Recognizing & Preventing
Youth Violence

A Guide for Physicians
& Other Health Care
Professionals

Center for Injury and Violence Prevention
Virginia Department of Health

The information contained in this guide is adapted
from *Recognizing and Preventing Youth Violence,*
a handbook of the Massachusetts Medical Society

Please note that this guidebook is a direct adaptation of the handbook, *Recognizing and Preventing Youth Violence*, produced by the Massachusetts' Medical Society Committee on Violence. While some information specific to Virginia has been added, the full credit for the comprehensive and useful information contained in the guidebook remains with the Massachusetts Medical Society. As such, "the guidelines and suggestions in this guidebook should not be construed as standards of care; treatment decisions must be made on the basis of the facts and circumstances of each individual case. The guidebook serves only as a starting point, and while care has been taken to accurately reflect current knowledge, medical standards are constantly evolving. The information contained herein does not constitute legal advice, and clinicians should seek the advice of their own counsel concerning the application of law to the facts they face."

R.Sege and V. Licenziato, editors. Recognizing and Preventing Youth Violence, A Guide For Physicians and Healthcare Professionals Massachusettes Medical Society, Waltham, MA; 2001.

In Virginia, violence is a leading cause of injury, death, and mental health concerns for our youth. The primary role of physicians and other health care professionals, has been in the treatment of injuries resulting from violence. However, according to recent research and practice, physicians and health care professionals can play a significant role in preventing violence from occurring.

The medical community has many encounters with youth. These occasions present good opportunities to provide preventive education, risk screening, and linkages to intervention and follow-up services.

This guide will focus on identifying known risk factors and predictors for violent behavior to reduce injury for all youth at risk.

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

Ylisabyth S. Bradshaw, D.O., M.S., Chair of MMS Committee on Violence and
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SOME SOBERING FACTS

- More than 400,000 youth ages 10 to 19 were injured in America as a result of violence in the year 2000. [1]
- Approximately 1 in 28 of these injuries required hospitalization. [1]
- Most young homicide victims are killed with guns. Firearms represent the third leading cause of death among Americans 10 to 14 years old and are the second leading cause of death among those 15 to 24 years old.[2]
- Teens are two and a half times more likely than adults to be victims of violence.[3]
- In a survey of high school students, more than one-third of the respondents reported being in a physical fight in the past 12 months, and 4% were injured seriously enough, in a physical fight, to require medical treatment by a doctor or nurse. [4,5]
- Of all the head injuries reported to the National Pediatric Trauma Registry between September 1988 and January 1996, 49 percent were the result of assault, while many of the remaining head injuries were due to child abuse.[6]
- Children who are witnesses and victims of violence are at significantly higher risk for developmental and mental health problems including depression, conduct and anxiety disorders, and post-traumatic stress disorder. The same children are more likely to become aggressive and violent than children not exposed to violence.[7]

two highly recommended publications

These publications are excellent resources on youth violence prevention for health care providers and will augment the information in this guide.

- *Connecting the Dots to Prevent Violence:* A Training and Outreach Guide for Physicians and Other Health Care Professionals. To obtain free copies, contact the American Medical Association at (312) 464-4520 or fax (312) 464-5842. This can also be downloaded via the Internet at www.ama-assn.org/violence
- *Best Practices of Youth Violence Prevention, A Sourcebook for Community Action* Thornton TN, Craft CA, Dahlberg LL, Lynch BS, Baer K. One free copy can be obtained by calling (888) 252-7751 or from www.cdc.gov/safeusa. This can also be downloaded via the internet at www.cdc.gov/ncipc

PRIMARY PREVENTION

Violent behavior is preventable. The factors that play a key role in the risk for violence-related injuries are individual and environmental— violent behavior is learned. Children learn about violence by observation and experience-in the home, community, and through the media. Too often, children learn that

violence is an appropriate way to resolve conflicts and assert power. Primary prevention teaches children how to solve conflicts in a nonviolent manner and how to interact with others in a cooperative way.

risk factors

Violent injury and death result from altercations between family members and acquaintances far more often than from robberies or other criminal activity.[8] The same can be said for youth involved with violence from minor conflicts to homicide; it results from arguments and conflicts between friends, acquaintances, parents, and siblings.[9] In addition, there are cultural and social factors that can influence risk-taking and subsequent involvement in violence.

