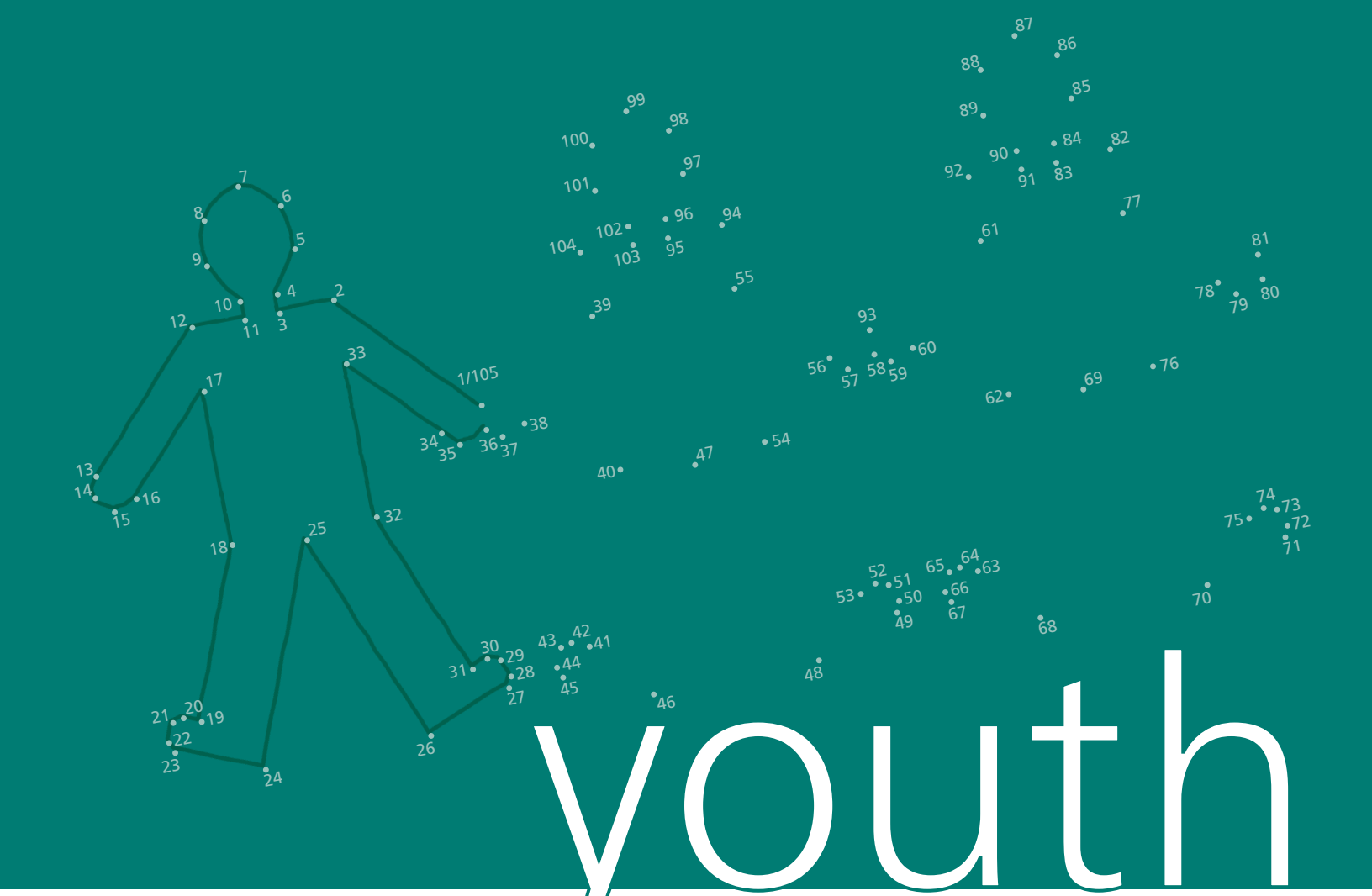

youth and violence

Medicine, Nursing, and Public Health: *Connecting the dots to prevent violence*

From the Commission for the Prevention of Youth Violence
December 2000

youth and violence

Medicine, Nursing, and Public Health: *Connecting the dots to prevent violence*

From the Commission for the Prevention of Youth Violence

December 2000

Table of contents

The Commission for the Prevention of Youth Violence

Commissioners

American Academy of Child and Adolescent Psychiatry
Marilyn Benoit, MD

American Academy of Family Physicians
Bruce Bagley, MD

American Academy of Pediatrics
Howard Spivak, MD

American College of Physicians-American Society of Internal Medicine
Whitney Addington, MD

American Medical Association
J. Edward Hill, MD
Nancy Nielsen, MD, PhD

American Medical Association Alliance
Susan Paddack

American Nurses Association
Elaine Williams, RN, NP

American Psychiatric Association
David Fassler, MD

American Public Health Association
Carol Easley Allen, RN, PhD

US Department of Health and Human Services
Nicole Lurie, MD, MSPH

The following people contributed considerably to the work of the Commission and deserve special recognition.

Carolyn Lopez, MD, Chair, Department of Family Practice, Cook County Hospital, Chicago, IL. Dr. Lopez represented the American Academy of Family Physicians.

Jack Ginsburg, Director of Policy Analysis and Research, American College of Physicians-American Society of Internal Medicine

Jacque Admire Borgelt, MSPH, Assistant Director, Scientific Activities Division, American Academy of Family Physicians

Barbara Hatcher, RN, PhD, MPH, Director of Scientific Activities, American Public Health Association

Project Staff
American Medical Association
Reed Tuckson, MD
Clair Callan, MD
Arthur Elster, MD
Roger Brown, PhD
Missy Fleming, PhD
Jim Lyznicki, MS, MPH (project manager)
Vickie Grosso (project assistant)

Writer
Lauren Phillips
Phillips Medical Writers, Ltd.

For further information or additional copies of this report, please contact

Jim Lyznicki, MS, MPH
American Medical Association
312 464-4520 (phone)
312 464-5842 (fax)
jim_lyznicki@ama-assn.org

This report is accessible via the Internet at:
http://www.ama-assn.org/violence

Dedicated to those—

Youth workers, educators, health care, law enforcement, and juvenile justice professionals, researchers, community advocates, victims, and survivors

—on whose shoulders we build.

The Commission for the Prevention of Youth Violence was established in October 1999, with funding by The Robert Wood Johnson Foundation, to apply the skills, scientific rigor, and insight of medical, nursing, and public health professionals to the issue of youth and school violence. Its charge was to: (1) conduct a detailed exploration of the critical questions concerning youth and school violence; and (2) develop and disseminate a report that identifies the role of health care professionals and others in violence prevention and intervention, including a specific action agenda. Toward this end, the Commission solicited testimony from both within and outside the health care community, including community advocates, concerned citizens, and youth representatives. This report synthesizes that testimony with the existing scientific literature to outline the rationale behind the Commission's recommendations, which are listed in the section "Priorities and recommendations."

Introduction

Connecting the dots

If my child lives long enough to die from lung cancer, I'll be thrilled.

— a mother's response to a query by physicians at Cook County Hospital in Chicago about why smoking cessation efforts targeting youth were not being embraced in the community.

Littleton, CO. . . Jonesboro, AR. . . West Paducah, KY. . . Moses Lake, WA. . . Pearl, MS. . . Edinboro, PA. . . Springfield, OR. . . Conyers, GA. . . Fort Gibson, OK. . .

These towns, where the shock of school shootings still reverberates, have become emblems for a nation's fear and bewilderment at the violence that threatens our children. The litany of place names evokes images of children and teenagers in small, peaceful places gunning each other down not in gang wars or for drug money but— for what? We do not know. We only know that violence has moved beyond the inner cities where we, to our shame as a nation, were willing to tolerate it. And that, finally, something must be done to stop it.

So far, that something has been largely punitive in nature and aimed at those who are already moving beyond the reach of family, education, health care, and social services into the realm of the law. The 1990s saw, in addition to the boom in prison construction, the introduction of new gun control policies, zero-tolerance policies, community policing initiatives, boot camps for juvenile offenders, and, perhaps most tellingly, the increased use of judicial waivers that permit us to pretend that violent children are simply small adults.[1] From 1992 to 1995, 47 states and the District of Columbia changed laws to allow increased prosecution of juveniles as adults; as a result more than 12,000 juveniles— 7 out of 10 African American—are transferred to adult court each year. Between 1994 and 1997, the number of youths under age 18 in the adult prison system rose 35%—despite irrefutable data showing that treating juveniles as adults increases both recidivism and violence.[2]

In 1997, 3.1 million students, disproportionately minorities and special education students, were suspended from school, leaving them vulnerable to a variety of health and safety risks, starting with higher dropout rates. Yet suspension rates bear no relationship to the actual incidence of school crime.[3]

Instead of being afraid *for* our children, we are becoming afraid *of* them. They also may be afraid of each other: Nearly 8% of adolescents in urban junior and senior high schools miss at least one day of school each month because they are afraid to attend.[4] Yet, despite the real threat of violence that exists in schools today, most students are safer in school than out of it and safer from each other than from some adults in their lives.

Even the murderers among them—and juveniles murder almost 10 people every day[5]—are not monsters before whom we can only cower in shock. They may or may not be beyond salvaging—we have hardly begun to try—but they were, at one time, simply hurt children. Young murderers typically were raised amidst violence, abused by one or more of the adults who were supposed to care for

them. Ninety-six percent of them have a diagnosable psychiatric disorder. Although most have been arrested before, only 14% have ever received any mental health care.[5]

Throughout the United States, dedicated individuals, groups, and institutions have reported varying degrees of progress toward improving the safety and well-being of children and adolescents. As a result of their ongoing work, we already know a great deal about how to prevent youth violence and we are learning more every day. What we must do now, in the words of psychiatrist Carl Bell, MD, is to "connect the dots" and bring together the expertise and experiences of people and organizations working on different pieces of the puzzle (Commission testimony, March 2000). Efforts to address individual aspects of the problem, however laudable, must pale compared with the power that can be brought to bear in a coordinated effort by all elements of the community to address the problem as a whole. Only in this way can we arrive at the critical mass essential for meaningful social change.

With this report, the Commission for the Prevention of Youth Violence calls upon our colleagues in medicine, nursing, and public health to join with others in taking a firm stand against the violence that is devastating families* and communities throughout this country. More school suspensions and more prisons are not the answer. *The answer, rooted in public health, is prevention.*

* Throughout this document the Commission uses the terms "parents" and "families" broadly, recognizing the variety of nontraditional family configurations and situations that exist in this country. The Commission appreciates that not all children grow up in families composed of the child and both biological parents. Rather, the Commission's report and recommendations are directed to adult caretakers generally; a parent is considered to be any adult legally responsible for the care of a child.

Youth and violence

Setting the stage

Violence is the #1 cause of violence.

