, from sleeping and feeding schedules to language acquisition. Therefore, discussing family dynamics and positive parenting skills is both expected and accepted.

Clinical Suggestions

Beginning in the postpartum period, ask about postpartum depression, family strife, and the presence or absence of support systems for parents.



As infants grow into toddlers, the focus shifts to behavior management. Providers can help parents learn about appropriate parenting and nurturing skills by using a variety of techniques:

- Screen for family violence and substance abuse.
- Ask about parental views regarding spoiling and discipline.
- Suggest using nonphysical discipline such as natural/logical consequences and time-out strategies. The American Academy of Pediatrics (AAP) recommends that parents be encouraged and assisted in the development of methods other than spanking for managing undesired behavior.¹⁶
- Encourage parents to find time to spend with their children by reading or playing with them. This is a powerful way for children to learn positive social skills.
- Explain the importance of monitoring and providing guidance for TV viewing.
- Talk about when children knowingly misbehave with assertive and aggressive behaviors. Is the child misbehaving in order to gain parental attention? While it is important that parents and others respond to negative behavior in a consistent manner, it is also critical for parents to consistently attend to and encourage appropriate behavior.
- Ask about the presence of handguns in the home. If removal is impossible, suggest safe storage: the gun should be stored unloaded and locked, with ammunition locked in a separate location.
- Children imitate their parents. Let parents know that the most effective teaching technique may be to simply model nonviolent behavior and conflict resolution for their children.
- Appropriate referrals to early intervention programs or to professionals experienced in treating behavior difficulties in this age group can decide a child's future.

TIP CARD: Raise Your Child With Praise

This card is for parents of children who are two to five years old. Based on behavioral techniques of positive reinforcement, the card uses straightforward language and examples to show parents how to use positive words and actions to teach young children which behaviors are expected of them. The card lays out practical tips and steps to help parents use praise to set clear rules and teach appropriate behavior in positive ways. Because toddlers and preschoolers are at different stages of development, there are separate examples for each age group.



TIP CARD: Time Out!

Using a step-by-step method, this card explains what a time-out is and why it is used, and prescribes time limits by age. Emphasizing a behavioral approach rather than a physically punitive approach, it is written specifically for parents of young children. The wording and design convey the information simply and in a format that can be posted on bulletin boards, the refrigerator, or taped to the wall as a reminder. Many parents misunderstand the meaning and use of a time-out; this card's practical suggestions and detailed guidance help parents avoid common pitfalls. Remind parents that for a time-out to be effective there is a need for a time-in: time spent with the child in positive experiences. To emphasize this point, consider handing out *Raise Your Child With Praise* along with *Time Out*!

Little i

When i am insecure i feel like the little i
usually because of someone else

when i remember this feeling

I try to help others

in hope that they will never know what
it's like to be the

little

i.

School-Aged Youth

By the time a child enters school, peer and community influences begin to be even more important. For children in this age group, violence-related risk factors include bullying at school, exposure to domestic violence at home, and witnessing violence on television. The presence of a gun in the home increases the risk of severe violence-related injury or death.¹⁷



Clinical Suggestions

Providers can do the following:

- Help parents understand a child's need to assume greater responsibilities. For example, children can assist with household tasks such as cleaning, doing the dishes, and caring for pets.
- Help parents understand the importance of anger management and conflict resolution skills, as well as appropriate empathy skills.
- Talk to parents about their own childhood experiences with violence, and remind them of the increasing availability and use of weapons. Many parents already understand that teaching these skills to their children may be a matter of life and death.
- Help parents understand the importance of developing consistent, clearly articulated family rules and agreed-upon consequences for breaking these rules.
- Encourage consistent discipline among different caregivers using nonviolent disciplinary strategies.
- Remind parents that they are role models for their children.
- Encourage parents to spend one-on-one time with individual children in order to nurture stronger relationships with the parent.
- Encourage children to engage in after-school activities: sports, music, theater, and recreational and community projects.

Sports-Related Violence

Recent tragedies have made it impossible to ignore the rising levels of violence that are being injected into youth sports. More than ever, sports are being viewed as win-at-all-costs activities, depriving children of the numerous benefits of sports participation. Because sports are an important part of our culture, exposing children to violence through sports has a profound impact on their behavior and development.

Health professionals can remind parents that the goal of sports participation for children is to have fun while learning skills. Competitive teams need to promote sportsmanship and strictly enforce no-tolerance rules for parental interference with referees, coaches, players, or other parents.

Sports offer an opportunity to teach children fairness, responsibility, and respect while providing an appropriate — and fun — outlet for energy and physical activity.



Media Violence

Not only is television viewing associated with involvement in violence, a recent large-scale study in California demonstrated that a reduction in television viewing leads to a reduction in fighting-related behaviors and attitudes.¹⁸ (Note: You may also want to tell parents that excessive television viewing is associated with childhood obesity.)¹⁹

The importance of monitoring and providing guidance for TV viewing starts at a very early age; however, with school-aged children, it is *total screen time* — TV, videos or DVDs, video games — that now becomes the issue. The AAP recommends a maximum of two hours a day of total screen time. An office visit is a good time to discuss the importance of limiting screen time. Encourage parents to talk openly about their objections to viewing violence with their children, and encourage parents to use age-appropriate alternatives such as the following:²⁰

- After-school activities — playing with friends, organized sports, reading
- Playing a musical instrument
- Listening to music or writing in a diary
- Mentoring programs, such as Big Brother and Big Sister, when appropriate

Parents might feel overwhelmed and helpless when it comes to media messages. Emphasize that while they may not be able to control everything their child sees, their guidance is important.

TIP CARD: Pulling the Plug on TV Violence

Children learn both good and bad habits from their TV heroes. This card discusses how violence seen on television affects children. While efforts to reduce violence on television have appeared controversial when reported in the media, countless studies of the effects of children's repeated exposure to TV violence have consistently demonstrated a causal link between television viewing and subsequent violence. According to an article in *Pediatrics*, children see over 12,000 violent acts per year on TV. Balancing facts with tips, this card gives parents information that will enable them to make personal decisions for their families about viewing violence on TV.

Adolescents

Adolescence is the time when the serious consequences of involvement in violence become apparent; youth between the ages of 15 and 24 have the highest incidence of homicide of any age group.²¹ Numerous research studies have been conducted, using a variety of methods, to help identify teenagers who are at a particularly high risk of violence-related injury.

From a clinical perspective, the lessons from these studies can be boiled down to a few salient facts. In early to mid-adolescence, teenagers become committed to a peer group with similar risk-taking behaviors. Teenagers who engage in antisocial or violent behaviors are also more likely to abuse drugs, be sexually precocious, and drop out of school.^{22, 23} It follows that the discovery of risky behavior in any one of these domains should lead to gentle inquiries into *all* of them.

From a community perspective, youth development programs that engage young people in meaningful activities typically protect them from multiple risk factors. The trend in medical practice is to incorporate an assessment of key assets for resilience — school attachment, belonging to pro-social groups, community service, future-orientation — into routine assessment of adolescents and young adults. Specific violence-related risk factors include witnessing or experiencing violence at home, a previous history of violence (i.e., recent fights and injuries), drug use, poor performance at school, truancy, and weapon carrying.^{24, 25}

Clinical Suggestions: Parents of Teens

Health care professionals can encourage parents to foster a child's independence and teach parents how to educate their children about the responsibilities of adulthood. However, parents need to maintain their attachment and involvement with their children during this process. Parental monitoring protects teenagers. Effective monitoring includes knowing where the child is at all times, finding out if there is adult supervision, and getting to know the parents of the adolescent's friends.