Violence is a complicated group of behaviors, and there are numerous theories and studies concerning the neurobiology of violence. A complex interaction, or combination of factors, leads to an increased risk of involvement in violence. These factors include the following:[10]

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

resiliency factors

Even when confronted with the previous risk factors, not all youths get involved in violent activities. Many young people have traits, characteristics, and environmental influences that allow them to cope positively with adversity. These characteristics are protective qualities or resiliency factors. These resiliency factors allow children to recover from adverse or disabling events.

Resiliency factors include the following: [11]

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

Environmental influences on resiliency such as the connections a youth has to the larger community. This includes involvement with athletic teams, adult mentoring, church and other religious groups, and neighborhood organiza-

tions. These activities promote meaningful connections with adults and friendships with peers who have positive pro-social personal values. Both organizational and individual connections promote resiliency.

developmental approach

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

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

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

CLINICAL SIGNS OF HIGH RISK FOR INVOLVEMENT WITH VIOLENCE

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

infants & preschool children

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

CLINICAL SUGGESTIONS

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

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

- Screen for family violence and substance abuse.
- Ask about parental views regarding spoiling and discipline.
- Suggest using nonphysical discipline such as natural/logical consequences and time-out strategies. The American Academy of Pediatrics (AAP) recommends that parents be encouraged and assisted in the development of methods other than spanking for managing undesired behavior.[12]
- Encourage parents to raise their children with praise.
- Encourage parents to find time to spend with their children by reading or playing with them. This is a powerful way for children to learn positive social skills.
- Explain the importance of monitoring and providing guidance for TV viewing.
- Talk about when children knowingly misbehave with assertive and aggressive behaviors. Is the child misbehaving in order to gain parental attention? While it is important that parents and others respond to negative behavior in a consistent manner, it is also critical for parents to consistently attend to and encourage appropriate behavior.
- Ask about the presence of handguns in the home. If removal is impossible, suggest safe storage: the gun should be stored unloaded and locked, with ammunition locked in a separate location.
- Children imitate their parents. Let parents know that the most effective teaching technique may be to simply model nonviolent behavior and conflict resolution for their children.
- Appropriate referrals to early intervention programs or professionals experienced in behavior difficulties with this age group can decide a child's future.

Little i
When I am insecure I feel like the little i
usually because of someone else
when I remember this feeling
I try to help others
in hope that they will never know what
it's like to be the
little
i.

school-age youth

By the time a child enters school, peer and community influences begin to be even more important. For children in this age group, violence-related risk factors include bullying at school, exposure to domestic violence at home, and witnessing violence on television. The presence of a gun in the home increases the risk of severe violence-related injury of death.[13]

CLINICAL SUGGESTIONS
Providers can do the following:

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

sports-related violence

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

Health professionals can remind parents that the goal of sports participation for children is to have fun while learning skills. Competitive teams need to

promote sportsmanship and strictly enforce no-tolerance rules for parental interference with referees, coaches, players, or other parents.

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

media violence

Not only is television viewing associated with involvement in violence, a recent large-scale study in California demonstrated that a reduction in television viewing leads to a reduction in fighting-related behaviors and attitudes.[14] (Note: You may also want to tell parents that excessive television viewing is associated with childhood obesity.) [15]

The importance of monitoring and providing guidance for TV viewing can start at a very early age; however, with school-age children, it is total screen time-TV, videos, video games- that now becomes the issue. The AAP recommends a maximum of two hours a day of total screen time. An office visit is a good time to discuss the importance of limiting screen time. Encourage parents to talk openly with their children about their objections to viewing violence and encourage parents to use age-appropriate alternatives: [16]

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

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

adolescents

Adolescence is the time when the serious consequences of involvement in violence become apparent; youth between the ages of 15-24 have the highest incidence of homicide of any age group.[17] Numerous research studies have been conducted, using a variety of methods, to help identify teenagers who are at a particularly high risk of violence-related injury.

From a clinical perspective, the lessons from these studies can be boiled down to a few salient facts. In early to mid-adolescence, teenagers become committed to a peer group with similar risk-taking behaviors. Teenagers who are at most likely to get hurt in fights are those who are more likely to abuse drugs, be sexually precocious, and drop out of school.[18] It follows then that discovery of risky behavior in any one of these domains should lead to gentle inquires into all of them. From a community perspective, youth development programs that engage young people in meaningful activities typically protect them from multiple risk factors.