— Tom VandenBerk, Founder and President of the Board, HELP for Survivors

Youth violence has been called an epidemic, comparable to the impact of war, more devastating than polio, AIDS, or motor vehicle crashes. One can debate the label, but not the facts behind it—starting with the fact that the United States has the highest youth homicide and suicide rates among the 26 wealthiest nations.[6]

Violence has many faces—from war to gang violence, from hate crimes to violence against intimates—and all of them affect children.[14] School violence is just the newest and most visible face of this deeply rooted, multi-faceted, societal problem. The rise in levels of fear about youth and school violence felt by children, parents, and public officials in recent years stems from four factors first seen in the adult population: (1) an increase in mass murder/suicides—in particular, shootings; (2) increased lethality of firearms and ammunition; (3) more random violence; and (4) fewer safe places.[1]

Some cold facts

- In 1933, 75% of deaths among youth aged 15-19 years were from natural causes; in 1993, 80% were the result of homicide and unintentional injury.[7]
- Among youth aged 10-14 years, homicide and suicide are the third and fourth leading causes of death, respectively; among 15-to19-year-olds, they are second and third.[6,8]
- About 1 in 8 people murdered each year in the United States are younger than 18 years of age.[9]
- Almost 40 children and adolescents are killed by violence each week in this country[2]; fewer than 1% of such violent deaths are associated with schools.[10]
- In 1999, the odds of dying a violent death in school were one in two million.[3]
- For the school year 1996-97, the US Department of Education reported 188,000 fights or physical attacks not involving weapons in schools, 11,000 fights involving weapons, and 4,000 incidents of sexual assault.[11]
- In an average month, public secondary schools nationwide experience 525,000 attacks, shakedowns, and robberies and 125,000 threats against teachers—more than 5,000 of whom are actually harmed.[4]
- In the United States, almost 16 million adolescents—including 70% to 95% of children in our inner cities—have witnessed some form of violent assault, including robbery, stabbing, shooting, murder, or domestic abuse.[7,12]
- Violent behavior peaks at ages 16-17; 80% of young people who behave violently during adolescence cease doing so by age 21.[13]

In this country, violence affects young African Americans and other minorities disproportionately, a disparity that follows them into emergency rooms, courtrooms, and morgues. For example:

- Young black females and males are 4 and 11 times, respectively, more likely to be killed than white youth.[15]
- African American juveniles are overrepresented at all stages of the juvenile justice system.[2]
- In 1997, minorities accounted for 24% of the total juvenile population but 67% of juveniles committed to public facilities.[2]

Violence is a learned behavior, and in life as in school, children are the students not the teachers. What adults do to children and to each other, children will also do. According to the American Academy of Pediatrics, exposure to violence and victimization are strongly associated with subsequent acts of violence by victims.[6] Children themselves may appreciate this cycle of violence—when asked about the causes of youth violence, they invariably put violence in the home as #1 and bullying at school as #2.[16]

Left unchecked, violence will likely proliferate in suburbs and small towns, where families and communities now grapple with the same phenomena that have left the urban poor so vulnerable for so long. These include gangs, drugs, and the lack of community bonding; all of which are good predictors of violence.[7] In many communities, the children of immigrants and refugees add to the volatile mix a plethora of cultures, languages, and experiences that can engender other risk factors such as social isolation, family disruption, bigotry, and poor academic skills, as well as post-traumatic stress disorders associated with victimization and war. Disturbing data also suggest that girls are now engaging in more violent behavior—and using guns—at rates approaching those of boys (Deborah Prothrow-Stith, MD, MPH, Commission testimony, January 2000).

Recent figures give some reason for hope. During the mid-1990s, the overall incidence of both weapon carrying and fighting—two risk factors strongly associated with violence—decreased among adolescents.[8] Between 1993 and 1997, the risk of serious violence at school, which is greater for urban than for suburban or rural students, declined 29% overall.[2,3] The 26 violent deaths associated with schools that took place in 1998-99—including the 12 at Columbine—represented a 40% drop from the previous year.[3] (What has risen is the number of *multiple-victim* events.) Indeed, the US homicide rate as a whole has been steadily decreasing since 1993, which was the first year in which arrests for weapons possession increased faster than the homicide rate since the latter began to rise sharply in 1985.[17] In 1997, the homicide rate among youth aged 14-17 years was the lowest since 1988.

While these trends are encouraging, the reasons behind them have been difficult to decipher. The causes and consequences of family, youth, and community violence are complex and closely intertwined. The boundaries between them are so porous that it is impossible to pinpoint the parameters of each problem, to say for example "Here is where youth violence begins and ends." We know that the seeds of violence are planted early. We know that children are harmed cognitively, emotionally, and developmentally when they witness or experience violence.[6] Even before that, we know that poor prenatal care and parental drug abuse, for example, leave infants vulnerable to an array of biological and functional disorders that can predispose them to violence later in life. And we know that appropriate parenting can go a long way to ameliorate the ill effects of biology and environment—to place a protective buffer around children, as it were, and to strengthen their abilities to cope in appropriate ways with whatever breaks through from the outside.

Only by preparing youth to be effective parents, educating current parents about how to better care for and nurture their children, and providing all families with ongoing community support can we hope to break the cycle of violence. *We have said that violence is learned behavior. . . So is nonviolence.*

The high cost of violence

It is impossible to put a price tag on youth violence that accounts for all the damage done to individuals, families, and communities. There is no way to measure the emotional pain, the lost opportunities, the stunted growth. It is, however, possible to estimate the dollar costs:

- Three percent of US medical spending each year is due to interpersonal violence.[18]
- Firearm injuries alone cost between $1.4 and $4 billion annually in direct medical costs—much of which is not reimbursed to hospitals—plus another $19 billion in indirect costs such as lost future earnings.[19]
- Approximately $44 million is spent annually to treat injuries caused by domestic violence, not including indirect costs.[20]
- The expense of treatment programs for child abuse and neglect is estimated at more than $500 million annually; and this covers only direct services and not long-term mental health care or educational services.[21]

Violence prevention

The public health approach

We must move from looking at individual children to looking at the toxic environment.

— Deborah Prothrow-Stith, MD, MPH,
Director, Division of Public Health Practice, Harvard School of Public Health

When polio was prevalent in this country, no one blamed our children for succumbing to it. Neither did we accept the inevitability of death and disability wrought by that disease, nor expect to eradicate it by relying on young people to always make the right choices. Yet we seem to have abandoned our children to the scourge of violence.

From the public health perspective, youth violence is not an inevitable fact of life but a social problem that can be prevented, using the same rational approach that had such great effect on other public health challenges such as drunken driving, use of seat belts, and smoking. The Commission for the Prevention of Youth Violence wholeheartedly embraces this constructive approach.

The public health model incorporates six core elements[15]:

1. Community-based methods to identify sources of the problem, assuming a population-based perspective.
2. Epidemiological data/analyses to identify patterns of risk and protective factors.
3. Ongoing surveillance and tracking to establish trends in the prevalence and incidence of risk factors.
4. Community-based interventions grounded in scientific analysis of the problem and designed to reduce or eliminate risk factors and enhance or introduce protective factors, ideally in multiple domains.
5. Evaluation and monitoring of interventions to establish and improve their effectiveness.
6. Public education to share information about the problem and about effective and ineffective interventions.

We have already described the nature of the problem and its dimensions. For the most part, steps 3 through 6 constitute the great work that lies ahead for the emerging youth violence prevention movement. What follows in this section is a look at the critical influences and factors that contribute to or protect youth from violence and fundamental approaches to violence prevention.

Critical influences on youth violence

Violence prevention and intervention efforts are best directed at eliminating or ameliorating risk factors and enhancing and promoting protective factors.[15] A youth does not pick up a gun and shoot

a classmate or rape a neighbor solely because he or she watched too much violent television or was abused at home or suffered racial injustice or could not read. A single event may set off the explosion but the charges were laid over time as a result of the interaction of multiple individual, situational, contextual, and societal influences.[22] Risk factors for violence and aggression are additive and follow a developmental sequence[20]; this is why programs designed to diminish them must be developmentally appropriate. Risk factors are also interdependent and are affected by a range of life experiences and influences involving family, peers, community, and culture, as well as an individual's personal physical and mental health status.

Behavioral influences. Most children and adolescents who engage in violence have pre-existing emotional, cognitive, neurodevelopmental, and/or psychosocial problems. They may have suffered recent loss, disappointment or rejection; felt alienated or disenfranchised; experienced academic failure; or fallen into alcohol or other drug abuse. For some, the early onset of aggressive behavior in childhood puts them at increased risk for delinquent behavior and criminal involvement later in life.[23] Most serious juvenile offenders have a history of childhood misbehavior, including antisocial behaviors such as physical aggression; conduct disorders; and disruptive, covert, oppositional, and defiant behaviors.[24]

Biological influences. Forty-three percent of juvenile murderers in one study suffered past serious head trauma, which may have contributed to the etiology of the murderous behavior.[5] But brain damage can result from emotional as well as physical blows. Scientists have shown that, as late as school age and even into adolescence, exposure to a single extreme situation of violence can change the structure and function of the brain in ways that are likely to interfere with academic performance and behavior.[25]

Research indicates the important role of certain brain chemicals, especially the neurotransmitters serotonin and noradrenaline, in regulating aggressive behavior; it also suggests that negative experiences in early childhood, particularly severe neglect and abuse, can cause long-lasting changes in the levels of these chemicals in some individuals.[26]

Economic influences. A quarter of all young children in the United States live in poverty, including 37% of African Americans and Hispanics under age 18 and 16% of white children.[2] Numerous dimensions of poverty relate to high rates of community violence, including high levels of transiency and unemployment, crowded housing, low levels of community participation and organization, firearm and drug distribution networks, increased school dropout rates, alcohol and other drug abuse, unemployment, and teen pregnancy.[23] In all ethnic groups, rates of violence are highest for boys and men at the lowest economic level. At any given economic level, few differences are found among racial groups.[15]

Compounding the effects of poverty on increased rates of crime and violence are the "spillover effects" of our large and still growing income inequality, which tends to coexist with underinvestment in people as measured in a variety of ways, including high dropout rates in schools.[27]

Societal, familial, and environmental influences. These factors include bigotry, intolerance, and injustice; easy access to weapons, alcohol, and other drugs; exposure to violence in the family and community; poor schools; and lack of opportunities for children to engage in purposeful, positive, supervised activity outside of school. Also included in this sphere, is the rampant violence that bombards children from video games and television, and from movie and computer screens.

Family violence has been said to be the training ground for youth violence, the breeder of hate. Less obvious but just as critical is inadequate parenting: failure by parents to set clear expectations for their children; failure to supervise and monitor their children's behavior; and excessively severe, overly harsh, or inconsistent parenting.[16] Family risk factors also include mental illness in the family, abuse of alcohol and other drugs by family members, large family size, stressful life events, family disorganization, and poor parental bonding.[28]

Many adolescents spend up to 40% of their non-sleeping time alone or with peers or adults who might negatively influence their behavior. Low-income youth are more likely than others to be home alone for three or more hours after school—which is the time during which most juvenile violent crime is committed.[29] Youth who embrace the culture of violence are most likely to feel socially disconnected, with no stake in society, no sense of a productive future, and no trust in adults.[29]

Key risk factors

Research indicates that a number of factors increase the risk of violence during childhood and adolescence. As mentioned previously, risk factors are complex and interdependent and can be influenced by multiple variables, individual and societal. In delineating specific risk factors for youth violence, we highlight six (alcohol and other drugs, child maltreatment, gangs, guns, media violence, and violence among intimates and peers) that were consistently singled out in testimony to the Commission as key pieces in the complex puzzle of youth violence:

Alcohol and other drug use. A strong link exists between alcohol use, crime, and violence.[30]

- More than 60% of domestic violence incidents involve an offender who is drinking.[30]
- In the United States, 40% of students who drank alcohol at school also carried a weapon at school compared with 4.4% of those who did not drink.[14]
- Half of youth homicide victims have elevated blood alcohol levels on autopsy, as do those youths who commit homicide and are apprehended in time to test.[7]
- Students' use of alcohol declined between 1978 and 1993 and has fluctuated within a limited range since then; still, 31% of high school seniors, 24% of 10th graders, and 14% of 8th graders reported heavy drinking in the two weeks preceding a 1998 survey.[2]

Drug use exacerbates juvenile violence in multiple ways. It is firmly associated with an increase in the prevalence of carrying firearms and it alters the perceptions and increases impulsivity of young people, who are already inclined during adolescence to take risks.[29] Drugs are also related to crime by generating violence and other illegal activity in connection with drug trafficking.[31] About 50% of youth who are arrested test positive for illicit drugs.[31]

Child maltreatment. The National Center on Child Abuse and Neglect recognizes six major types of child maltreatment: physical, sexual, and emotional abuse and physical, educational, and emotional neglect.[21] The effects of child abuse and neglect reverberate through the years:

- In 1997, almost 300,000 children in the United States were the subject of confirmed reports of abuse and over half a million more were found by child protective agencies to be neglected.[26]
- Unreported incidents of maltreatment are estimated to be as high as three million a year.[32]
- In 60% to 75% of families in which a woman is battered, children also are battered.[16]
- Experiencing childhood abuse and neglect increases the likelihood of arrest as a juvenile by 53% and of committing a violent crime by 38%.[29]
- Children who are abused or neglected are far more likely to abuse their own children later in life.[26]

Many parents would be shocked to find that "ordinary" corporal punishment—spanking—has the identical effect on children as child abuse, albeit with lower frequency. In one high-crime neighborhood, youths whose fathers used corporal punishment on them (and a quarter of 16-year-olds are hit by their parents, nationwide) were more likely than other youth to be convicted of a serious crime (34% vs 14%). While approval of spanking has dropped from 96% to 54% over the last 30 years, 94% of parents still spank toddlers; while 34% of parents admit to hitting an infant under age one (Murray Straus, PhD, Commission testimony, May 2000).