It is also important for health care professionals to encourage parents to discuss sensitive topics such as drug use and sex with their teens. Physicians and other professionals can help parents establish family rules that deal with potential areas of conflict like driving privileges, curfews, substance abuse, and school and household responsibilities.



TIP CARD: Some Myths and Facts About Violence and Tips on How You Can Help

This straightforward summary of common misconceptions about violence refutes a number of myths with the facts. The disturbing but captivating drawings and personal stories of children who have experienced or witnessed violence give poignant testimony to the tragedy of violence. This card identifies factors that place youth at risk for involvement in violence and provides specific tips for counseling. This parent education card was originally developed for professional audiences. Included in the card is valuable information for professionals who are working with children. This is also an excellent handout when speaking with schools and community groups. Much of the material contained in the background sections of this guide is summarized in the card.

Clinical Suggestions: Violence-Related History

Providers can discuss with adolescents strategies for avoiding or resolving interpersonal conflicts with friends and peers as well as what constitutes a safe dating relationship. Using the FISTS mnemonic to ask about *Fighting*, *Injuries*, *Sex*, *Threats* and *Self-Defense* provides the basis for an assessment of an adolescent's risk for involvement in violence.

(The FISTS mnemonic is adapted with permission from the Association of American Medical Colleges. Alpert, Elaine J., M.D.; Bradshaw, Ylisabyth S., D.O., M.S.; Sege, Robert D., M.D., Ph.D. "Interpersonal Violence and the Education of Physicians," Journal of Academic Medicine, vol. 72, no. 1, January 1997, p. S46.)

FISTS: Fighting — Injuries — Sex — Threats — Self-Defense

Fighting

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

Adolescents who report that they have been in more than two physical fights in the past year are at a substantially increased risk for future violence-related injury.²⁴ For those adolescents who disclose a recent fight, it is appropriate to get a more detailed account of that incident. Pay careful attention to how it started, what motivated this individual to fight, who else was there, and whether a weapon was involved. Explore whether there could have been a non-fighting resolution and assess this youth's ability to resolve a conflict easily.



Injuries

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

These two questions can help providers elicit an estimate of the severity of previous fights. Patients who have been injured are more likely to be injured in the future because of unresolved conflicts.

Sex

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

Remember that adolescents are often reluctant to talk about violence in their relationships because they may not have previous experience with a healthy dating relationship, are afraid of getting hurt, or are embarrassed, ashamed, or confused. It is important to provide teens with a safe environment where they can feel comfortable speaking frankly about their experiences.

Threats

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

These questions can be used to address the manner in which the youth reacts to a tense or threatening situation. They also help the health care professional assess the types of situations in which the adolescent is involved and whether or not these situations contribute to the adolescent's victimization or involvement in violence. If it is common for the youth to be involved in conflicts or react explosively to those conflicts, the youth is at a higher risk of engaging in violent behavior.

Self-Defense

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



Asking about weapons in the context of self-defense facilitates a more candid response. In all cases, carrying a firearm indicates high risk. Carrying a knife is not as clearly identified with violent behavior. For example, a small pocketknife may or may not be considered high risk.

After a history is obtained, providers can determine if the youth's risk for involvement in violence is low, moderate, or high. Based upon the level of risk, a discussion of an appropriate intervention or prevention strategy can then take place.

Low-Risk Youth

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

Intervention & Prevention Ideas

- Validate low-risk behavior.
- Ask about how the teen resolves conflicts while successfully avoiding fights.

Moderate-Risk Youth

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

Intervention & Prevention Ideas

- Take time to discuss the most recent fight and the kinds of strategies that can be used to de-escalate future situations. This is the opportunity to discuss anger management strategies and offer information about community resources.
- Consider referring this patient to a counselor to further discuss the issues and risky behaviors identified.
- With the teen's consent (although consent is not required), consider discussing intervention ideas with parents.

High-Risk Youth

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

Intervention & Prevention Ideas

- Talk with the family and the patient about the recent fights and discuss ways to avoid confrontations in the future. These may include anger management strategies, disassociation from a dangerous peer group, and learning to walk away.
- Youths at high risk may require intervention that is beyond the scope of primary care. Referrals to the appropriate mental health or social service resources may be required.

Caution: Violence at Home

When working with children and their families, it is assumed — usually correctly — that parents will respond appropriately, in a nurturing manner, to our behavioral suggestions. However, youth involved in violence are more likely than the general population to experience physical or emotional abuse from their parents. At times, these parents may respond inappropriately or violently towards their children when informed about their adolescents' risky behavior. When appropriate, seek a teenager's permission to discuss with their parents information that was confidentially obtained.

Dating Violence

While there are many reasons why teenagers may not want to discuss dating violence with their primary health care professionals, this is where an intervention by a provider can make a big difference. Adolescent victims of dating violence are more likely to attempt suicide, engage in risky sexual behaviors, report substance abuse, become pregnant, experience forced sex, ride in a car with a drunk driver, and develop eating disorders. Perpetrators of dating violence are more likely to demonstrate risky sexual behaviors (including those with same-gender partners), engage in forced sex, use illicit drugs, report increased depression, and show an increase in antisocial behaviors such as the use of violence against others. It is important to note that intimate partners and others known to the victim often commit coercive or violent sexual acts against adolescents.^{26, 27}

TIP CARD: Teen Dating Violence

Dating violence can assume a number of forms that include physical, verbal, emotional, sexual, and psychological violence. This card offers a comprehensive introduction to the issue of teen dating violence and the role that parents can play in its prevention. The card describes common myths about dating violence, the warning signs of becoming either a victim or a violent partner, how parents can communicate with their children about dating violence and relationships, and the reasons why teen dating violence is often difficult to detect.

Violence!!!

One final suggestion about primary prevention — inform as many other people as possible.

- Educate your administrative staff about the problem of youth violence.
- Have educational materials available in your office, patient rooms, waiting rooms, and emergency departments to educate parents, patients, and visitors.
- Use the Massachusetts Medical Society's *Violence Prevention for Children and Youth Parent Education Cards* (Tip Cards) and materials from other professional organizations to supplement your own educational materials.
- Make lists of referrals available to patients, parents, and staff. Keep lists updated, and add new resources as they become available.

PREVENTION OF REINJURY

In Boston, children and teenagers who are injured once in a fight, robbery, or assault and who require medical attention are six times more likely to be injured again.²⁸ Since professionals in the Emergency Department (ED) are the ones who often have contact with individuals immediately after a violent incident, the ED staff can play a critical role in identifying ways to prevent further injury.

Clinical Suggestions

Evaluation and intervention need to happen as soon as the initial injury is stabilized and a medical treatment plan has been initiated. This is important, because the goal is to decrease the potential for any debilitating psychological sequelae such as depression and post-traumatic stress disorder. The focus of this initial evaluation is crisis intervention. It does not matter whether the patient is the victim or the perpetrator, since studies have shown similar psychological profiles for both. Additionally, research has shown that victims frequently become perpetrators in future assaults.²⁹

This is also the time to gather information regarding other risk factors and premorbid conditions in order to direct additional follow-up. The interview to get this information can be done by a social worker, ED trauma nurse, psychologist, or physician. Topics to explore include the following:

- Previous weapon use
- Alcohol and drug abuse
- Mental health history
- Ongoing family violence
- Life at school
- Criminal history

Prior to discharge, find out if the fight is over. The following questions may help to get this current situation resolved:

- Is the conflict settled?
- Do you feel safe leaving the hospital?



- Is there a safe place to go while things cool off?
- What plans do you have regarding the other person(s) involved in the fight?
- Are you thinking about revenge?
- Is there an adult who can help mediate the fight? Is there a peer mediation program in your school or community?