Specific violence-related risk factors include witnessing or experiencing violence at home, a previous history of violence (i.e., recent fights and injuries), drug use, poor performance at school, truancy, and weapon carrying.[19]

CLINICAL SUGGESTIONS: PARENTS OF TEENS

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

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

CLINICAL SUGGESTIONS: VIOLENCE-RELATED HISTORY

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

(*The* FISTS *mnemonic is adapted with permission from the Association of American Medical Colleges, Alpert, Elaine J.,* M.D., *Bradshaw, Ylisabyth S.,* D.O., M.S., *Sege, Robert D*., M.D., Ph.D. *Interpersonal Violence ad the Education of Physicians, Vol. 42, No. 1, January 1997, page 546*.)

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

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

Adolescents who report that they have been in more than two physical fights in the past year are at a substantially increased risk for future violence-related injury.[19] For those adolescents who disclose a recent fight, it is appropriate to try to get a more detailed account of the incident. Pay careful attention to how it started, what motivated this individual to fight, who else was there, and whether a weapon was involved. Explore whether there could have been a non-fighting resolution and assess this youth's ability to resolve conflict easily.

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

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

Sex
- Has your partner ever hit you?
- Have you ever hit (hurt) your partner?

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

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

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

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

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

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

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

LOW-RISK YOUTH

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

Intervention & Prevention Ideas
- Validate low-risk behavior
- Ask about how the teen resolves conflicts while successfully avoiding fights

MODERATE-RISK YOUTH

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

Intervention & Prevention Ideas
- Take time to discuss the most recent fight and the kinds of strategies that

can be used to de-escalate future situations. This is the opportunity to discuss anger management strategies and offer information about community resources.
- Consider referring this patient to a counselor to further discuss the issues and risky behaviors identified.
- With the teen's consent, consider discussing intervention ideas with parents.

HIGH-RISK YOUTH

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

Intervention & Prevention Ideas

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

CAUTION: VIOLENCE AT HOME

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

DATING VIOLENCE

Dating violence can assume a number of forms that include physical, verbal, emotional, sexual, and psychological violence. There are many reasons why teenagers may not want to discuss dating violence with their primary health care professional, this is where an intervention by a provider can make a big difference. Girls who report dating violence are more likely to attempt suicide, engage in risky sexual behaviors, use injectable drugs, become pregnant, experience forced sex, and ride in a car with a drunk driver. Boys associated with dating violence are more likely to demonstrate risky sexual behaviors (including those with same-gender partners), engage in forced sex, and threaten with physical violence. It is important to note that coercive or violent sexual acts against adolescent girls are often committed by their boyfriends.[20]

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

- Educate your administrative staff about the problem of youth violence.
- Have educational materials available in your office, patient rooms, waiting rooms, and emergency departments to educate parents, patients, and visitors.
- Make lists of referrals available to patients, parents, and staff. Keep lists updated, and add new resources as they become available.

PREVENTION OF RE-INJURY

Children and teenagers who are injured once in a fight, robbery, or assault- and require medical attention are more likely to be injured again.[21] Since professionals in the Emergency Department (ED) often have contact with individuals immediately after a violent incident, the ED staff play a critical role in identifying ways to prevent further injury.

clinical suggestions

Evaluation and intervention need to happen as soon as the initial injury is stabilized and a medical treatment plan has been initiated. This is important, because the goal is to decrease the potential for any debilitating psychological sequence such as depression and post-traumatic stress disorder. The focus of this initial evaluation is crisis intervention. It does not matter whether the patient is the victim or the perpetrator, since studies have shown similar psychological profiles for both. Additionally, research has shown victims frequently become perpetrators in future assaults.[22]

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

Topics to explore the following:
- Previous weapon use
- Alcohol and drug abuse
- Mental health history
- Ongoing family violence
- Life at school
- Criminal history

Prior to discharge, find out if the fight is over. The following questions may help to get this current situation resolved:
- Is the conflict settled?
- Do you feel safe leaving the hospital?
- Is there a safe place to go while things cool off?
- What plans do you have regarding the other person(s) involved in the fight?