Gangs. Youth gangs are responsible for a disproportionate share of all criminal offenses, violent and nonviolent.[2] While the proportion of juvenile crime committed in groups did not change significantly between 1973 and 1997, gang problems now affect more jurisdictions than before, including rural and suburban areas with no previous gang experience. A quarter of rural areas, a third of small cities, and 57% of suburbs now report active gangs. This may help explain the rise in gang participation by whites, which is higher—up to 32%—outside of big cities. The proportion of female gang members is small but apparently also on the rise. Likewise, more students report the presence of gangs in their schools, where gang activity has boosted the violent victimization rate from 2.7% to 7.5%.[2]

Gang members are more likely than nonmembers to be involved with guns: in one study, 68% regularly bought and sold guns and 61% described "driving around shooting at people you don't like" as a regular gang activity.[29]

Guns. The rise in murders of juveniles from the mid-1980s through the peak year of 1993 was *entirely* firearm-related, as was the subsequent decline in juvenile murders through 1997.[2] In many parts of the country, firearms have surpassed auto crashes as the leading cause of death among children and youth.[7] In fact, homicides involving firearms have been the leading cause of death for black males aged 15 to 19 since 1969, and teenage boys in all racial and ethnic groups are more likely to die from gunshot wounds than from all natural causes combined.[29]

Since 1889, 223 million firearms have been produced in or imported to the United States.[19] An estimated 192 million guns are in private hands today; at least 25 million households keep handguns and 50% of their owners keep them loaded.[19,33] Handgun owners typically cite self-defense to justify this practice, but suicides, homicides, and accidental deaths in the home outnumber deaths associated with self-defense by 40 to 1.[19] Family and friends are the primary sources of guns for young people; only 5% have asked someone else to purchase a gun for them from legal or illegal sources.[34]

As a direct result of America's fascination with firearms, the US firearm-related homicide rate for children is more than twice that of Finland, the country with the next highest rate.[2] Sixty percent of youth incarcerated in the United States see nothing wrong with shooting someone to "get what you want" (James Wright, PhD, Commission testimony, May 2000).

Media violence. The average child views about 25 acts of violence a day on television, or some 200,000 such acts by age 18.[16] According to the Federal Trade Commission, movie studios, record companies, and video game producers are actively marketing violent entertainment products to children.[35] While teenagers do not believe that violent TV shows, video games, and movies cause violence in real life, they concede that the media may have a role in promoting violence and desensitizing them to it.[16] They are right. Based on more than 30 years of research, the conclusion among public health professionals is that viewing entertainment violence can lead to increased aggressive attitudes, values, and behavior, particularly in children.[36]

Studies of the effects of TV violence suggest that children confronted incessantly by violent images in the media may:[37]

- become immune to the horror of violence;
- come to accept violence as a way to solve problems;
- imitate the violence they observe; and
- identify with victims or victimizers in unhealthy ways.

Children are certainly affected by the massive coverage given by news media to sensational violence, including incidents of mass murder/suicide, which may trigger copycat behavior in some children and adolescents.[14]

Violence among intimates and peers. Some two million women are assaulted each year by domestic intimates,[38] more than 50% of such women live with children younger than 12.[32] More than 3.3 million children witness physical and verbal domestic abuse each year, and they are 15 times more likely to be maltreated than youth in homes without domestic violence.[16] They are also more likely to be victimized in intimate relationships as adults as well as to become a perpetrator or victim of violence on the streets.[7,26] The effects of witnessing domestic violence, even among very young children, can include traumatic stress reflected in higher levels of depression and anxiety, attention and learning problems, and greater likelihood of developing aggressive and anti-social behavior.

Between 10% and 30% of teens experience violence while dating, which is not surprising in view of a survey in two Chicago high schools in which 28% of boys responding believed that "girls needed to be punched or slapped sometimes."[32] One in seven school children is either a bully or a victim of a bully, one of the distinct warning signs of youth violence.[4,3]

Warning signs of youth violence

Many children and youth who behave violently have a long history of emotional and behavioral problems. Signs and symptoms of trouble usually have existed for years, not as isolated behaviors or single emotional outbursts. Consultation with a mental health professional should be considered for children who display behavior patterns incorporating one or more of the following signs:

- frequent loss of temper
- frequent physical fighting
- significant vandalism or property damage
- making serious threats
- extreme impulsiveness
- alcohol and other drug abuse
- easily frustrated
- hurting animals
- preoccupation with violent or morbid themes or fantasies in schoolwork, artwork, or choice of entertainment
- carrying a weapon
- name calling, abusive language
- bullying or being bullied
- truancy
- excessive feelings of rejection, isolation, or persecution
- gang affiliation
- depression, despair
- low self-esteem
- threatening or attempting suicide
- extreme mood swings
- deteriorating school performance
- being witness to or the subject of domestic abuse
- setting fires
- preoccupation with weapons and explosive devices
- history of discipline problems
- social withdrawal
- blaming others for difficulties and problems

(Sources: 32,33,39; David Fassler, MD, Commission testimony, March 2000)

Note: These indicators are not necessarily reliable precursors or predictors of violent or delinquent behavior. They must be interpreted carefully and cautiously to avoid the risk of unfairly labeling and stigmatizing an individual. Just as important as responding to early warning signs is not over-reacting, in what US Secretary of Education Richard W. Riley called "mechanical profiling of students."[39] Stereotyping and labeling can have devastating and indelible effects.

Protective factors

When we look at children who have overcome adversity in their lives, we are most likely to see the effect of protective factors.[15] These include intact family structures, positive peer groups, and supportive communities that can work to[28]:

- decrease dysfunction directly;
- buffer the effects of violence risk factors;
- disrupt the mediational chain by which risk leads to disorder; and
- prevent the initial occurrence of risk factors.

To some extent, resilient children may be born that way. They enter the world with certain qualities—intelligence, an easy disposition—that are themselves protective against violence.[20] For the most part, however, protective factors fall into three broad domains, all of which can be altered and all of which can be mediated to some extent by poverty[28]:

- individual characteristics, including not only temperament, which is a given, but cognitive and social skills, which are not;
- environmental interactions, starting with secure attachments to parents and extending to peers and other adults who engage in positive behaviors and have positive values; and
- aspects of the larger community such as quality schools, recreational and cultural opportunities, and regulatory activities such as laws limiting youth access to alcohol and firearms.

Effective parenting equips children with essential skills (social, cognitive, emotional), the confidence to use them appropriately, and positive goals toward which to strive. To a great extent, success or failure in developing these skills depends on the strength of the parent-child bond that is created, ideally, in infancy. Multiple, positive interactions with warm, nurturing parents form a solid foundation from which children may venture into the world with their self-esteem intact, bolstered in many groups by a strong spiritual orientation. Children who report feeling connected to a parent, regardless of race or economics, are protected against many health risks, including violence and suicide.[7]

For this reason, efforts to foster resiliency and build social and cognitive skills in children must begin early—with classes for expectant parents, home visitation for at-risk families with newborns, and early childhood development programs such as Head Start for all children.[40] The degree of social cohesion, indicated by factors such as civic trust and community involvement, can further foster resiliency by building confidence and self-esteem in children and adolescents.[27] We have seen, for example, that adult supervision and involvement of youth in prosocial activities provide further protection against the development of delinquent behavior.[29]

Levels of intervention: coordination is key

The public health model calls for community action to influence one or more critical factors. To be most effective, such action must be coordinated across three different fronts:

Primary prevention targets an entire population with universal programs designed to prevent problem behaviors from developing in the first place. Strategies include strengthening positive aspects of the family and community; enhancing the developmental competencies of youth; and improving the environment by, for example, implementing a comprehensive school health and mental health curriculum or providing school staff with diversity training.

Secondary prevention identifies and serves specific populations at risk for or involved in violence such as children who have been exposed to violence in the home. Selective and sustained programs such as home visitation for low-birth-weight babies, support groups for children who have suffered loss, and school counseling services are examples of secondary prevention.

Developmental assets

The Search Institute has identified 40 developmental assets, which can be seen as both building blocks and measurements in the construction of resiliency in individual children, groups of children, and communities.[41] The assets focus on positive experiences with the people and institutions in young people's lives (external) and on the shaping of dispositions that encourage responsibility and compassion (internal).

External assets

- Support (family support, positive family communication, other adult relationships, caring neighborhood, caring school climate, parent involvement in schooling)
- Empowerment (community values youth, youth as resources, service to others, safety)
- Setting of boundaries and expectations (family, school, and neighborhood boundaries; adult role models; positive peer influence; high expectations)
- Constructive use of time (creative activities, youth programs, religious involvement, community service)

Internal assets

- Commitment to learning (achievement motivation, school engagement, homework, bonding to school, reading for pleasure)
- Positive values (caring, equality and social justice, integrity, honesty, responsibility, restraint)
- Social competencies (planning and decision-making, interpersonal and cultural competence, resistance skills, peaceful conflict resolution)
- Positive identity (personal power, self-esteem, sense of purpose, positive view of personal future)

According to the Search Institute, assets have "tremendous power to protect youth from many different harmful or unhealthy choices." In a survey of almost 100,000 6th-12th graders during the 1996-97 school year, only 6% of students with 31-40 assets had engaged in violence, compared with 33% of those with 0-10 assets.

Tertiary prevention, more commonly called treatment, is aimed at children and youth who have already demonstrated problem behaviors, including not just the 108,000 who are incarcerated but the 1.8 million who are processed through the courts each year.[2] The US Justice Department advocates a graduated sanctions system that combines treatment and rehabilitation, including secure care programs for the most violent offenders (Betty Chemers, Commission testimony, January 2000).

Prevention of firearm-related injuries provides a good example of how coordinated actions on each level can reinforce one another, as shown below:

	Primary prevention	Secondary prevention	Tertiary prevention/treatment
Strategy examples	Gun safety-lock legislation; public education on potential hazards of firearms; collection of standardized firearm injury data	Firearm safety education for families of gun owners; clinical intervention and screening for gun owners	Confiscation of gang weapons; mental health intervention for shooting victims and perpetrators

Identifying and promoting leadership, linkages, and coordination within the community are key to public health intervention at all levels. Collaboration ensures that the best possible use is made of all resources—human, financial, space, and time—and that individual efforts create a continuum of service that is easily accessed and understood. Unexpected partnerships can energize and focus people who might otherwise spend valuable time sparring over strategies and resources. For example, connecting different groups of survivors of youth violence locally and nationally can multiply the effectiveness of this forceful, committed but often splintered constituency, allowing it to assume its appropriate leadership role.

Other examples of community partnerships to prevent youth violence include:

- Public health agencies helping schools collect and analyze data and implement prevention programs, as well as providing health and social services;
- Medical professionals working with school personnel and correctional authorities to provide evaluation and health care services;
- Social service agencies helping law enforcement by providing case management services for families of children and youth who repeatedly collide with the law;
- Faith communities joining with schools, community agencies, and prisons to promote spirituality, morality, and healthy decision-making among teens.
- Police working with elected officials and public health authorities to reduce widespread, easy, and unsupervised access to firearms by children and youth.

Violence prevention

Programs and strategies

Science is not dogma. It has to be used in context and shouldn't keep us from being creative. Just because a good idea didn't work in one place doesn't mean it can't work.

— Kimberly Joseph, MD, Trauma Surgeon, Cook County Hospital, Chicago

The success of violence prevention efforts in Boston in the late 1980s and early 1990s—when the number of children murdered annually in the city dropped from a high of 14 in 1988 to zero in 1996—was the result of a comprehensive, community-wide campaign. The campaign cost $20 million in federal juvenile justice funds and involved both deterrent actions (arrests of gang members and gun dealers) and supportive interventions, such as the hiring of more than 100 part-time counselors for teens, a basketball league limited to gang members, and the coordination of city-funded community centers and local churches.[42] While it is impossible to say precisely which environmental, social, and programmatic factors had the greatest impact—and, certainly, not all of them would work in the same way in every community—it is clear that the Boston effort succeeded only because multiple sectors of the community came together, took ownership of the problem, and dealt with it.