Once this information has been obtained, interventions and referrals can then be based on individual circumstances.

Since these youths are at a substantial risk for a recurrent violence-related injury, consider trying to connect them with the appropriate services prior to discharge from the hospital. When all involved — patient, referral agencies, and the parent/guardian — have a good understanding about the follow-up services prior to discharge, health care professionals are increasing the chance of a successful intervention.

Social work assessments in the ED usually focus on crisis intervention; longer-term counseling and community outreach programs have been implemented in many communities.

Programs that teach skills such as conflict resolution, anger management, and sensitivity provide valuable tools for youth who have been injured. Other programs, such as those that offer job training, recreation opportunities, and spiritual/religious support, play an important role as well. In many cases, these programs provide links to other services that prove to be influential in preventing youths from being injured again.³⁰

Massachusetts law requires health care professionals to notify the Department of Social Services immediately when the health care professional has reasonable cause to believe that a youth has been subject to abuse or neglect.³¹ Note that a report must be made even in those cases in which the youth denies a history of abuse or neglect. Cases of rape and sexual assault must be reported to the Executive Office of Public Safety and the local police, without including the patient's identifying information.

Specific plans for revenge may call for police involvement if the health care professional believes that the youth remains determined to retaliate in kind and that the threat is both real and immediate. Given the broad protection of patient confidentiality afforded by state and federal law, the potential liability from violating patient confidentiality, and the undeveloped state of the law in Massachusetts concerning the duty to warn third parties, legal counsel should always be consulted before the police are contacted to protect a third party. If appropriate, an attempt should first be made to defuse the situation.

TIP CARD: Street Violence — Your Child Has Been Hurt — What You Can Do

This card is written for parents of children who required medical attention after being injured in a fight, robbery, or assault. It guides parents in what they can say and do for their injured child. Realistic advice is given on how parents can develop a safety plan for their child in addition to several no-nonsense tips on what parents can do to protect their child. The card provides guidance to parents on helping their children learn new behaviors, and offers practical tips for parents to share with their children on how to keep an argument from turning into a fight. This card is designed to help parents use an injury as an opportunity to prevent future — and possibly more serious — injuries.

Suggestions for Clinical Documentation

It is essential to have thoroughly documented medical records. These records may be used to provide concrete evidence of a violent incident, and they may be crucial to the outcome of any future legal proceedings. Critical elements include the following:²⁴

- History — a description of the violent event in the patient's own words, and past medical and social history. Avoid reaching conclusions here; simply state what the patient reports. Descriptions of the patient's affect and behavior and that of others' behavior with the patient are useful. It is best to name individuals rather than roles (e.g., "my boyfriend") and report the temporal connection between events.
- Physical examination — detailed description of injuries: type, number, size, location, stage, illustrations, and/or photos
- Results of diagnostic tests
- Forensic and evidentiary materials — *particularly crucial in cases of sexual abuse or assault*
- Diagnosis
- Referrals — including confidential legal referrals, when appropriate
- All information conveyed to the patient
- Discharge instructions

GAY, LESBIAN, BISEXUAL, AND TRANSGENDER (GLBT) YOUTH

People who self-identify as gay, lesbian, bisexual, or transgender (GLBT), or who are perceived to be GLBT, are at increased risk for involvement in violence, usually as victims. A national study reported close to 2,000 anti-GLBT incidents in 2002. Approximately 17 percent of these incidents occurred among individuals 22 years old and under. The same study reported 131 incidents targeting 163 individuals in Massachusetts; 12 percent of these victims were under the age of 22.³² Many of these attacks were hate crimes — the beating or murder of someone based upon beliefs, race, religion, or sexual orientation. Hate crimes may be particularly savage and include humiliation, rape, torture, and other unusually cruel acts. One case in Massachusetts involved a teenage boy having the word “homo” carved on his back in five-inch letters by two of his classmates using a pocketknife.³³

The Facts

- In a Massachusetts survey of high school students, adolescents who are self-identified as gay, lesbian, or bisexual were more likely to be attacked and/or threatened in school, and more likely to have skipped school because of fear about their personal safety.³⁴
- Many studies have shown that GLBT youth have an increased risk compared to their non-GLBT peers for suicidal thoughts and behaviors and suicide risk factors such as depression, hopelessness, alcohol abuse, recent suicide attempts by a peer or a family member, and experiences of victimization.^{35, 36, 37}

Two clinical issues further complicate counseling GLBT youth. First, many adolescents are not comfortable discussing issues of sexuality with their doctors. Second, many health care professionals are unaware of the physical and mental health risks facing these adolescents. With this high risk population, an open and honest discussion can serve as a bridge to educating adolescents about violence prevention, which in turn will help them access care for other complex physical and mental health matters.

However, an open and honest discussion of an adolescent’s sexual orientation may be difficult for the health care professional and the patient. One study showed that up to two-thirds of GLBT patients had never discussed their sexual orientation with their health care professional, but reported a desire to do so.³⁸ Concern of confidentiality, which was assured to fewer than one-half of the respondents in that study, was cited as a barrier to this discussion. On

the provider side, a lack of familiarity with GLBT-specific sexuality and health concerns may hamper discussion; however, a more important barrier is the *assumption of heterosexuality*.³⁹

Clinical Suggestions

For all adolescents, providers can do the following:

- Ask questions about their sexual behaviors in an open manner without making assumptions or judgments.
- Listen to and discuss the potential difficulties for youth that are developing their sexual identity — gay, lesbian, bisexual, transgender, and straight.
- Establish an atmosphere in which patients feel comfortable talking about sex.
- Develop an ongoing relationship with the youth, and let them know you are there to help. In the long run, this will be the most powerful thing a health care provider can do.

For GLBT youth, providers can do the following:

- Make the clinic as welcoming as possible — use posters, stickers, and “gay-friendly” rainbow flags to communicate to GLBT youth that they are welcome.
- Train reception and support staff about the myths and misconceptions about the GLBT community and how to be welcoming.
- Inform GLBT youth about the specific physical and mental health risks they face, and encourage them to attend GLBT support groups if necessary.

In Massachusetts, adolescents may seek medical advice without parental involvement if they qualify as emancipated minors or “mature minors.” See the Legal Resources section for more information about these rules for Massachusetts.

Advocacy

- Encourage school administrators and community leaders to develop programs addressing the problem of bias and hate crimes.
- Educate colleagues and staff about misconceptions regarding violence and the GLBT community. Like other assault victims, many victims of bias/hate crimes know their assailants.
- Support and participate in school-based health education programs that include special attention to issues affecting GLBT youth.

SEXUAL ABUSE

Any sexual activity between an adult and a child/adolescent (or an adolescent and a child) is considered sexual abuse. Sexual abuse takes many forms, including unwanted and inappropriate touch, exposure to sexual activity, and pornography.

The Facts

- According to the Department of Health and Human Services, there were 88,000 substantiated or indicated cases of child sexual abuse in the United States in 2000.⁴⁰
- Studies have shown that socioeconomic status, race, and ethnicity have almost no impact on the likelihood of experiencing child sexual abuse.⁴¹
- Sexual abuse rarely occurs as an isolated incident — children who are sexually abused are more likely to have experienced various forms of neglect, physical and emotional abuse, domestic violence, and household dysfunction.⁴²

Clinical Suggestions: Primary Prevention

Some physicians find it most natural to include information about sexual abuse as part of sex and personal safety education during well-child visits. Others discuss the topic during the appropriate part of the physical exam.

Providers should emphasize the importance of maintaining open communication between parents and children. Children can be encouraged to immediately tell their parents if an adult wants them to keep something a secret from their parents, or wants to see or touch parts of their bodies that are usually covered by a bathing suit. In addition, parents can be educated to be cautious if they notice a particular adult continually seeking opportunities to be alone with their child.