- Are you thinking about revenge?
- Is there an adult who can mediate the fight? Is there a peer mediation program in your school or community?

Once this information has been obtained, interventions and referrals can then be based on individual circumstances. Since these youths are at a substantial risk for a recurrent violence-related injury, consider trying to connect them with the appropriate services prior to discharge from the hospital. When all involved - patient, referral agencies, and if possible, the parent/guardian – have a good understanding about the follow-up services prior to discharge, health care professionals are increasing the chance of a successful intervention.

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

Programs that teach skills such as conflict resolution, anger management, and sensitivity provide valuable tools for youth who have been injured. Other programs, such as those that offer job training, recreational opportunities, and spiritual/religious support, play an important role as well. In many case, these programs provide links to other services that prove to be influential in preventing youths from being injured again.[23]

A history of abuse or neglect requires notification of the Department of Social Services.

Specific plans for revenge may call for police involvement, but only after attempts have been made to defuse the situation and when the health care professional believes that the youth remains determined to retaliate in kind and that the threat is both real and immediate. Given the seriousness of violating patient confidentiality concerning the duty to warn third parties, legal counsel should always be consulted before the police are contacted to protect a third party.

suggestions for clinical documentation

It is essential to have thoroughly documented medical records. These records may be used to provide concrete evidence of a violent incident, and they may be crucial to the outcome of any future legal proceedings. Critical elements include the following: [21]

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

- Referrals—including confidential legal referrals, when appropriate
- All information conveyed to the patient
- Discharge instructions

SPECIAL ISSUES

gay, lesbian, bisexual, transgender (glbt) youth

People who self-identify gay, lesbian, bisexual, or transgender (GLBT), or who are perceived to be GLBT, are at increased risk for involvement in violence, usually as victims. A national study reported that in 1999 there were at least 2,000 attacks against GLBT individuals, many of whom were teenagers and young adults.[24] Many of these attacks were hate crimes-the beating or murder of someone based upon beliefs, race, religion, or sexual orientation. Hate crimes may be particularly savage and include humiliation, rape, torture, and other unusually cruel acts. One case involved a teenage boy having the word "homo" carved on his back in five-inch letters by two of his classmates using a pocketknife.[24]

Recent studies comparing GLBT and non-GLBT youth have shown that GLBT youth are more likely to be victimized and threatened at school and are more likely to have skipped school because of their fear about personal safety. [25] These and other studies have shown that up to one-third of all GLBT youth have attempted suicide in a given year[26,27] They are more likely to experience depression and other psychosocial problems.[28] Therefore, GLBT youth are not only at risk from others, but from themselves.

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

However, an open and honest discussion of an adolescent's sexual orientation may be difficult for the professional and the youth. One study showed that up to two-thirds of GLBT patients had never discussed their sexual orientation with their health care professional, but reported a desire to do so.[29] Concern of confidentiality, which was assured to fewer than one-half of the respondents in that study, was cited as a barrier to this discussion. On the provider side, a lack of familiarity with gay-specific sexuality and health concerns may hamper discussion.

CLINICAL SUGGESTIONS

For all adolescents, providers can do the following:

- Ask questions about their sexual behaviors in an open manner without making assumptions or judgments.

- Listen to and discuss the potential difficulties for youth who are developing their sexual identity—gay, lesbian, bisexual, transgender, and straight.
- Establish an atmosphere in which patients feel comfortable talking about sex.
- Develop an ongoing relationship with the youth, and let them know you are there to help. In the long run, this will be the most powerful thing a health care provider can do.

For GLBT youth, providers can do the following:

- Train reception and support staff about the myths and misconceptions about the GLBT community and how to be welcoming.
- Inform GLBT youth about the specific physical and mental risks they face, and encourage them to attend GLBT support groups if necessary.

ADVOCACY

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

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

pregnant teens

When a teenager comes in for an appointment for an evaluation of her pregnancy, the focus of the visit can quickly turn to prenatal care and the outcome of the pregnancy. However, pregnant teens are at risk for dating violence, sexual abuse, and nonconsensual intercourse, and may have become pregnant as a result of forced or coercive sex. These risks may continue throughout the pregnancy and threaten the well-being of both mother and fetus.