At this point, it is sometimes easier to pinpoint what does not work: scare tactics, boot camps, zero-tolerance programs that segregate aggressive or antisocial students, brief instructional programs unsupported by a positive school climate, programs that focus exclusively on self-esteem enhancement or that provide only information without skills, and gun buy-back programs that bring out law-abiding citizens with rusty rifles.[43] This does not mean that we cannot move forward, only that we must do so cautiously, using all appropriate tools from the medical and social sciences, and with a spirit of skeptical optimism. In so doing, the Commission urges researchers, health care, education, social service, and criminal justice professionals to utilize the following criteria for evaluating the effectiveness of violence prevention programs.

Ideally, an effective violence prevention program should[15,43,44]:

- be evaluated using an experimental or quasi-experimental design with random assignment or a matched control group;
- be based on assessment of objective, community-specific data;
- be evidence-based;
- be implemented consistently over time;
- meet measurable goals and objectives;
- be reevaluated periodically;
- provide evidence of a statistically significant deterrent effect on delinquency, drug use, and/or violence, lasting at least one year following treatment;

- be replicated in at least one additional site with demonstrated effects;
- use a collaborative-participatory model that addresses links among community systems and constituencies; and
- use materials and methodologies that are culturally sensitive and developmentally appropriate.

Single-focus interventions are unlikely to be effective because antisocial behavior emerges from a complex array of risk factors. Programs aimed directly at violent activity, per se—programs to reduce aggression, fighting, and weapon carrying, for example—may make a positive if moderate difference, but they are only part of the solution. Without reinforcement, their impact may be limited to the proximate period of intervention. Sustainability is also key. Research has shown that programs that are too brief and not supported by sufficient resources are generally ineffective, as are many programs that provide only information without a skills training component (Rodney Hammond, PhD, Commission testimony, January 2000).

Program models

The Commission joins the US Justice Department and the Centers for Disease Control and Prevention in endorsing 10 youth violence prevention and intervention programs. These programs, collectively known as "Blueprints," meet many of the criteria cited above and have been thoroughly evaluated by the University of Colorado's Center for the Study and Prevention of Violence.[44] They include:

Prenatal and Infancy Nurse Home Visitation. A program to send community and public health nurses into the homes of at-risk women pregnant with their first child to ensure the health of mother and child. The visits promote the physical, cognitive, and emotional development of the children and provide general and parenting support to the parents for two years.

The Bullying Prevention Program. A school-based initiative that attempts to restructure the primary and secondary school environment to reduce opportunities and rewards for bullying behavior.

Promoting Alternative Thinking Strategies. A multi-year, elementary school-based prevention model designed to promote emotional and social competence, including the understanding and expression of emotions.

Big Brothers Big Sisters of America. A mentoring program in which mentors meet with 6- to 18-year-old disadvantaged youth from single-parent households at least three times a month for three to five hours.

Quantum Opportunities. An educational incentives program for disadvantaged teens. By providing educational, developmental, and services activities combined with a sustained relationship with a peer group and a caring adult during the high school years, it aims to help high-risk youth graduate and move on to college.

Multisystemic Therapy. A short-term, intensive program that targets specific factors, including family, peers, school, neighborhood, and support network, which contribute to antisocial behavior.

Functional Family Therapy. A family treatment model designed to motivate youth and families to change their communication, interaction, and problem-solving patterns.

The Midwestern Prevention Project. A comprehensive, community-based program that uses five intervention strategies—involving mass media, school, parents, community organizations, and health policy—over five years to prevent junior high and middle school students from using cigarettes, alcohol, and marijuana.

Life Skills Training. A three-year primary prevention program that provides general life and social resistance skills to increase knowledge and improve attitudes about drug use among junior high and middle school students.

Multidimensional Treatment Foster Care. An alternative to residential treatment for problem adolescents, who instead are placed in strictly monitored and supervised foster families for six to nine months and who undergo weekly individual therapy while their biological parents learn behavior management techniques.

Note: A detailed history and description of these programs, including references, is available on the Web site of the Center for the Study and Prevention of Violence at http://www.colorado.edu/cspv.

Elsewhere, academic and government researchers have identified other programs that have yet to meet the scientific standard of evidence of the "Blueprints" programs but show varying degrees of promise. These fall into the following broad program categories, which the Commission believes merit further study and consideration:[24,29,43]

- truancy reduction
- national and community service opportunities
- peer mediation and conflict resolution
- long-term frequent home visitation combined with preschool education
- clarifying and communicating behavioral norms in schools
- use of organizational development strategies to foster innovation in schools
- parent or caretaker training about delinquent and at-risk preadolescents

A strategic approach

Former Surgeon General Julius Richmond has said that three things are needed to significantly impact the problem of youth violence in this country: the knowledge base, strategy, and political will (Mark Rosenberg, MD, MPH, Commission testimony, January 2000). Having reviewed the current knowledge base, the Commission has identified five strategic requirements for advancing the youth violence prevention agenda:

1. The isolated quick fix must give way to the comprehensive, long-term solution.

The failure of narrowly focused, short-term programs of violence prevention to produce lasting benefits reflects the reality that violent behavior itself is a symptom of problems that are pervasive, multiple, and chronic. The only hope of changing well-established behavior patterns in either individuals or communities lies in coordinated, sustained,

Commonalities of successful programs

When analyzing programs for effectiveness, certain elements consistently appear as important indicators of success:[43]

- participation of survivors of youth violence;
- participation of committed, impassioned staff;
- provision for staff and volunteer training;
- positive climate that does not tolerate aggression or bullying;
- adherence to high standards of behavior;
- integration of services along a continuum;
- opportunities to rehearse social and cognitive skills; and
- availability of adequate and consistent resources for implementation.

Chief among the common characteristics of successful programs, however, is close, respectful, long-term relationships between youth and concerned adults. The specific role of the adult—mentor, counselor, teacher, social worker, case manager, psychologist, community aide—is not as important as the intensity and duration of his or her attention.

multi-year programs that target multiple negative outcomes in multiple domains. Individuals and organizations that sign on to this cause must be committed to staying the course for the long term.

2. Work must proceed on multiple fronts simultaneously.

Obviously, no one program can effectively address all the different risk factors, ages and developmental stages, cultures, and systems that together influence youth and violence. Nor can one program necessarily undertake primary, secondary, and tertiary interventions. Furthermore, most communities lack the resources to launch full-scale assaults on all vulnerable points at once. But leaving any element out of the overall plan puts the rest at peril. The objective is not to be caught in an either/or trap, focusing on children who are in trouble now and ignoring early childhood development or vice versa.

3. All stakeholders must be involved in the planning, implementation, and evaluation of programs.

Educators, social service workers, police and probation officers, policy makers, mass media, judges, teachers, health and mental health care professionals, community leaders, youth workers, activists, clergy, parents, youth, survivors. . . Whoever is not at the table from Day One represents a potential stumbling block down the road. This includes representatives of all target risk groups. Teams at the unit or program level must likewise be interdisciplinary in scope and collaborative in nature. At all levels of activity, those who organize teams must be able to persuade the parties to leave their special interests and turf battles behind, share resources, and work to overcome confidentiality issues all of which too often and unnecessarily derail sound partnerships.

It is especially important that young people be involved directly in efforts to address juvenile violence and victimization. In this way, the community benefits from the energy and talent of youth and youth benefit by learning that they can make a positive contribution to their community.

4. Efforts must begin early.

Only by starting at the beginning—with classes for expectant parents, home visitation for at-risk parents with newborns, and early childhood development programs—can we arrive at a happier ending for the thousands of children otherwise destined for detention centers, street corners, hospital emergency rooms, and morgues across the country. The more effort we put into preventing trauma from warping the development of infants and young children, the less we will have to expend to protect, treat, and rehabilitate children and teenagers.

5. Collaboration must occur at all levels, including the community.

The public health model of youth violence prevention encourages a partnership of community leaders to determine their community's readiness for a comprehensive, risk-focused prevention effort and to identify or create a community entity to conduct the risk assessment. This approach allows the development of strategies tailored to the unique risk and resource profile of the individual community.

Strategies that promote the kind of informal social control and involvement that neighborhoods once enjoyed in the form of stay-at-home moms or dads and watchful senior citizens and neighbors can strengthen today's communities, as can programs such as community-oriented policing strategies that foster partnerships among law enforcement, citizens, businesses, and schools.

A success story: The Galveston Island Youth Programs

Between 1994 and 1999, violent crime in the United States dropped 19%. During that same period, it dropped 78% in Galveston, Texas. This remarkable development was the direct result of a network of five programs designed to address different risk factors at different developmental stages:

- *Youth Activities* provides supervised recreation with trained leaders for all ages focused in neighborhoods of highest need.
- *Second Step*, a violence prevention curriculum, provides critical social and problem-solving skills in elementary schools.
- *Peer Court* works with youths convicted of misdemeanor offenses, involving them and other youths in a creative approach to community restitution and education.
- The *Truancy Abatement and Burglary Suppression Program* brings together local schools and police to work with truants.
- *Second Chance* is an intensive home-based counseling service using a family preservation approach to working with frequent offenders or violent delinquents.

The network was built from the ground up by the Island Youth Advisory Board—a group representing city government, law enforcement, juvenile justice, public recreation, public schools, the University of Texas Medical Branch, and concerned families—to stop "young people falling through the cracks of different social services and systems that, in many cases, didn't even know of each other's existence." Today, collaborative training of adult leaders ensures a consistent approach across agencies and activities, which magnifies their effect. The City Department of Parks and Recreation, Galveston Independent School District, and the Boys and Girls Club developed a cooperative plan and share resources to reach youth and families in areas that have historically lacked youth programs and facilities.

As the city's first truly representative, community-wide collaborative initiative of any kind, the Galveston Island Youth Programs is living proof that diverse elements of a community, including ivory tower professionals and minority activists, can find common cause in preventing youth violence—and can work together on an ongoing basis to further that cause (Christopher Thomas, MD, Commission testimony, May 2000).

Priorities and recommendations

After reviewing the scientific literature and listening to scores of witnesses, the Commission came to one unequivocal conclusion: *Youth violence in this country can and must be prevented.*

The causes of youth violence are many. Therefore, the solutions we propose are also multiple and encompass action across seven interrelated priorities. Within each priority, we list strategic recommendations, two of which are highlighted (in boldface type) for special attention.

To implement these recommendations, the Mobilizing change section contains action steps targeted to each community segment. These were culled from examples and experiences shared with the Commission and are intended to inspire and guide the implementation efforts of individuals and groups.

We recognize that these recommendations are ambitious. However, we believe that with a long-term commitment from all segments of the community—health and mental health care professionals, families, schools, business and civic leaders, faith-based organizations, law enforcement and the justice community, legislators, and the media—each of these recommendations can be put into action to improve the safety and well-being of all children and youth. Working together, we will make a difference.

Priority 1: Support the development of healthy families

Violence prevention begins in the home. Children and youth who are victims of abuse, who witness domestic violence, or who are subject to harsh and inconsistent parenting are at greater risk than other children of committing violence. To provide for healthy child development, the community must support parents and other adult caretakers of children. Basic support for families includes affordable housing, access to health care, employment, quality day care, quality education, and safe neighborhoods. Specific focus must be directed at teenage parents who are at very high risk of limited parenting skills.

Strategic recommendations:

1.1 Advocate for policy initiatives to meet basic family support needs including housing, food and nutrition, prenatal and child care, and for universal access to health and mental health care and quality education.

1.2 Coordinate hospital, medical, nursing, public health, managed care, and social services groups to provide home visitation for infants in families at risk for problems (eg, teenage parents, parents with a history of alcohol and other drug dependency, parents with a history of violence).