TIP CARD: Protecting Your Child From Sexual Abuse

This new tip card provides straightforward answers to questions that parents commonly ask about child sexual abuse. It includes practical suggestions for parents to protect their children from sexual abuse, information about the behavioral and physical symptoms of sexual abuse, and a list of phone numbers for parents to call if they are concerned about sexual abuse.

Clinical Suggestions: When There Is Suspicion of Sexual Abuse

While physical exams are often negative for signs of sexual abuse, behavioral indicators are often present. Sexually abused children may show nonspecific symptoms such as enuresis, encopresis, changes in sleep patterns, weight gain, provocative behavior, fear of a physical exam, or more specific behaviors, such as sexualized play or precocious knowledge of sexual activity. Additionally, they may act fearful of previously routine contacts, such as a hug from a caregiver. Although some touching and sexual exploration can occur as a normal component of healthy development, this usually occurs only with similar-aged peers during other routine play.

Sexual abuse is most often perpetrated by a trusted adult — an immediate or extended family member, family friend, or a member of the child's school, church, or athletic team community. Some of the families where sexual abuse occurs present with the following risk factors:

- Substance abuse in the home
- Parental mental illness
- History of abuse of the child's parent or caregiver
- Current or past history of domestic violence in the home

The diagnosis of child sexual abuse rests on three things: what the child says happened (disclosure), how the child acts (specific sexualized behaviors that the child exhibits), and the results of an anogenital examination. Of these, the disclosure is most important. Disclosure of sexual abuse by a child victim rarely occurs spontaneously. It is a process that occurs over time, usually in a structured dialogue with a mental health provider. Disclosure is a complicated process because of a child's limited understanding of sexual abuse, and because the perpetrator has made threats to the safety of the child or other family members.

Although physical examination often fails to reveal any tissue damage or proof that sexual abuse has occurred, all children who are suspected of having been victimized should be examined by a trained health care professional. This is essential to reassure the child that she or he is "okay down there." As with abuse or neglect, a report must be made immediately to the Department of Social Services if the health care professional has reasonable cause to believe that a child has been subject to sexual abuse. Reports of rape and sexual assault must be made to the Executive Office of Public Safety and the local police, without including the patient's identifying information.

PREGNANT TEENS

When a teenager comes in for prenatal care, health issues and the outcome of the pregnancy — parenting, adoption, abortion — can quickly become the focus of the visit. However, pregnant teens are at high risk for dating violence and sexual abuse, and may have become pregnant as a result of forced or coercive sex.⁴³ These risks may continue throughout the pregnancy and the postpartum period, threatening the well-being of both mother and child.

The Facts

- Teen pregnancy is an established sign of potential sexual abuse — studies have found that up to 66 percent of pregnant teens report a history of sexual abuse.⁴⁴
- In a 2001 study, 16.1 percent of pregnant teens reported prenatal violence, including 9.4 percent who experienced severe violence such as hitting, stabbing, or kicking.⁴⁵
- One study found that out of 535 pregnant teenagers, 44 percent had been raped, with 11 percent becoming pregnant as a result of the rape.⁴⁶
- Violence during pregnancy often continues into the postpartum period. In a study involving 570 adolescents, 75 percent of teens who reported violence during pregnancy also reported violence two years postpartum. Seventy-eight (78) percent of those who reported violence postpartum did not report any violence during pregnancy.⁴⁷

Clinical Suggestions

Because pregnant teenagers are at such a high risk for violence, physicians should consider screening for intimate partner violence repeatedly throughout the pregnancy and the postpartum period.⁴⁸ Research has shown that abused women are twice as likely to begin prenatal care during the third trimester compared to nonabused women.⁴⁹ Therefore, repeated questioning throughout the pregnancy, or asking about abuse later in the pregnancy is likely to elicit a higher reporting rate.⁵⁰

Teenagers in an abusive relationship may be unwilling — or unable — to discuss this violence for many reasons. However, professionals caring for pregnant teens are in a unique position to screen for involvement in violence. Repeated contacts during prenatal and well-baby care visits provide a unique opportunity to develop trust, which is essential in a woman's decision to disclose violence.

The steps in screening and intervention for intimate partner violence are summarized in the acronym RADAR, developed by the Massachusetts Medical Society.



(The RADAR mnemonic is adapted with permission from the Massachusetts Medical Society. Alpert E, Freud K, Park C, Patel J, Sovak M. Partner Violence: How To Recognize and Treat Victims of Abuse. Waltham, Massachusetts: Massachusetts Medical Society, 1992.)

RADAR

R — **Routinely screen every patient.** Screening should occur at multiple times during and after the pregnancy. This is because some women do not disclose violence the first few times they are asked, and abuse may occur later. It may also be helpful if the provider mentions that screening for violence is routine, so that the teenager does not feel like she is being singled out.

A — **Ask specific and direct questions in a caring and nonjudgmental manner.** Many women who experience violence do not identify themselves as “abused” because of the social stigma attached to that label. Thus, asking the teenager “*Are you being abused?*” may not be as effective as asking direct questions such as “*Are you frightened by your boyfriend’s temper?*” or “*Has your boyfriend ever hurt you or threatened to hurt you?*” To ensure the patient’s safety, the provider should avoid asking about violence in the presence of intimate partners, friends, or family members. The provider should also avoid asking questions that may increase the shame and humiliation that the patient is experiencing, for example, “*Why don’t you just leave?*” or could be interpreted as blaming her for the situation, for example, “*What did you do to make your boyfriend hit you?*”

D — **Document information about suspected intimate partner violence in the patient’s chart.** If sexual abuse is disclosed and the patient is under 18, health care professionals must notify the Department of Social Services immediately and should refer the patient to someone with experience in counseling for sexual abuse and violence. Rape and sexual assault must be reported to the Executive Office of Public Safety without including the patient’s identifying information.

A — **Assess the patient’s safety.** Questions should focus on whether violence or the threat of violence has escalated recently and whether there are any weapons — especially guns — in the home. If it is determined that the patient is in danger, a safety plan should be established before the teenager leaves the office if possible. Contact local domestic violence advocates for more information regarding a safety plan.

R — **Review options and provide referrals.** Providers should have a current list of local resources for victims of intimate partner violence. Whenever possible, teenagers should be connected with the proper social services *prior to leaving the office* that can teach parenting skills and prenatal care, as well as skills on how to protect themselves and their children from abuse. For follow-up visits, there are steps that can be taken to ensure against “no shows.” These include allowing for emergency visits and allowing the teen to wait in an inner office room upon arrival to decrease the likelihood that she will depart from the waiting room.



Despite tragic events in the 1990s, schools are still the safest place for children and adolescents. Health care professionals can help by informing parents and educators about prevention and response strategies.

The Facts

- Less than 6 percent of all serious child assaults occur in schools.⁵¹
- Being at school and receiving passing grades are protective factors against a violence-related injury.²⁴

Children do not learn only academics at school. They also learn socialization skills and how to function in their communities and in society. Schools can have a great impact on affecting positive outcomes and preventing violence by identifying risk and resiliency factors in children. In addition, school programs that teach students how to avoid behaviors that lead to involvement in violence are especially helpful. Students may benefit from programs that teach media literacy, conflict resolution, and resistance to risky sexual behavior and drug use.

School Settings

Elementary

Violence prevention efforts start in elementary school. At this age, bullying is a major problem. Bullying, the repeated victimization of one or more students by a stronger student, has potentially serious social and mental health consequences for children and adolescents. Victims of bullies were the perpetrators of several of the school shootings in the 1990s, demonstrating the extraordinary anger and resentment that bullying engenders.