CLINICAL SUGGESTIONS

Teenagers in abusive relationships may be unwilling—or unable—to discuss this violence for many reasons. However, physicians and other professionals caring for pregnant teens are in a unique position to screen for involvement in violence. During pregnancy, teenagers can be encouraged to think about the safety of their unborn child, along with their own safety. Consequently, it has been suggested that professionals include a screening for domestic violence in the initial evaluation and follow-up visits for prenatal care.[32] Abused women are twice as likely as non-abused women to begin prenatal care during the third trimester.[33] Therefore, repeated questioning throughout the pregnancy, or asking patients about the abuse later in the pregnancy, is likely to elicit a higher reporting rate.[34]

Pregnant and sexually active adolescents should have a completed physical examination and for health care professionals to take a thorough sexual history. When the possibility of violence is involved, a comprehensive obstetric

intake should include a focus on abuse and violence-related factors. When screening for violence and abuse, the following questions may be effective:

- What happens when you and your partner disagree?
- How does he treat you?
- Does he ever hit you?
- Are you afraid of him?
- Have you ever experienced nonconsensual sexual touching or intercourse?
- Did your pregnancy result from nonconsensual or coerced intercourse?

If sexual abuse is disclosed, and the patient is under 18, health care professionals need to notify the Department of Social Services and refer the patient to someone with experience in counseling for sexual abuse and violence, such as the Virginia Family Violence and Sexual Assault Hotline 1-800-838-8238.

COUNSELING

If the teen has not been referred to counseling, whenever possible, she should be connected with the proper services prior to leaving the office. For follow-up visits, there are steps that can be taken to ensure against "no shows". These include allowing for emergency visits and allowing the teen to wait in an inner office upon arrival to decrease the likelihood that she will depart from the waiting room.

Interventions for preventing further unintended pregnancies and fostering a nonviolent environment for the infant can be started during the pregnancy. It has been found that programs focusing on delaying additional sexual involvement, increased use of contraceptives, delay of a second pregnancy, and increased education and employment opportunities have positive outcomes decreasing unintended pregnancies. It is most effective to connect pregnant teens with social service programs that teach parenting skills and prenatal care, as well as skills on how to protect themselves and their children from abuse.

schools

Historically, schools have been a safe haven for students. However, with recent high-profile and particularly violent tragedies, this perception of safety has been dramatically reduced. Nevertheless, as the following facts illustrate, schools are still the safest place for children and adolescents, and health care professionals can help reduce the fear people have about school safety by informing them about the facts and working with them on prevention strategies.

Two important facts:

- Less than 6 percent of serious child assaults occur in schools.[34]
- Being at school (and receiving passing grades) is a protective factor against a violence-related injury.[19]

Children do not just learn academics at school. They also learn socialization skills and how to function in their community and society. Schools can have a great impact on effecting positive outcomes and preventing violence by identifying risk and resiliency factors in children. In addition, school programs that teach students how to avoid behaviors that lead to involvement in violence are

especially helpful. Students may benefit from programs that teach media literacy, conflict resolution, and resistance to risky sexual behavior and drug use.

SCHOOL SETTINGS

Elementary

Violence prevention efforts start in elementary schools. At this age, bullying—the repeated victimization of one (or more) students by a stronger student—is a major problem. In fact, victims of bullies have been the perpetrators in several of the recent school shootings, thus demonstrating the extraordinary anger and resentment bullying engenders.

Fortunately, effective interventions to prevent or eliminate bullying have been developed and extensively evaluated. Effective interventions require the involvement of the entire school and an understanding of the three roles associated with bullying—the victim, the bully, and the bystander. A coordinated intervention at all levels-school, classroom, and individual—results in a school that is "bully proof." An excellent description of these programs can be found in "Best Practices of Youth Violence Prevention, a Source book for Community Action" and "Bullying at School: What We Know and What We Can Do" by Dan Olweus (see the Referrals and Resources section of the guide for more information). If the school is not aware of these programs, the pediatrician can advise the administration to put these in place.

Middle

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

According to one study, highly perceived levels of drug use among one's peers, as well as the actual prevalence of drug use in an adolescent's middle school, was a strong predictor on involvement in violence.[35] Therefore, drug education and guidance to help middle school children learn how to resist such offers may yield an added violence-reduction bonus.