1.3 Expand parent education, parental support, and parent-child interaction programs in schools and communities.

1.4 Implement early childhood intervention programs that demonstrate effectiveness for improving child resiliency.

1.5 Educate parents and caregivers on problems associated with coercive discipline and corporal punishment in the home and help parents and caretakers incorporate alternative methods for disciplining their children.

1.6 Expand national, state, and local efforts to prevent teenage pregnancies and enhance support for teenage parents.

1.7 Expand and support programs to prevent violence within families and between intimate partners because of the strong link between family violence and youth violence.

Priority 2: Promote healthy communities

Healthy communities support healthy families, which in turn support healthy child development. Despite complexity, variety, and inequity, our nation's communities exert powerful influences—for good or ill—on the ability of families to raise healthy children. The following recommendations can help ensure these influences are positive.

Strategic recommendations:

2.1 Convene multidisciplinary community-based coalitions of concerned health, mental health, legal, law enforcement, and juvenile justice professionals, elected officials, school personnel, media, clergy, youth, victims, and others to address issues of public education, legislation, and interventions necessary to reduce violence in schools and surrounding communities.

2.2 Establish mentoring and peer support programs within communities to foster youth interaction and connectedness, and to provide positive relationships with persons who can offer advice, support, and healthy role modeling.

2.3 Provide increased opportunities for children and youth at risk for violence and delinquency to participate in recreational activities, after school programs, job training programs, and employment opportunities. This is especially critical for communities affected disproportionately by violence.

2.4 Enforce restrictions that eliminate youth access to alcohol and other drugs.

2.5 Increase federal support to (a) develop, implement, and evaluate appropriate violence prevention and aggression reduction programs; and (b) disseminate research findings on effective interventions and violence prevention programs to health and mental health care professionals and others in the community who work with children, youth, and families.

2.6 Increase community awareness of the hazards of firearms, alcohol, and other drugs and the consequences of family and media violence.

2.7 Increase funding for comprehensive and coordinated school health and mental health services. A comprehensive prevention curriculum should exist in every school (K-12). Programs must be age, developmentally, and culturally appropriate with clearly defined procedures for outcome assessment and ongoing evaluation.

2.8 Increase the capacity of schools to provide safe and effective educational programs by which children can learn to reduce and prevent violence. This includes: (a) providing programs to teach, as early in childhood as possible, nonviolent conflict resolution, sensitivity to cultural diversity, interpersonal problem-solving, and tolerance; (b) implementing violence reduction curricula as part of the education and inservice

training of teachers, administrators, and school staff; (c) providing age-appropriate educational materials about family, dating, and community violence to all elementary, middle, and high school students; (d) taking proactive steps to eliminate bullying; and (e) encouraging parental involvement.

2.9 Expand gang prevention and intervention efforts within communities.

2.10 Ban the use of corporal punishment in schools, juvenile facilities, child care facilities, and all other public or private institutions where children are cared for or educated.

Priority 3: Enhance services for early identification and intervention for children, youth, and families at risk for or involved in violence

Coordinated, comprehensive community-wide programs and services must be available to identify and intervene as soon as possible with children, youth, and families at risk for or involved in violence. At-risk children, youth, and families may be identified in a variety of circumstances and settings (eg, correctional institutions, schools, youth-serving agencies, faith-based organizations, and health care facilities). Community support services should be available to assist these persons with appropriate treatment, referral, and follow-up care.

When considering persons at risk for violence, the Commission cautions that routine "profiling" is unacceptable and dangerous and contributes to rather than reduces risk. Labeling children can have detrimental effects on academic performance and social and emotional well being. To date, there is no scientific rationale to support the use of profiling children and adolescents at risk for violence because there are too many false positives.

However, there are known factors that increase risk when one looks at an entire population. For example, early exposure to violence within families is a well-documented factor that elevates the risk of involvement with violence later in life.

Strategic recommendations:

3.1 Expand screening and increase support services within health care facilities, schools, child protection agencies, and the juvenile court system to ensure that children and youth who are at risk of psychiatric illness, abuse, neglect, alcohol and other drug abuse, violence, and other potentially dangerous behaviors are identified and have access to appropriate monitoring and treatment services.

3.2 Increase funding for long-term prevention, education, screening, and treatment programs in the community for children and youth at risk for psychiatric illness, abuse, neglect, alcohol and other drug abuse, violence, and other potentially dangerous behaviors.

3.3 Ensure that every youth who enters the juvenile justice system (including detention) is screened for a current or prior history of psychiatric illness, child abuse, neglect, or alcohol and other drug abuse, and if appropriate, provide intervention and treatment services. These services also should be offered to the children and families of violent adult offenders.

3.4 Implement alternative programs in schools as an adjunct to "zero-tolerance" policies to provide a safety net of school-based educational opportunities for youth who have been expelled, violate probation, or demonstrate delinquent behavior.

3.5 Allow juvenile court judges flexibility and discretion in sentencing children and adolescents. Eliminate the detention and incarceration of youth in adult jails and correctional facilities.

Priority 4: Increase access to health and mental health care services

Health and mental health care services can play an important role in violence prevention on all levels (primary, secondary, and tertiary), including preventing problem behaviors from developing; identifying and serving specific, at-risk populations; and reducing the deleterious effects of violence on victims and witnesses. To accomplish these objectives, health and mental health care professionals must work closely with the juvenile justice and school systems, community groups, and others to ensure that a full spectrum of quality care is provided to all young people and their families.

Strategic recommendations:

4.1 Ensure health coverage for all children and adolescents in the United States. Coverage should include preventive care and access to comprehensive health and mental health care services.

4.2 Establish parity for coverage of mental health care services and reduce financial and other barriers to these services.

4.3 Promote public and private initiatives and solutions (such as the State Children's Health Insurance Program, SCHIP) to ensure expanded coverage for health care services for all uninsured and underinsured children and adolescents.

4.4 Integrate police, health, mental health, and school responses to violence so that children exposed to violence receive the full range of coordinated medical, mental health, substance abuse, and crisis intervention services.

4.5 Implement programs in hospital emergency and trauma departments for appropriate assessment, evaluation, intervention, and follow-up of people with injuries; particularly those with intentional injuries.

Priority 5: Reduce access to and risk from firearms for children and youth

A public health approach must be taken to reduce the risk of injury and death caused by firearms. This approach recognizes the importance of eliminating easy and unsupervised access to firearms by children and youth, improving firearm safety, and creating a community environment that supports nonviolent solutions to conflict.

Strategic recommendations:

5.1 Develop and provide educational messages to all segments of society that (a) firearm owners should remove handguns from environments in which children and youth live and play; and (b) all firearms should be properly and safely stored (eg, firearms should be unloaded and locked; ammunition should be stored and locked up separately from firearms).

5.2 Increase legal, regulatory, and enforcement efforts to reduce widespread, easy, and unsupervised access to firearms by children and youth.

5.3 Support public education on the proper use and potential danger of firearms.

5.4 Counsel parents and other caretakers of children to remove all firearms from homes with a child who shows signs or symptoms of depression or who expresses suicidal thoughts or behavior.

5.5 Advocate for legislative action to establish a coordinated and comprehensive national, state, and local data collection and surveillance system for tracking firearm-related injuries and deaths to support public policy-making and facilitate public health research and prevention efforts.

5.6 Advocate for legislative and industry action to equip all firearms with safety devices that render them inoperable by children.

5.7 Advocate for legislative action in all states to establish 18 as the minimum age for the purchase of all firearms and ammunition.

5.8 Mandate and enforce strong penalties and criminal prosecution for crimes committed with the use of a firearm, including illegal sale and possession of a firearm.

5.9 Maintain a national waiting period of 3 to 5 days that allows for a "cooling off period" and completion of a criminal background check for the purchase of all firearms from licensed firearm dealers and expand this to include purchases via the Internet and at gun shows.

5.10 Advocate for legislative action to ban the manufacture, importation, and sale of any firearm that cannot be detected by metal detectors and standard security screening devices.

5.11 Advocate for legislative action to ban the sale and private ownership of (a) large clip, high-rate-of-fire automatic and semi-automatic firearms or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon; and (b) inexpensive handguns commonly referred to as "Saturday Night Specials."

Priority 6: Reduce exposure to media violence

Children and youth are greatly influenced by what they hear and see in movies, television, the Internet, video games, and music. Extensive evidence documents the strong, pervasive, and deleterious effects of media violence on children. The media industry must be responsive to these scientific data.

Strategic recommendations:

6.1 Urge parents and guardians to monitor and control the use by children of television, music, video games, and the Internet.

6.2 Urge the media industry to (a) reduce the amount of violence in TV programming, movies, music, video games, and the Internet; (b) depict successful nonviolent solutions for anger and conflict; and (c) depict accurately the pain, remorse, and other consequences of violence and violent behavior on individuals, families, and society.

6.3 Mobilize consumers to demand accountability of the media industry for significant reduction of media violence.

6.4 Conduct a national violence prevention campaign about the impact of media violence on children.

Priority 7: Ensure national support and advocacy for solutions to violence through research, public policy, legislation, and funding

Although communities hold the key to eliminating youth violence, national leadership is necessary to ensure that new scientific approaches are identified and disseminated, adequate funding is provided to states and communities, and unnecessary barriers to providing coordinated and comprehensive programs and services among state and local organizations and agencies are removed.

Strategic recommendations:

7.1 Establish a national task force of organizations representing medicine, nursing, public health, mental health, education, juvenile justice, law enforcement, youth and family services, and other advocates to mobilize societal action to prevent violence. This group should provide leadership on policy, legislation, training, and research in violence prevention.

7.2 Advocate for the integration of violence prevention, screening, and treatment into existing program objectives of national and state agencies and private organizations that address juvenile justice, alcohol and drug abuse, elementary and secondary education, and research.

Mobilizing change

Putting recommendations into action

Ultimately it is up to us—the adults—to stop children from hurting each other. More to the point, it is up to us to stop children from being hurt in the first place. According to the Attorneys General of the United States, "we as a society need to get at the root causes [of violence]: We need to pay far more attention to how we raise and nurture our children, how we listen to them and what we hear, how we teach them to deal with problems, how we act as role models for them, and how we make them feel part of a community of people who care for and support one another."[16]

In other words, we must treat children as the precious assets they are. We must provide them with clear and consistent values that condemn violence at home and in the community. We must use everything in our power to overcome those factors that place them at risk—from inadequate prenatal care to bigotry to a culture that glorifies guns, violence, and alcohol—and capitalize on those factors that strengthen their resilience, including cognitive skills and close parental bonds.

Mustering the will to move against violence—as we have moved against smoking, drunk driving, and failure to use seat belts—is largely a matter of developing a critical mass of concerned citizens, community leaders, and the popular media and giving them clear and accurate information about the causes and effects of violence and what they can do, collectively and individually, to make a difference. Social change also requires political action to ensure consistent implementation and enforcement of new and existing laws and regulations and to provide adequate resources (dollars, time, labor) to sustain programs and services over time.

Common sense tells us that, as a society, we must turn away from fatalism and racism; enlarge our perspective from "me and mine" to encompass all children; strengthen the parent-infant bond; take time to really listen to children; and make sure that all children receive good, consistent health and mental health care. Empirical evidence suggests that all elements of the community have a role to play in turning the problem around: health and mental health care professionals, families, educators, community leaders, law enforcement, the judiciary, legislators, faith-based organizations, and the media.

To the question asked everywhere with increasing urgency—*What can I do?*—the Commission cites some of the ways it has learned that people across the country are already helping to "connect the dots" on a local level.

Note: These lists are not intended to be exhaustive, merely examples of the work that, in many cases, is already being done. Not all will be appropriate for all communities and circumstances.

What health professionals can do:

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

What schools can do:

- Create a school-wide ethos that fosters positive discipline, academic success, and mental and emotional wellness.
- Intervene early with the 10% to 15% of students at risk for severe academic or behavioral problems.
- Directly provide or arrange for immediate and intensive intervention for problem students in the form of coordinated, comprehensive, sustained, and family-focused services.
- Eliminate bullying and promote tolerance.
- Improve awareness and communication, so that children are knowledgeable about the signs of mental illness and violence and the importance of telling a responsible adult when they see troubling behavior in classmates.
- Appoint multidisciplinary teams to design and implement comprehensive violence prevention and response plans.
- Be active participants in community discussions and decisions on violence prevention.
- Enlist law enforcement professionals in the development of a school safety plan that addresses weapons and drug search policies; visitor protocols; use of screened and trained parents as volunteer monitors; positive incentives for good school citizenship; suspension and expulsion policies; and codes of student conduct.
- Involve parents in all school activities.
- Encourage participation in on-site after-school programs by offering such programs free or providing scholarships and transportation and by partnering with external program sponsors.