Effective interventions require the involvement of the entire school and an understanding of the three roles associated with bullying — the victim, the bully, and the bystander. A coordinated intervention at all levels — school, classroom and individual — results in a school that is “bully-proof.” Descriptions of these programs can be found in *Best Practices of Youth Violence Prevention, A Sourcebook for Community Action and Bullying at School: What We Know and What We Can Do*. (See the Introduction section of this guide for more information.) If the school is not aware of these programs, the pediatrician can advise the administration to put these in place.

The U.S. government's program, Take a Stand. Lend a Hand. Stop Bullying Now! is available online at www.stopbullyingnow.hrsa.gov. This website was developed by the Department of Health and Human Services and the Maternal and Child Health Bureau based on the input of 9 to 13-year-olds. It contains extensive information on bullying in a kid-friendly format that includes animated "webisodes," featured profiles, and games.

TIP CARD: Bullying — It's Not Okay

Because bullying affects the victim, the bully, and bystanders, it must be addressed from every possible angle. This card provides general facts about bullying and tips on how to approach the issue with the victim, the bully, and the bystander. It also encourages the involvement of school administrators in bullying prevention.

Middle

In middle school years — an age of rapid growth in serious injury for students — violence prevention efforts can teach nonviolent conflict resolution skills and focus on the reduction of associated risks, including drug use and precocious sexual activity.

In one study, high perceived levels of drug use among one's peers and the actual prevalence of drug use in an adolescent's middle school were strong predictors of involvement in violence.⁵² Therefore, drug education and guidance to help middle school children learn how to resist drugs may yield an added violence-reduction bonus.

Research shows the positive effects of teaching conflict resolution skills to youth at this age.⁵³ Several curricula have been developed and assessed; the most effective of these involve the extensive use of role-playing interactions to transform cognitive understanding into changed behaviors.

High

In high school, the programs begun in the middle school need to be continued, but with an emphasis on dating violence intervention and peer mediation. Peer mediation curriculums are available and have proven to be successful.



School-Based Clinics

Comprehensive school-based health care in Massachusetts includes the following:

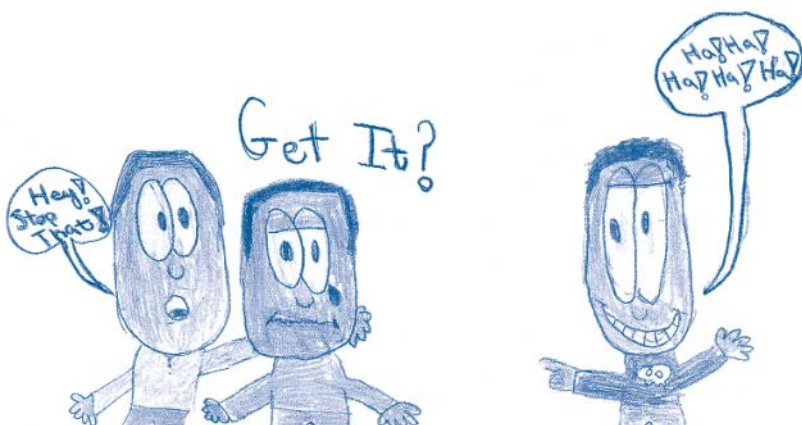
- Comprehensive health education curriculum
- School counseling and psychological services
- School health services
- Coordination of school and community resources
- School climate/environment

For a successful, comprehensive health education program, collaboration must exist between the school, the family, and the community.⁵⁴

Clinical Suggestions/Advocacy

As part of the community, physicians and other health care professionals can do the following:

- Advocate for violence prevention and intervention programs in schools.
- Encourage the use of schools as a community resource. After-school programs are an excellent use of school buildings. Physicians can support the use of schools as a community resource by offering educational programs for parent and teacher groups, as well as student groups.
- Advocate for the availability of and access to health and mental health services in the school or in agencies that are closely linked to the school.
- Encourage parents to discuss violence and violence-based issues with their teenagers.



Coordinated Response to Violent Incidents

Fortunately, it is very rare for violent events at a school to result in injuries and longer-term psychological sequelae for the entire school and the community. Violence prevention programs are most likely to be successful and beneficial when everyone in the community works together as a team and members of the team are clear about their roles. Physicians and other health care professionals can work closely with schools (teachers, administrators, and students), families, relevant community agencies, and other community members on the development of the following:

- Prevention programs
- Emergency response plans
- Efforts to effectively and appropriately identify students at risk or in need of services

The roles and responsibilities of all individuals and agencies, as well as the overall plan, must be clear to everyone involved. This promotes collegial interaction among all relevant players, allows coordinated rapid responses when necessary, and avoids unnecessary and detrimental finger-pointing. The most effective responses are those planned in advance. It is important to keep in mind that each act of violence at a school is unique, and therefore the plans need to be flexible to account for this.

As part of the community, physicians and other health care professionals can do the following:

- Work with schools in the development of response planning and offer to develop the appropriate medical responses.
- Develop appropriate screening efforts to identify children at risk and to assure that inappropriate labeling and profiling does not occur.
- Help to assure that key players are involved in all planning and implementation activities.

THE JUVENILE JUSTICE SYSTEM

Despite a steady decline in juvenile crime over the past decade, 2.3 million youth under 18 years of age were arrested in 2001. While most youth are arrested for nonviolent offenses, youth are responsible for 15 percent of all violent crimes. The majority of youths who go through the juvenile justice system are put on various forms of probation, but about 14 percent end up in correctional facilities.⁵⁵

Youths in the juvenile justice system are often disenfranchised from traditional health care services in the community. For many of these youths, health care provided through correctional facilities may be their major or only source of health services. Thus, health care providers have a unique opportunity to help improve the well-being of this underserved and vulnerable group of adolescents.

The Facts

- Approximately 10 percent of teenagers entering juvenile correctional facilities have significant medical problems (excluding substance abuse and uncomplicated STDs) that could seriously affect their functioning if left untreated. The most commonly diagnosed conditions were asthma, orthopedic problems, mental illness, and hearing-related problems.⁵⁶
- Detained youths have higher rates of STDs and increased rates of sexual risk behaviors compared to their peers. In a 2003 study, 95 percent of juvenile detainees reported 3 or more risk behaviors for HIV and AIDS.⁵⁷
- Nearly two-thirds of male and nearly three-quarters of female juvenile detainees met diagnostic criteria for one or more psychiatric disorders. Nearly 50 percent of males and females had a substance use disorder, and more than 40 percent of males and females met criteria for disruptive behavior disorders (oppositional defiant disorder and conduct disorder).⁵⁸
- A 2004 study in Cook County, Illinois found that 92.5 percent of juvenile detainees experienced at least one traumatic incident, and 11 percent met criteria for post-traumatic stress disorder in the past year. The most commonly reported trauma was witnessing or hearing someone get seriously injured or killed.⁵⁹

Many youth offenders develop physical and mental health problems during their incarceration. Youths in juvenile detention are at high risk for injury, especially intentional injury.⁶⁰ Incarcerated adolescents also have higher rates of suicide attempts and use more violent methods of attempt than adolescents in the general population.⁶¹ Youths may also become victims of physical and sexual

abuse perpetrated by other inmates or staff during incarceration. This may be influenced by many factors, including overcrowding and poor supervision or behavioral management.⁶²

Identifying the risk and resiliency factors involved in juvenile delinquency is an essential step in developing interventions. Most experts agree that no single factor leads a child to delinquency. Rather, the likelihood of juvenile delinquency increases as risk factors accumulate and resiliency factors decrease. These factors operate in many domains including the individual, family, peer group, school, neighborhood, and the media.⁶³