- Implement a school health program that features comprehensive health education; provide counseling and social services; ensure a safe physical and psychosocial environment; and promote family and community involvement.
- Advocate for smaller size schools that counter competitive pressures and social isolation.
- Promote on-site screening and intervention, including mental health care services for trauma, loss, use of alcohol and other drugs, and abuse.
- Integrate violence prevention into all curricula levels; teach conflict resolution.
- Make parenting classes mandatory in high school.
- Ensure that all students, including those who violate disciplinary codes, are in either regular or alternative classrooms rather than on the street.
- Expand access to alcohol and drug dependency treatment programs.
- Encourage community service.

What business and civic leaders can do:

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

What law enforcement and the justice community can do:

- Actively enforce laws that reduce youth access and exposure to firearms, alcohol, and illicit drugs.
- Work with schools and parents to promote the removal of firearms from environments in which children live and play.
- Help school personnel perform security surveys of their facilities.
- Consult with schools about security on an ongoing basis.
- Train the entire school community in personal safety.
- Develop partnerships with area schools.
- Work with schools and parents to lower truancy rates.

- Serve on school disciplinary action assessment teams.
- Provide comprehensive information about the consequences of violence.
- Provide comprehensive screening for youth entering the juvenile justice system in order to facilitate early intervention for problems.
- Provide intake officers with tools to distinguish between serious/less serious and occasional/frequent juvenile offenders.
- Promote the use of unified family courts that handle the full range of family-related cases, including family violence, mental health, delinquency, and dependency.
- Institute Court Appointed Special Advocate Programs (CASAs), which use trained volunteers (guardians ad litem) to stabilize the lives of victimized children.
- Enhance local efforts to investigate and prosecute child abuse and neglect cases and strengthen child protective services.
- Include alcohol and mental health assessment and mandatory treatment in all criminal justice responses to children and youth.

What the media can do:

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

What families can do:

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

What faith-based organizations can do:

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

What legislators can do:

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

What youth can do:

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

References

1. Elliott D, Hamburg B, Williams K. Violence in American schools: an overview. In: Elliott D, Hamburg B, Williams K, eds. *Violence in American Schools*. Cambridge: Cambridge University Press;1998:3-28.
2. Snyder H, Sickmund M. *Juvenile Offenders and Victims: 1999 National Report*. Washington, DC: US Department of Justice;1999.
3. Brooks K, Schiraldi V, Ziedenberg J. *School House Hype: Two Years Later: Executive Summary*. Washington, DC: Justice Policy Institute/Children's Law Center; April 2000.
4. Batsche G, Moore B. Bullying fact sheet. In: *Behavioral Interventions: Creating a Safe Environment in Our Schools*. Bethesda, Maryland: National Mental Health and Education Center for Children and Families; National Association of School Psychologists;1998:14-16.
5. Myers W, Scott K, Burgess A, Burgess A. Psychopathology, biopsychosocial factors, crime characteristics, and classification of 25 homicidal youths. *Am Acad Child Adoles Psychiatry*. 1995;34:1483-1489.
6. Task Force on Violence, American Academy of Pediatrics. The role of the pediatrician in youth violence prevention in clinical practice and at the community level, policy statement. *Pediatrics*. 1999;103:173-181.
7. Mann Rinehart P, Borowsky I, Stolz A, Latts E, Cart C, Brindis C. *Youth Violence: Lessons from the Experts*. Washington, DC: Maternal and Child Health Bureau; Health Resources and Services Administration; Public Health Service; US Department of Health & Human Services;1998.
8. Cohen L, Potter L. Injuries and violence: risk factors and opportunities for prevention during adolescence. *Adoles Med*. 1999;10:125-135.
9. Rennison CM. *Criminal Victimization 1999: Changes 1998-99 with Trends 1993-99*. NCJ 182734. Washington, DC: US Department of Justice; August 2000.
10. Kachur SP, Stennies GM, Powell KE, Modzeleski W, Stephens R, Murphy R, et al. School-associated violent deaths in the United States, 1992 to 1994. *JAMA*. 1996:275:1729-33.
11. US Department of Education. *Principal/School Disciplinarian Survey on School Violence*. Fast Response Survey System 63. Washington, DC: National Center for Education Statistics;1997.
12. Ayne C, Pynoos R, Cardenas J. Wounded adolescence: school-based psychotherapy for adolescents who sustained or witnessed violent injury. In: Shafii M, Shafii S, eds. *School Violence: Contributing Factors, Management and Prevention*. Washington, DC: American Psychiatric Press. In press.
13. Hamburg A. Youth violence is a pubic health concern. In: Elliott D, Hamburg B, Williams K, eds. *Violence in American Schools*. Cambridge: Cambridge University Press;1998:31-54.
14. Bell C, Gamm S, Vallas P, Jackson P. Strategies for the prevention of youth violence in Chicago public schools. In: Shafii M, Shafii S, eds. *School Violence: Contributing Factors, Management and Prevention*. Washington, DC: American Psychiatric Press. In press.
15. Center for Mental Health Services. *A Preview of the New CMHS School Violence Prevention Program*. Washington, DC: Substance Abuse and Mental Health Services Administration, US Department of Health & Human Services. Working paper, updated April 30, 1999.
16. Horn D. *Bruised Inside: What Our Children Say About Youth Violence, What Causes It, and What We Need To Do About It*. Washington, DC: National Association of Attorneys General; April 2000.
17. Sherman L. Gun carrying and homicide prevention. *JAMA*. 2000;238:1193-1195.
18. The health care community. In: Beatty D, et al. *New Directions From the Field: Victims' Rights and Services for the 21st Century*. Washington, DC: Office of Justice Programs; Office for Victims of Crime; US Department of Justice;1998:199-218.
19. American College of Physicians. Firearm injury prevention. *Ann Intern Med*. 1998;128:236-241.
20. Group for the Advancement of Psychiatry, Committee on Preventive Psychiatry. Violent behavior in children and youth: preventive intervention from a psychiatric perspective. *J Am Acad Child Adoles Psychiatry*. 1999;38:235-241.
21. Commission on Behavioral and Social Sciences and Education, National Research Council, Institute of Medicine. Family violence and family violence interventions. In: Chalk R, King A, eds. *Violence in Families: Assessing Prevention and Treatment Programs*. Washington, DC: National Academy Press;1998:31-58.

22. Hawkins J, Herrenkohl T, Farrington D, Brewe D, Catalano R, Harachi T. A review of predictors of youth violence. In: Loeber R, Farrington D, eds. *Serious and Violent Juvenile Offenders: Risk Factors and Successful Interventions*. Thousand Oaks, CA: Sage Publications;1998:106-146.

23. Dahlberg L. Youth violence in the United States: major trends, risk factors, and prevention approaches. *Am J Prevent Med*. 1998;14:259-272.

24. Wasserman G, Miller L. The prevention of serious and violent juvenile offending. In: Loeber R, Farrington D, eds. *Serious and Violent Juvenile Offenders: Risk Factors and Successful Interventions*. Thousand Oaks, CA: Sage Publications;1998:197-247.

25. Pynoos R. *The Legacy of Violence and the Restoration of Our School Communities*. Plenary Address, National Education Association Annual Meeting, July 1999.

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

27. Kawachi I, Kennedy B. Socioeconomic determinants of health: health and social cohesion: why care about income inequality? *BMJ*. 1997;314:1037.

28. Greenberg M, Domitrovich C, Bumbarger B. *Preventing Mental Disorders in School-Age Children: A Review of the Effectiveness of Prevention Programs*. Prevention Research Center for the Promotion of Human Development, Pennsylvania State University. Submitted to Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health & Human Services; July 1999. Available at: http://www.psu.edu/dept/prevention/cmhs.html. Accessed: 1/23/00.

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

30. Greenfeld L, Henneberg M. Alcohol, crime and the criminal justice system. In: *Alcohol and Crime: Research and Practice for Prevention*. Washington, DC: Center for Substance Abuse Prevention; Substance Abuse and Mental Health Service Administration; US Department of Health & Human Services; and the National Crime Prevention Council; June 2000.

31. Drug Policy Information Clearinghouse. *Drug-Related Crime*. NCJ 181056. Washington, DC: Office of National Drug Control Policy; March 2000. Available at http://www.whitehousedrugpolicy.gov. Accessed: October 2000.

32. American Medical Association Alliance, Inc. *SAVE (Stop America's Violence Everywhere) Schools from Violence*. Chicago: AMA Alliance, Inc; Summer 1999.

33. Gross R, Ratner R, Shrier D. *Youth and School Violence: Panel Presentation*. Proceedings AMA National Coalition on Adolescent Health Meeting. Chicago: American Medical Association; June 11, 1999.

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

35. Federal Trade Commission. *Marketing Violent Entertainment to Children: A Review of Self-regulation and Industry Practices in the Motion Picture, Music Recording, and Electronic Game Industries*. Washington, DC: Federal Trade Commission; September 2000. Available at: http://www.ftc.gov/opa/2000/09/youthviol.htm.

36. American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Psychological Association, American Medical Association. *Joint Statement on Impact of Entertainment Violence on Children*. Washington, DC: Congressional Public Health Summit; July 26, 2000.

37. American Medical Association. *Physician Guide to Media Violence*. Chicago: American Medical Association;1996.

38. Council on Scientific Affairs, American Medical Association. Violence against women: relevance for medical practitioners. *JAMA*. 1992;276:184-189.

39. Dwyer K, Osher D. *Safeguarding Our Children: An Action Guide (Implementing Early Warning, Timely Response)*. Washington, DC: US Departments of Justice and Education, American Institutes for Research; April 2000.

40. Murphy L, Pynoos R, James C. The trauma/grief-focused group psychotherapy module of an elementary school-based violence prevention/intervention program. In: Osofsky J, ed. *Children in a Violent Society*. New York: Guilford Press;1997:223-255.

41. Search Institute. *40 Developmental Assets*. Available at: http://www.search-institute.org/assets/forty.htm. Accessed: 5/23/2000.

42. Prothrow-Stith D, Spivak H. America's tragedy. *Psychiatric Times*. 1999;16:1-7.

43. Sherman L, Gottfredson D, MacKenzie D, Eck J, Reuter P, Bushway S. Preventing crime: what works, what doesn't, what's promising: report to Congress. *Research in Brief*. Washington, DC: National Institute of Justice; US Department of Justice; July 1998. Available at: http://www.ncjrs.org/works/index.htm.

44. Muller J, Mihalic S. *Blueprints: A Violence Prevention Initiative*. Fact Sheet. #110. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice; June 1999.

Additional information sources

The following list of Internet sites is extensive but is not intended to be exhaustive. It provides some useful starting points for those who wish to learn more about violence prevention and intervention in families, schools, and communities.

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

American Academy of Family Physicians
http://www.aafp.org

American Academy of Pediatrics
http://www.aap.org

American Bar Association-Juvenile Justice Center
http://www.abanet.org/crimjust/juvjus/home.html

American College of Emergency Physicians
http://www.acep.org

American College of Physicians/American Society of Internal Medicine
http://www.acponline.org

American Medical Association
http://www.ama-assn.org

American Medical Association Alliance
http://www.ama-assn.org/ama/pub/category/2109.html

American Nurses Association
http://www.ana.org

American Psychiatric Association
http://www.psych.org

American Psychological Association
http://www.apa.org

American Public Health Association
http://www.apha.org

Centers for Disease Control and Prevention, Division of Violence Prevention
http://www.cdc.gov/ncipc

Center for Mental Health Services: Safe Schools/Healthy Students Initiative
http://www.mentalhealth.org

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

Department of Education, Safe and Drug Free Schools Program
http://www.ed.gov/offices/OESE/SDFS/index.html

Department of Justice, Bureau of Justice Assistance
http://www.ojp.usdoj.gov/BJA

Department of Justice, Information Center
http://www.ncjrs.org

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

Educational Resources Information Clearinghouse (National Library of Education)
http://www.accesseric.org

Family Violence Prevention Fund (Health Resource Center)
http://www.fvpf.org

Join Together
http://www.jointogether.org

National Assembly on School-based Health Care
http://www.nasbhc.org

National Association of Attorneys General
http://www.naag.org

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

National Crime Prevention Council
http://www.ncpc.org

National Education Association
http://www.nea.org

National Institute of Mental Health
http://www.nimh.nih.gov

National School Safety Center
http://www.nssc1.org

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

Partners Against Violence Network
http://www.pavnet.org

Peace it Together: Strategies for Violence Prevention
http://www.mcet.edu/peace/

Physicians for Social Responsibility
http://www.psr.org

Prevent Child Abuse America
http://www.preventchildabuse.org

Resources for Youth
http://www.preventviolence.org

Suicide Prevention Advocacy Network
http://www.spanusa.org

The Help Network (Handgun Epidemic Lowering Plan)
http://www.helpnetwork.org

Acknowledgements

A. The Commissioners and project staff appreciate the time and special efforts of the following people who contributed to this project.

Mohammad Akhter, MD, MPH, Executive Director, American Public Health Association, Washington, DC

Mary Crosby, Deputy Executive Director, American Academy of Child and Adolescent Psychiatry, Washington, DC

Jane Edgerton, Project Manager, Office of Children, American Psychiatric Association, Washington, DC

Brian Flynn, EdD, Director, Program Development, Special Populations and Projects Division, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Washington, DC

E. Ripley Forbes, Senior Advisor to the Assistant Secretary for Health, US Department of Health and Human Services, Washington, DC

Beverly Malone, RN, PhD, Deputy Assistant Secretary for Health, US Department of Health and Human Services, Washington, DC

Jennifer McQuiston, American Nurses Association, Washington, DC

Christine McShane, American Medical Association Alliance, Chicago, IL

Heather Newland, Manager, Division of Child and Adolescent Health, American Academy of Pediatrics, Elk Grove Village, IL

Judith Stavisky, Senior Program Officer, The Robert Wood Johnson Foundation, Princeton, NJ

B. The Commissioners and project staff greatly appreciate the following people who provided expert and inspirational testimony for this report.

Commission Meeting I
(January 8-9, 2000; Chicago, Illinois)

Susan Avila, RN, Department of Trauma, Cook County Hospital, Chicago, IL

Lisa Barrios, DrPH, Division of Adolescent and School Health, Centers for Disease Control and Prevention, Atlanta, GA

Betty Chemers, Office of Juvenile Justice and Delinquency Prevention, US Department of Justice, Washington, DC

Rodney Hammond, PhD, Director, Division of Violence Prevention, Centers for Disease Control and Prevention, Atlanta, GA

Linda Murray, MD, Medical Director, Ambulatory Services, Cook County Hospital, Chicago, IL

Deborah Prothrow-Stith, MD, MPH, Associate Dean for Faculty Development, Director, Division of Public Health Practice, Harvard School of Public Health, Boston, MA

Mark Rosenberg, MD, MPH, Executive Director, Task Force for Child Survival and Development, Atlanta, GA

Dennis Vickers, MD, Director, Ambulatory Pediatrics, Cook County Hospital, Chicago, IL

Commission Meeting II
(March 8-9, 2000; Chicago, Illinois)

Speakers:

Carl Bell, MD, President and CEO, Community Mental Health Council, Clinical Professor of Psychiatry and Public Health, University of Illinois at Chicago, Chicago, IL

Robert Hahn, PhD, Senior Scientist, Guide to Community Preventive Services Activity, Division of Prevention Research and Analytic Methods, Centers for Disease Control and Prevention, Atlanta, GA

Norman L. Kerr, Coordinator of Community Development, The Chicago Project for Violence Prevention, Chicago, IL

Panelists:

Alicia Amador, Youth Supervisor, Mujeres Latinas en Accion, Chicago, IL

Clementine Barfield, Founder and President, Save Our Sons and Daughters, Detroit, MI

Roberta Bartik, Commander of Youth Groups, Chicago Police Department, Chicago, IL

Debbie Bretag, MSW, Executive Director, Illinois Center for Violence Prevention, Chicago, IL

Beverly Brown, MEd, Assistant Director, Youth and Community Development, YMCA of the USA, Chicago, IL

Evelyn Chang, MSW, Youth Coordinator, Chinese Mutual Aid Association, Chicago, IL

Steve Drizin, JD, Supervising Attorney, Children and Family Justice Center, Northwestern University School of Law, Chicago, IL

Susan Gamm, JD, Chief, Specialized Services Office, Chicago Public Schools, Chicago, IL

Carole Grant Hall, MS, Fight Crime: Invest in Kids, Chicago, IL

Nathaniel Howard, President, MAD DADS Chicago Chapter, Chicago, IL

Kimberly Joseph, MD, Trauma surgeon, Cook County Hospital, Chicago, IL

Leslie Landis, JD, Program Manager, Mayor's Office of Domestic Violence, Chicago, IL

Sheila Lyne, RSM, Commissioner, Chicago Department of Public Health, Chicago, IL

Susan McGee, Assistant Director, Big Brothers Big Sisters of Chicago, Chicago, IL

Clyde Murphy, JD, Executive Director, Chicago Lawyers' Committee for Civil Rights Under Law, Inc., Chicago, IL

Rosario Pesce, PhD, Student Assistance Program Coordinator, Morton East High School, Cicero, IL

Father Michael Pfleger, Pastor, St. Sabina Parish, Chicago, IL

Kenyatta Pratt and Victoria Rivera, Students Against Violence Everywhere (S.A.V.E.) Proviso West High School, Hillside, IL (students were accompanied by Mr. Bill McCarthy, S.A.V.E. club advisor).

Madeline Rich, Executive Director, YWCA of Metro Chicago, Chicago, IL

Barbara Shaw, Executive Director, Illinois Violence Prevention Authority, Chicago, IL

Anne Thompson, Program Commissioner, National PTA, Chicago, IL

Tom VandenBerk, MBA, Founder and President of the Board, HELP for Survivors, Chicago, IL

Charlene Vega, EdD, Pupil Support Services Officer, Chicago Public School System, Chicago, IL

Martha Witwer, MPH, MSW, Executive Director, Handgun Epidemic Lowering Plan, Children's Memorial Hospital, Chicago, IL

Ephraim Wolfe, student, Ida Crown Jewish Academy, Chicago, IL

Pat Zamora, Youth Struggling for Survival/Alternatives, Inc., Chicago, IL

Leslie Zun, MD, MBA, Chairman, Emergency Medicine, Mt. Sinai Medical Center, Chicago, IL

Commission Meeting III
(May 9-10, 2000; Houston, Texas)

Speakers:

Connie Deshpande, MPA, Special Advisor to the Assistant Secretary, Safe and Drug Free Schools Program, US Department of Education, Washington, DC

Stephen Hargarten, MD, MPH, Director, Firearm Injury Center, Chairman, Department of Emergency Medicine, Medical College of Wisconsin, Milwaukee, WI

Robert Pynoos, MD, Professor, Department of Psychiatry, Director, Trauma Psychiatric Services, University of California at Los Angeles, Los Angeles, CA

Murray Straus, PhD, Professor, Department of Sociology, Co-Director, Family Research Laboratory, University of New Hampshire, Durham, NH

James Wright, PhD, Favrot Professor of Human Relations, Department of Sociology, Tulane University, New Orleans, LA

Panelists:

George Buenik, Captain, Juvenile Division, Houston Police Department, Houston, TX

Thomas Chapmond, Director, Division of Prevention and Early Intervention, Texas Department of Regulatory and Protective Services, Austin, TX

Ann Clark, MEd, Supervisor, Safe and Drug Free Schools, Houston Independent School District, Houston, TX

Barbara Crews, Executive Director, Galveston Partnership, Galveston, TX

Rev. Timothy Dixon, Director, Good Gang USA, Youth Pastor, Community of Faith Church and Program, Houston, TX

Johnny Enriquez, President, Galveston Boys & Girls Clubs, Galveston, TX

Tracy Levins, PhD, Director of Prevention, Texas Youth Commission, Austin, TX

Curtis Mooney, PhD, President & CEO, DePelchin Children's Center, Houston, TX

Richard Nedelkoff, MS, JD, Executive Director, Criminal Justice Division, Office of the Governor, Austin, TX

Kim Ogg, JD, Executive Director, Crimestoppers, Houston, TX

Scott Poland, EdD, Director, Psychological Services, Cypress-Fairbanks Independent School District, Houston, TX

Christopher Thomas, MD, Professor, Department of Child and Adolescent Psychiatry, University of Texas Medical Branch at Galveston, Galveston, TX

Rev. Rueben Max Torres, Founder & Director, CrossRoad Youth Ministry, El Tabernaculo Assembly, Houston, TX

Youth representatives from the:

- Community of Faith Church, Houston, TX (Zedrick Aplin, Courtney Hicks, Aisha Shepard, Lemisha Stephens)
- Depelchin Children's Center, Houston, TX (Katie Ahlers, Will Kennedy, Ana Silva)
- Galveston Island Youth Program, Galveston, TX (Tamisha Anderson, Tommy Carter, DeAnna Fields, Kenneth Fleming, Dana Little, Tamiko Phillips, Nasatcia Rhodes, Asley Thibodeaux; youths were accompanied by Ms. Chatman and Ms. Paul of the Galveston Boys and Girl Club).
- Reagan High School Peer Leadership Program, Houston, TX (Patrick Conner, Viridiana Gamez, Myriam Garcia, Romula Navarro, Benita Zamora, Juan Zapata)
- Young Texans Against Gun Violence, Houston, TX (Emily Young, Brett Chisholm)

Commission Meeting IV
(August 1-2, 2000; Washington, DC)

Delbert Elliot, PhD, Scientific Editor, Surgeon General's Report on Youth Violence, Director, Center for Violence Prevention, University of Colorado, Boulder, CO

Captain Patricia Rye, Managing Editor, Surgeon General's Report on Youth Violence, Rockville, MD

Commissioner biographies

Whitney Addington, MD, MRCP, MACP, is chairman of The Urban Health Institute of Chicago and senior executive of the Metropolis 2020 Initiative of The Commercial Club of Chicago. In 2000, Dr. Addington completed his term as president of the American College of Physicians-American Society of Internal Medicine. Dr. Addington was formerly a professor of medicine, family practice and nursing at Rush-Presbyterian-St. Luke's Medical Center in Chicago and Director of the Rush Primary Care Institute, where he promoted comprehensive community-based care and new models of primary care. Dr. Addington also served as President of the Chicago Board of Health from 1989 to 1999. Due to his long devotion to issues of public health, both in the United States and internationally, Dr. Addington serves on the Poverty and Health Committee of the World Health Organization. Throughout his career in various sectors of internal medicine and public health, Dr. Addington has written and lectured extensively on lung disease, the delivery of health care, and health care reform. Dr. Addington received both his medical degree and internal medicine training from Northwestern University in Chicago, following his undergraduate education at Princeton University. He went on to serve as Lt. Commander in the US Public Health Service in Oklahoma City, during which he received an MS degree at the Oklahoma University School of Public Health. Following his military service, Dr. Addington was a National Institutes of Health Postgraduate Fellow in thoracic services at Boston University Medical School. He is an honorary Fellow of the Royal College of Physicians of London, Australia, Scotland, and Ireland and in 2000 was awarded a Mastership in the American College of Physicians-American Society of Internal Medicine.