One important risk factor is exposure to violence. Using data from the *National Longitudinal Study of Adolescent Health*, researchers have found that victims of violence were significantly more likely than nonvictims to become violent offenders. They also found that victims and perpetrators of violence share many of the same risk factors, including previous violent victimization and offending, drug and alcohol use, and depression. This finding is particularly important because it suggests that interventions directed at preventing victimization could also reduce offending, and vice versa.⁶⁴

Girls in the Juvenile Justice System

The number of adolescent girls arrested and incarcerated in the United States has been steadily increasing over the past years. In 2001, there were 645,000 arrests of females under the age of 18, accounting for 28 percent of all juvenile arrests. Most of these arrests were for nonviolent offenses — usually drug-related crimes — but the number of violent crimes committed by girls is rising.⁵⁵

Research has shown that girls in the juvenile justice system appear to have both increased and different mental health needs than their male counterparts.⁶⁵ Girls have higher rates of psychological symptoms and psychiatric disorders. They have higher incidence of physical, emotional, and sexual abuse, physical neglect, and family history of mental illness.⁶⁶ Girls also report more traumatic experiences and are 50 percent more likely than males to be diagnosed with post-traumatic stress disorder.⁶⁷

Some adolescent girls in the juvenile justice system are pregnant or already parents. Thus, girls have multiple and unique programming needs, including health care, education, mental health treatment, prenatal care and parenting skills, substance abuse treatment, family support, and job training.

Minorities in the Juvenile Justice System

In contrast to their representation in the population, minorities are overrepresented in juvenile arrests for nonviolent and violent crimes. This is especially true for African Americans. In 2001, the racial composition of the juvenile population was 17 percent African-American, yet of all juvenile arrests for violent crimes, 43 percent involved African-American youth.⁵⁵ Although researchers have long been aware of racial and ethnic differences that occur along various points of the juvenile justice system, interpreting these differences has been problematic. Nevertheless, it is important for health care providers to be aware of these differences in order provide the best care for the juvenile population.

Clinical Suggestions

Physicians and other health care professionals can recognize and diagnose medical and psychiatric disorders in incarcerated juveniles and can provide them with the care and treatment they need. Appropriate and comprehensive treatment of these youths' medical and mental health conditions puts them on the track to better overall health and can help prevent future involvement in violence.

While clinical assessments need to include a complete history, physical exam, and psychiatric evaluation, taking a *violence history* is key when encountering juvenile offenders as patients.

A comprehensive violence history involves assessing the following:

- History of trauma and exposure to violence
- Victimization
- Aggression

This approach recognizes the three roles in a violent act: victim, bystander, and aggressor. By finding out the patient's role, the provider can better treat the individual.

Medical and mental health care must continue after a young person is released from a juvenile justice agency. Medical services, particularly mental health services, can prevent delinquents from committing further crimes, and help assure their rehabilitation once released from juvenile justice centers.

Currently, much research is being conducted on the aftercare model, which provides youth with comprehensive health, mental health, education, family, and vocational services upon their release from the juvenile justice system. The model combines strategies to change individual behavior with surveillance mechanisms to protect the community from further harm. Programs based on the aftercare model have been shown to be effective. For more information, refer to *Aftercare Services*, published by the Office of Juvenile Justice and Delinquency Prevention. This article is available online at www.ncjrs.org/html/ojjdp/201800/contents.html.

Advocacy

- Support rigorous research to accurately describe the health care and mental health status of juveniles in the justice system.
- Support multimodal, community-based treatments to address the needs of incarcerated juvenile patients.
- Help train legal and correctional professionals in contact with juveniles about child and adolescent development and mental health disorders.



THE ACUTELY VIOLENT PATIENT

One of the greatest concerns of practitioners is encountering a violent patient. These encounters are infrequent, but the establishment of policies and procedures for managing violent patients will help reduce the incidence of violence, increase the sense of security among staff members, and ultimately provide better patient care.

Health care professionals should approach a violent patient with the view that violence is a symptom of a larger problem. Maintaining this perspective can help uncover underlying etiology and direct the patient toward appropriate care.

When faced with a patient who is contending with a history of violent behavior or a recent violent act, a health care professional's first priority is to ensure safety for the patient and for those in the immediate area.

Patients at high risk for violence must be evaluated in a secure environment. All potentially dangerous materials, including heavy or sharp objects and furniture that can be used as weapons, should be removed from the interview space. In addition, the area should allow for escape and visibility, and quick backup help should be available. During the interview, the examiner needs to pay close attention to the patient's verbal communication and body language — escalating anxiety and tension, increasing verbal abuse and profanity, and increasing hyperactivity may be signs of imminent violence.

In an acute situation, medical conditions that result in aggression or irritability and may require emergent therapy must be ruled out. The **WHIMPS** mnemonic is a helpful place to begin the process:

- W** — Wernicke's or withdrawal
- H** — Hypoxia, hypoperfusion, hypertensive crisis, hypoglycemia, or hypo/hyperthermia
- I** — Intracranial bleed/mass or intoxication
- M** — Meningitis
- P** — Poisoning
- S** — Status epilepticus

In addition, for children, also consider lead poisoning, iron poisoning, iron deficiency, evidence of abuse from a skin or x-ray examination, and drug intoxication.

A general Mental Status Exam is essential for an adequate assessment of violent patients. It should include a sense of the patient's sensorium to rule out delirium and screen for affective, thought, and anxiety disorders. An assessment of the level of cognitive function can frequently uncover deficits in the patient's communication skills and ability to respond appropriately to challenging situations.

Since the best predictor of violence is past violence, a comprehensive violence history is extremely important in assessing a patient's risk for violence. Details of current and past episodes of violence, including the beginning or precipitants, the nature of the violence, and the conclusion or consequence, must be investigated. Screening questionnaires, such as the Violence and Suicide Assessment (VASA), are helpful tools in this process.⁶⁸ If possible, collateral information should be obtained from the patient's family, school, and other sources. Since abuse and neglect are the most common contributors to violent behavior, collaboration with social workers and state social service agencies is frequently required.

Clinical Suggestions

Whenever a parent, physician, or other adult is concerned about violent behavior, they should immediately arrange for a comprehensive evaluation by a mental health professional, since early treatment can often help. Diagnostic assessments frequently uncover multiple diagnoses. These problems can be addressed by individual and group treatments that focus on helping children to do the following:

- Control and express anger and frustration in appropriate ways
- Improve social skills — communication, relationship-building and maintenance, problem-solving, and conflict resolution
- Take responsibility and accept the consequences of their actions

Psychopharmacologic assessment is important in addressing conditions that may be responsive to medication, including post-traumatic stress disorder, attention deficit hyperactivity disorder, bipolar disorder, atypical depression, anxiety disorders, autism, and schizophrenia. Problems with substance abuse need to be addressed, since alcohol increases the risk for violence by a factor of 12. Recovery from drug addiction often requires a multimodal treatment approach.

In addition, family conflicts, school problems, and community issues must be addressed. Management of the at-risk adolescent often necessitates a multidisciplinary approach. Social and mental health services are frequently involved, since emotional issues that affect teens are complex and beyond the scope of the general pediatrician.

Family-based interventions that have proven to be successful focus on building cohesion and emotional warmth within the family, strengthening adaptive behavior in the adolescent, and minimizing marital problems that interfere with the parents' ability to function effectively. Family Stabilization Teams can provide intense support to families in crisis and coordinate the establishment of treatment plans. Community-based interventions include Big Brother and Big Sister programs and other mentorship programs that often involve community leaders and educators.

Physicians and other professionals can be important advocates and coordinators of services for patients with violent behavior. Most communities have psychiatric crisis hotlines that provide information and evaluation services. The Department of Social Services and the Department of Mental Health can provide information about the services available in your area.



Recent studies have confirmed the correlation between the availability of guns in the home and the risk of unintentional shootings, homicides, and suicides among children and teenagers.⁶⁹ Although many Americans keep guns in their homes in the hope of protection, statistics show that these guns are more likely to be used accidentally by a child, increase the risk of a suicidal adolescent completing suicide, and be involved in intimate partner violence.^{70, 71}

In 2001, 3,749 children and teenagers (under 21 years of age) died of firearm injuries in the United States.¹ Thousands of children were permanently disabled as a result of firearm injury.⁷² In addition, recent studies have shown that the majority of children who are hospitalized due to firearm injuries are injured at home.⁷² Therefore, the AAP, the AMA, the ACP, and other professional organizations have advised physicians and other professionals to educate patients and parents about the dangers of owning guns and keeping them in the home, particularly handguns.^{73, 74}

Facts About Guns

- Thirty-five (35) percent of households in the United States own at least one gun.⁷⁵
- In a 1995 national survey, 59 percent of parents who acknowledged having a gun in the home did not lock the gun away from their children.⁷⁶
- In a 2003 CDC survey, 6.1 percent of high school students in the United States reported carrying a gun at least once in the last 30 days.⁵
- Persons with a history of at least one handgun purchase in the family are twice as likely to commit suicide or homicide than those who do not.⁷⁷
- For every time a gun in a home is used in self-defense, there were four unintentional shootings, seven criminal assaults or homicides, and 11 attempted or completed suicides.⁷⁸
- Firearms are the most common method of completed suicide.⁷⁹
- Persons living in homes where a gun is available are 5 times more likely to commit suicide than those living in homes without a gun.⁸⁰
- In 2001, firearms were used in 33 percent of suicides among 10 to 14-year-olds and 54 percent of suicide cases among 15 to 24-year-olds.⁸¹
- As a result of guns, the following occur every day in the United States:
 - One child under the age of 10 is killed and two are accidentally injured.
 - Eight adolescents between the ages of 15 and 19 are killed, and 38 are injured.⁸²

Clinical Suggestions

Discuss the risks associated with keeping a gun in the home and encourage parents to remove guns from their homes. If a parent cannot remove a gun from the home, stress the importance of storing all guns unloaded, storing bullets separately in a locked compartment, and utilizing safety mechanisms such as trigger locks and loaded chamber indicators. Many physicians find this conversation most comfortable in the context of childproofing the home from other common household hazards.

Encourage parents to ask their neighbors, friends, and family whether they own a gun, and if so, whether or not the gun is unloaded and locked in a place where a child cannot access it.

Recent research suggests that teaching children and parents about gun safety may be ineffective. First, it fails to address a key issue: many parents believe their own children are already safe, and they may not interpret the advice as applicable to themselves or their children.^{83,84} In a 2003 study,⁸⁵ 87 percent of parents that were surveyed believed that their children would not touch a gun if they found one. The most common reason given was their children were “too smart for that” or “knew better.” In contrast to parental expectations, research has shown that most children will readily handle a firearm if given the opportunity, regardless of how much previous gun safety education they have received.^{86,87,88} Thus, health care providers’ interventions may be more effective if they emphasize children’s developmental capabilities and behavioral tendencies during discussions about gun safety.

Health care professionals can also do their part in preventing gun violence by advocating for stricter regulations of gun sales, promotion of safer guns, and strict enforcement of existing regulations designed to prevent youth from acquiring guns. Several professional organizations, including the AAP, have called for bans on sales of handguns as well as assault weapons.

TIP CARD: Protecting Your Child From Gun Injury

Although numerous educational programs have sought to teach gun safety to children, these programs cannot overcome children’s natural curiosity about items they encounter in their environment, including guns. This tip card provides information to parents of young children about steps they can take in order to protect their child from gun injury or death.



Emancipated Minor and Mature Minor Rules

As a general rule, Massachusetts law requires a minor who seeks medical treatment to obtain the consent of a parent or guardian. However, an emancipated minor may give consent to confidential health care (except abortion and sterilization), evaluation, and treatment without the consent of a parent or guardian. A minor is an emancipated minor if he or she fits one of the following categories:

- The minor is or was legally married. (This minor may also consent to abortion or sterilization.)
- The minor is a parent.
- The minor is pregnant or believes she may be pregnant. (Some physicians limit the medical treatment to only that which relates to the pregnancy.)
- The minor is living independently, physically and financially.
- The minor is a member of the Armed Forces of the United States.
- The minor reasonably believes that he or she has come into contact with a disease dangerous to the public health (but the care rendered must be limited to that related to the diagnosis or treatment of the disease).

In all of these circumstances, if there is a danger to the life or limb of the minor, the minor must be notified that the health care professional must inform the parent or guardian.

In addition to the emancipated minor rule, the mature minor rule permits adolescents to seek medical advice without parental involvement if they qualify as “mature minors.” In order to determine that an adolescent is a mature minor within the meaning of Massachusetts law, a health care professional must determine the following before providing treatment without parental consent:

1. That the best interests of the minor will not be served by seeking consent from a parent; and
2. That the minor is capable of giving “informed consent.”⁸⁹

The mature minor rule does not apply to abortion or sterilization. If the health care professional does not believe a youth is capable of giving informed consent for any reason, the legal situation becomes much more complicated, and advice of counsel should be sought before care is provided without parental consent.⁹⁰

Reporting Youth Violence and Child Abuse

Under Massachusetts law, health care providers and many other professionals who work with children are defined as “mandated reporters.” Mandated reporters are required to immediately make an oral report to the Department of Social Services, when in their professional capacity, they have reasonable cause to believe that a child under 18 years of age is suffering from abuse or neglect. This includes any physical or emotional injury resulting from abuse, including sexual abuse; or any indication of neglect, including malnutrition; or any instance in which a child is determined to be physically dependent upon an addictive drug at birth.

A written report must be submitted to the Department of Social Services within 48 hours after the oral report has been made. Failure to make the required oral or written reports is punishable by a fine.

For more information, refer to *Child Abuse and Neglect Reporting: A Guide for Mandated Reporters*, published by the Massachusetts Department of Social Services. This downloadable guide is available online at www.mass.gov/dss/mandatedreporter.pdf.

The complete text of the relevant Massachusetts law is also available online at www.state.ma.us/legis/laws/mgl/119-51A.htm.

Reporting Rape and Sexual Assault

Under Massachusetts law, every physician attending, treating, or examining a victim of rape or sexual assault must report the case immediately to the Executive Office of Public Safety, Statistical Analysis Center, and to the local police of the town where the attack occurred. The report must not include the victim’s name, address, or any other identifying information. Failure to make the required report is punishable by a fine. The complete text of the relevant Massachusetts law is available online at www.mass.gov/legis/laws/mgl/112-12a.5.htm.

Over time, laws are revised. If there is any question about the reporting of youth violence or a violence-related injury, consult your organization’s legal resources or personal legal counsel.

Violence is a medical and public health issue. Pediatrician advocacy starts in the patient's early childhood. Advocacy at this age can involve encouraging daycare centers to provide adequate staffing and parenting skills education, lobbying with physician organizations for insurance coverage for mental health needs of pediatric patients, and staffing at schools for children with special needs.

Teach Your Peers

Use seminar opportunities — for example, grand rounds — to teach others about the risks of violence and the methods of prevention and intervention.

Teach the Public

Once you have developed a knowledge base, share the information with the community. As a health care provider, you are in a unique position to influence public opinion. For public speaking or writing opportunities, you can contact the speakers bureau of your professional association.