Bruce Bagley, MD, a family physician in Albany, New York, is the current chair of the Board of Directors for the American Academy of Family Physicians (AAFP). The AAFP represents more than 89,400 family physicians, family practice residents and medical students nationwide. Dr. Bagley provides the full range of family medicine services in a single specialty group practice. Under his leadership, the eight-partner group has been a pioneer in the community in adapting to the challenges of managed care, quality improvement and informatics. He is board certified in the specialty of family practice and is affiliated with four hospitals in the Albany area. Dr. Bagley graduated cum laude, from Albany Medical College. In addition to his full-time medical practice, he is a clinical assistant professor at Albany Medical College and Upstate University Medical Center in Syracuse. He is a Fellow of the AAFP, an earned degree awarded to family physicians for distinguished service and continuing medical education. Dr. Bagley served as AAFP president in 1999-2000. He has served on numerous commissions and committees in the areas of resident and student affairs, public relations and marketing, member services, and insurance and financial services. In 1998, he chaired the AAFP's Commission on Health Care Services, which guides AAFP policy in the areas of health care financing and delivery systems, practice management and organization and managed care. Dr. Bagley also chaired the AAFP's Task Force on Hospitalist Physicians, which studied the impact of "inpatient teams" on patients and the specialty, the Task Force on Obstetrics in Family Medicine, the Task Force on Quality Enhancement and the Task Force on Quality in Family Medicine. He currently chairs the ad hoc committee on electronic medical records for the AAFP. Dr. Bagley has spoken extensively on the topics of quality improvement, family practice management, and electronic medical records.

Carol Easley Allen, RN, PhD, is president of the American Public Health Association (APHA), the largest and oldest association of public health workers in the world. A public health nurse most of her professional career, she has taught graduate and undergraduate programs in community health nursing and in higher education administration. Dr. Allen holds a BS degree in nursing from Columbia Union College (Takoma Park, Maryland), a masters degree in public health nursing, with a minor in higher education, and a PhD degree in nursing both from New York University. Dr. Allen's research interests include the use of philosophical methods in nursing research with particular emphasis on the sociology of knowledge. She has published and presented in this area and on issues related to poverty and disparities in health outcomes among the poor and ethnic minorities. Currently, Dr. Allen serves as professor and chair of the Department of Nursing at Oakwood College, a historically black college in Huntsville, Alabama. Dr. Allen has presented a number of workshops on cultural diversity and educational methodologies in nursing, and the Easley-Storfjell Instruments for Caseload/Workload Analysis in Community Health Nursing, which she co-authored.

Marilyn Benoit, MD, a child and adolescent psychiatrist, is president-elect of the American Academy of Child and Adolescent Psychiatry (AACAP). She is a clinical associate professor of psychiatry at Georgetown University Medical Center and program director of Children's Psychiatric Services at Howard University Hospital and Medical School. Dr. Benoit has served as the representative of the AACAP on the American Medical Association's National Council on Family Violence since its inception in 1993. She was appointed by the president of the AACAP to serve as the chairperson in the AACAP's initiative to establish a coalition of professional societies to address youth violence and advocate for appropriate treatment of juveniles in the juvenile justice system. She is past chair of the AACAP's Child Abuse Committee and of the Media Committee. Her career has spanned academia and the private and public domains. Dr. Benoit is a national advocate for children, appearing before congressional committees and at the White House to testify on behalf of children on a range of issues pertaining to the welfare of children (eg, child abuse, drug abuse, media violence, community violence, suicide in youth, teenage pregnancy, foster care).

She has authored and published several articles on related topics. Her commentary is frequently sought nationally by television, radio, and print media on child-related issues.

David Fassler, MD, is a child and adolescent psychiatrist. He is clinical director of Otter Creek Associates in Burlington, Vermont, a multidisciplinary practice providing comprehensive psychiatric, psychological and substance abuse treatment services for children, adolescents, and families. Dr. Fassler serves as chair of the Council on Children, Adolescents and Their Families of the American Psychiatric Association, and as president of the Vermont Association of Child and Adolescent Psychiatry. He is also a clinical associate professor in the Department of Psychiatry at the University of Vermont College of Medicine, and a member of the national Board of Directors of the Federation of Families for Children's Mental Health. Dr. Fassler is the co-author of numerous books for children and families, including "Help Me, I'm Sad: Recognizing, Treating and Preventing Childhood and Adolescent Depression" (Viking, 1999). He is a recent recipient of an Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill, and a Green Ribbon Award for Public Education and Advocacy from the National Mental Health Association.

J. Edward Hill, MD, a family physician from Tupelo, Mississippi, is a member of the American Medical Association (AMA) Board of Trustees. In addition to his active participation in the AMA, Dr. Hill has served in a variety of leadership positions in state and specialty medical organizations. Dr. Hill received both his BS and MD degrees from the University of Mississippi. He completed his internship while serving four years as a commissioned officer in the US Navy, in addition to serving as a general medical officer in a naval destroyer group. A board-certified family physician, Dr. Hill began his professional career in the rural Mississippi delta where he practiced for 27 years. His dedication to

patient care has been recognized in both his home state and at the national level, as evidenced by such awards as "Mississippi Family Doctor of the Year" and runner-up for Good Housekeeping magazine's "Family Doctor of the Year." Due to his wealth of medical practice experience and recognition as a role model for young doctors, Dr. Hill was asked to become director of the Family Practice Residency Program at North Mississippi Medical Center, which is the nation's largest rural hospital. In addition to his busy professional life, Dr. Hill is also an active participant and leader in community activities. He has served as president of the Mississippi Affiliate of the American Heart Association, chair of the Industrial Development Committee for his local Chamber of Commerce, member of the Advisory Board for his county Head Start program, president of his local school board, and a member of the Board of Directors of his church.

Nicole Lurie, MD, MSPH, serves as Principal Deputy Assistant Secretary for Health at the US Department of Health and Human Services (HHS), the second-highest ranking official within the Office of Public Health and Science (OPHS). The Office serves as the focal point for leadership and coordination across the department in public health and science; provides direction to program offices within OPHS; and provides advice and counsel on public health and science issues to the Secretary. Dr. Lurie came to the HHS from the University of Minnesota School of Medicine, where she was professor of medicine and public health, and held the posts of director of primary care research and education and director of the Division of General Internal Medicine. While at the University of Minnesota, she received numerous grants to conduct research on improving access to health care among low-income patients across a wide variety of clinical conditions, organizations and communities. Prior to her time in Minnesota, Dr. Lurie served as a consultant for the RAND Corporation in Santa Monica, California, and as an assistant professor of medicine at the University of California at Los Angeles (UCLA). Dr. Lurie received her BA and MD degrees from the University of Pennsylvania. She completed her residency at UCLA, where she also received her MSPH degree and was a Robert Wood Johnson Clinical Scholar. Dr. Lurie is the recipient of numerous honors. She has served as the president of the Society of General Internal Medicine and senior associate editor for the journal *Health Services Research* and on the editorial boards of multiple journals.

Nancy H. Nielsen, MD, PhD, an internist with a private practice in upstate New York, is vice speaker of the American Medical Association (AMA) House of Delegates. Her other AMA responsibilities have included membership on the National Patient Safety Foundation (NPSF) Board of Directors and the NPSF's National Pharmaceutical Safety Steering Committee, the Council on Scientific Affairs, and the Medical Advisory Board of the Society for the Advancement of Women's Health Research. Dr. Nielsen is a member of the Board of Directors of the Medical Liability Mutual Insurance Company, one of the largest malpractice carriers in the country. She was president of her county medical society as well as her hospital's medical staff. She is currently associate medical director for quality of a major HMO in New York State. In addition, Dr. Nielsen is a former member of the Board of the New York State Society of Internal Medicine. Dr. Nielsen holds a PhD in microbiology and received her medical degree from the State University of New York (SUNY) School of Medicine and Biomedical Sciences in Buffalo, where in addition to her practice, she is assistant dean for Academic and Curricular Affairs. A participant in the EPEC (Education for Physicians about End-of-life Care) project, she is now incorporating end-of-life care as a curricular element for her medical students. She has served as trustee of the State University of New York and as a trustee of SUNY's Research Foundation.

Susan Paddack of Ada, Oklahoma, is president of the American Medical Association Alliance. Ms. Paddack has served in various officer positions at the national level since 1992. She also has been president of the Oklahoma State Medical Association Alliance and currently serves on the Oklahoma State Medical Association's Domestic Violence Committee. Among her other volunteer activities, Ms. Paddack held leadership roles for organizations

such as the Ada City School Foundation, the Oklahoma Institute for Child Advocacy, the Oklahoma Foundation for Excellence, and her local United Way. She currently is on the board for the Jasmine Moran Children's Museum and serves on the City of Ada Board of Adjustments. She received the Friend of Education Award from her local school system. Ms. Paddack holds a BS degree in education from the University of Colorado, and completed her master of education degree in secondary education at East Central University. Having taught secondary school science for many years, she is currently employed as director of Local Education Foundation Outreach for the Oklahoma Foundation for Excellence.

Howard Spivak, MD, is chief of the Division of General Pediatrics and vice president for Business and Community Health Programs at New England Medical Center in Boston, Massachusetts. He is a professor of pediatrics and community health at Tufts University School of Medicine. He is also the executive director of the Bingham Program, a philanthropic trust funding public health initiatives in rural Maine and administered by the New England Medical Center. Dr. Spivak has served as deputy commissioner of public health for the Commonwealth of Massachusetts and, prior to that, as director of adolescent health services for the Boston Department of Health. He is currently chair of the American Academy of Pediatrics Task Force on Violence. Dr. Spivak has been involved with activities in youth violence prevention for over fifteen years. These activities have included: co-founding of the Boston Violence Prevention Program (the first community-based public health violence prevention program in the nation); development of the Office of Violence Prevention for the Commonwealth of Massachusetts (the first such state level initiative in the nation); authorship of numerous articles on violence prevention among youth; participation in numerous studies and evaluations of youth violence prevention efforts; and development of the first emergency room surveillance initiative on weapon-related injuries. He speaks regularly around the nation on youth violence prevention strategies and works on an ongoing basis with many communities in the development of violence prevention programs.

Elaine Williams, RN, serves on the Board of Directors of the American Nurses Association. She is a graduate of the Cook County School of Nursing and Kennedy-King College in Chicago. Ms. Williams is employed at Cook County Hospital in Chicago where she has worked for the past 23 years as a nurse practitioner in the Department of Surgery. She is past president of the Illinois Nurses Association (INA) and served on the INA board for 9 years. During that time, Ms. Williams held the position of first vice president, director, and president of the Cook County Hospital local unit. She was chair of the nursing committee for the commissioner of health for the Health Care Summit for Cook County and the city of Chicago. She served on the Mayor's Infant Mortality Committee and traveled to Cuba with other health care professionals in a trip sponsored by the American Public Health Association and Johns Hopkins University to study health care issues in that country.

Preventing violence *in America*

A commitment from Medicine, Nursing, and Public Health

We in the health professions pledge to make violence prevention one of our highest priorities. Working with educators, judges, lawyers, psychologists, social workers, police, community activists, clergy, and others, we must take a firm stand against the violence that is devastating families and communities throughout this country. More school suspensions and more prisons are not the answer. The answer, rooted in public health, is prevention.

Together, we must work to overcome those factors that place children, youth, and families at risk for violence and capitalize on factors that promote healthy development and resilience such as close parental bonds, safe and stable communities, and good consistent health and mental health care. As scientists and humanitarians, we will incorporate into our clinical and advocacy efforts everything possible to contribute to the violence prevention movement.

We resolve to:

Be involved in the community

We will increase our participation in community-based coalitions and programs to prevent violence and seek to enhance the physical and mental health status of children and adolescents in the community.

Put violence prevention into practice

We will implement violence screening and response protocols to identify children, youth, and adults at risk for violence, including identification of abuse-related injuries, and provide them with appropriate intervention. We will also talk with young patients and their parents about the potential hazards of firearms, alcohol and other drugs, and exposure to violence at home and in the community.

Educate ourselves about violence prevention and intervention

As part of our professional development, we will seek education and training on the diagnosis, comprehensive treatment and prevention of problems associated with alcoholism, drug abuse, domestic violence, child abuse, and elder abuse. We will learn to provide culturally competent and supportive guidance and education to family members at risk for or involved in violence. In addition, we will become informed about local resources and referral services for victims and witnesses of violence and family members at risk of harm.

Advocate for violence prevention

We will work with local, state, and federal policy-makers to increase resources dedicated to a comprehensive and coordinated public health approach to violence prevention.