Get Involved in the Community

There are many opportunities to build goodwill in young people and your community. See if your place of employment can offer a young person a summer or after-school job. You may also want to consider volunteering for or serving on the board of directors for one of the many community-based organizations in your area that work with youth. Pediatricians can also bring children and adolescent health needs to the attention of their religious organizations.

Advocate

Health care providers can be very effective citizen-advocates. You can contact legislators, make yourself available to testify before committees, or encourage your professional association to become more involved and active on local, state, and national levels. Some important telephone numbers to help you get started are:

Local City/Town Hall: _____

Commonwealth of Massachusetts: Governor's Office — (617) 725-4000

Senate — (617) 722-2000, House of Representatives — (617) 722-2000

National: U.S. Senate — (202) 224-3121,

U.S. House of Representatives — (202) 224-3121

REFERRALS & RESOURCES

National Resources

- The American Academy of Pediatrics: www.aap.org
- The Children's Safety Network: www.edc.org/HHD/csn
- Coalition for Juvenile Justice: www.juvjustice.org
- Join Together: www.jointogether.org, (617) 437-1500. This is a national resource for communities fighting substance abuse and gun violence.
- Website for GLBT Students: www.gayfortwayne.com
- Parents and Friends of Lesbians and Gays (PFLAG): www.pflag.org. Go to the "Chapters" link for a listing of local chapters. (202) 467-8180.
- National Mental Health Association — Juvenile Justice Section: www.nmha.org/children/justjuv/index.cfm.

Primary Prevention — Preteens

- Department of Social Services: www.state.ma.us/dss, (617) 748-2000.
- Parental Stress Line: (800) 632-8188
- Child At Risk Hotline: (800) 792-5200
- Boston Public Health Commission, Healthy Baby/Healthy Child: (617) 534-5832; ext. 112, program director; ext.103, information
- Ware Coalition for a Better Community, Ware, MA: (413) 967-6241

Primary Prevention — Adolescents

- Center for the Study of Sport in Society, Northeastern University, Boston, MA: www.sportinsociety.org, (617) 373-4025. The mission of the Center is to increase awareness of sport and its relation to society and to develop programs that identify problems, offer solutions, and promote the benefit of sport.
- National Youth Sports Safety Foundation, Inc.: www.nyssf.org, (617) 367-6677. NYSSF is a national nonprofit educational organization dedicated to reducing the number and severity of injuries youth sustain in sports and fitness activities. NYSSF with the Governor's Committee on Physical Fitness and Sports developed a Sport Parent's Code of Conduct to promote sportsmanship.
- Massachusetts Department of Public Health — Violence Prevention Services for Adolescent Services: (617) 624-5476

Boston Area

- Boston Public Health Commission, Adolescent Wellness Program: www.CityofBoston.gov/publichealth, (617) 534-5196.
- Teens Against Gang Violence: www.tagv.org, (617) 825-8248. A teen peer-leadership program that is not against gangs, but against gang violence.
- Boston Asian Youth Essential Services: (617) 482-4243
- Tree of Life/Arbol de Vida, Jamaica Plain Coalition, Jamaica Plain, MA: (617) 522-4832. Provides workshops for parents and youth on violence risk behaviors.
- Project FREE, Roxbury, MA: (617) 988-5053. This is a violence intervention program for at-risk youth in the Franklin Hill and Franklin Field communities.

Outside the Boston Area

- GATHER — Greater Attleboro/Taunton Health and Education Response, Attleboro, MA: (508) 823- 4822. Provides education and information on referral and support services for parents and children at risk.
- Melrose Alliance Against Violence, Melrose, MA: (781) 662-2010. Community-based organization focused on violence prevention through community awareness, education and outreach.
- Quabbin Mediation, Athol, MA: (978) 544-6142. This is a coalition of organizations, including schools, the YMCA, law enforcement, and private businesses who are developing a strategic plan to decrease youth violence in the North Quabbin region.



Gay, Lesbian, Bisexual, and Transgender (GLBT) Youth

- GLBT Health Access Project: (617) 988-2605
- Fenway Community Health Center, Boston, MA: General Information, (617) 927-6000; GLBT Help-Line, (617) 267-9001; Peer Listening Line: 1-800-399-PEER
- Northampton Community Health and Safety Advisory Committee, Northampton, MA: (413) 587-1361. School-based program that educates at-risk youths on conflict resolution, community service, substance abuse, homophobia, and gang involvement. As a referral program, it has extensive services for GLBT youth.
- Sidney Borum Jr. Health Center: General Information, (617) 457-8140; GLBT, (617) 988-2605. This center provides primary medical care, substance abuse and mental health counseling, general psychiatric services, and HIV case management for adolescents and young adults, as well as specialized services for gay, lesbian, bisexual and transgender youth, street youth, and persons living with HIV/AIDS.

Schools

- Department of Education — Safe and Drug Free Schools Initiative: (781) 338-6309
- Lexington Public Schools, Health Protection Advisory Council, Lexington, MA: (781) 861-2348. An activity-based after-school program for eighth grade students that focuses on teaching conflict resolution, reducing opportunities for risky behavior, and encourages a successful transition to high school.
- Marblehead Public Schools: Health Protection Advisory Committee, Marblehead, MA: (781) 639-3147. Program designed to increase community involvement in violence prevention efforts; services are offered within the schools.
- Northampton Community Health and Safety Advisory Committee, Northampton, MA: (413) 587-1361. School-based program that educates at-risk youths on conflict resolution, community service, substance abuse, homophobia, and gang involvement. As a referral program, it has extensive services for GLBT youth.

Juvenile Justice System

- Children's Law Center of Massachusetts: (781) 581-1977
- Committee for Public Counsel Services: (617) 482-6212. Arranges for public defenders and private counsel. The Youth Advocacy Project deals with juvenile delinquency and youthful offenders, and the Children and Family Law Program deals with civil family cases.
- Haverhill Police Department, Haverhill, MA: (978) 373-1212, ext. 148. Provides violence education to police, health care workers, and educators and will implement community program on violence.

Boston Area

- Boston Community Centers' Street Worker Program: (617) 635-4920
- Boston Juvenile Probation: (617) 788-8571
- Boston Police: Gang Unit, (617) 343-4246; General, (617) 343-4200
- Community Justice Partners, Roslindale, MA: (617) 474-8301. A program that helps juvenile offenders adjust back to the community.
- ROCA — Restorative Justice groups; street workers involved with gangs and/or the courts; Alternatives with Work Program; Leadership Programs: (617) 889-5210

Recommended Publications

These publications are excellent resources on youth violence prevention for health care providers and will augment the information in this guide. *Note: All resources were checked and found to be available at the time of publication.*

- *Youth and Violence — Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence.* American Medical Association, Committee for the Prevention of Youth Violence, 2002.

To obtain free copies, contact the AMA at (312) 464-4526, or by fax at (312) 464-5842. This can also be downloaded via the internet at www.ama-assn.org/go/violence.

- *Best Practices of Youth Violence Prevention, A Sourcebook for Community Action.* Thornton T., Craft C., Dahlberg L., Lynch B., Baer K., eds. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2002.

This can be downloaded via the internet at www.cdc.gov/ncipc/dvp/bestpractices.htm.

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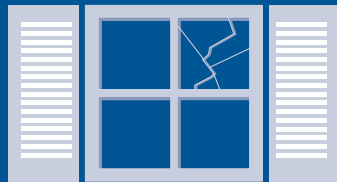
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"Prejudice is a form of violence that can't be stopped simply by words. We have to take action like saying kind things, and not making fun of people for things they can't help. Just by doing that, we can begin to create peace in our lives."

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