Research shows the positive effects of teaching conflict resolution skills to youth at this age.[36] Several curriculums have been developed and assessed; the most effective of these involve the extensive use of role-playing interactions to transform cognitive understanding into changed behaviors.

High

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

School-Based Clinics

Comprehensive school-based health care includes the following:

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

For a successful comprehensive health education program, collaboration must exist among the school, the family, and the community.[37]

CLINICAL SUGGESTIONS/ADVOCACY

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

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

COORDINATED RESPONSE TO VIOLENT INCIDENTS

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

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

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

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

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

guns

As recent high profile cases have illustrated, the homes of family and friends are often an easily accessible source of guns for children and teens. The AAP

has advised physicians and other professionals to educate parents about the common misconceptions about and dangers of owning guns, particularly handguns. [58,59]

GUN SAFETY

The American Academy of Pediatrics, as well as other medical organizations, promotes the idea that a home without a gun is the safest home, however, many patients have guns in their homes. Physicians and other professionals can help prevent tragedies by educating and explaining the risks and dangers of gun ownership. There are many inexpensive products to secure guns including a variety of safety devices and storage containers. As a healthcare provider, you can ask your patients about potential guns in the home, and encourage parents to implement safe storage practices, to utilize safety mechanisms such as trigger locks, or simply to remove guns from the home.

FACTS ABOUT GUNS

- In 2000, 86 children ages 14 and under died from unintentional firearm-related injuries. Children ages 10 to 14 accounted for 57 percent of these deaths.[40]
- In 2001, nearly 1,400 children ages 14 and under were treated in hospital emergency rooms for unintentional firearm-related injuries; 21 percent of these injuries were severe enough to require hospitalization.[40]
- The unintentional firearm injury death rate among children ages 14 and under in the United States is nine times higher than in 25 other industrialized countries combined.[40]
- In 2001, more than 8,000 children ages 14 and under were treated in hospital emergency rooms for non-powder gun-related injuries (e.g., BB guns, pellet guns).[40]
- An estimated 3.3 million children in the United States live in households with firearms that are always or sometimes kept loaded and unlocked.[40]
- Thirty-four percent of children in the United States (representing more than 22 million children in 11 million homes) live in homes with at least one firearm.[41]
- In 69 percent of homes with firearms and children, more than one firearm is present.[41]

REFERRALS & RESOURCES

Best Practices of Youth Violence Prevention, a Sourcebook for Community Action Thornton, TN, Craft CA, Dahlberg LL, Lynch BS, Baer K.
One free copy can be obtained by calling (888) 252-7751 or from cdc.gov/safeusa. This can also be downloaded via the Internet at www.cdc.gov/ncipc

Bullying at School: What We Know and What We Can Do
Dan Olweus, Blackwell Publishers, Oxford UK and Cambridge USA, 1993

Youth and Violence-Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence
This can be downloaded via the Internet at www.ama-assn.org/violence
Blueprints for Violence Prevention (Center for the Study and Prevention of Violence, University of Colorado at Boulder):
www.colorado.edu/cspv/blueprints

national resources

- American Academy of Pediatrics: www.aap.org
- Children's Safety Network: www.edc.org/HHD/csn
- Children's Safety Network: National Injury and Violence Prevention Resource Center: www.childrenssafetynetwork.org
- Coalition for Juvenile Justice: www.juvjustice.org
- CSAP Model Programs (U.S. Department of Health and Human Services): www.samhsa.gov/centers/csap/modelprograms Harvard Youth Violence Prevention Center: www.hsph.harvard.edu/hicrc/prevention.html
- Join Together: www.jointogether.org
- National Center for Injury Prevention and Control: Youth Violence in the United States: www.cdc.gov/ncipc/factsheets/yvfacts.htm
- National Mental Health Association-Juvenile Justice Section: www.nmha.org/children/justjuv/index.cfm
- National Resource Center for Safe Schools: www.safetyzone.org
- National Youth Violence Prevention Resource Center: www.safeyouth.org
- Parents and Friends of Lesbians and Gays (PFLAG): www.pflag.org
- Youth Violence: A Report of the Surgeon General: www.surgeongeneral.gov/library/youthviolence

virginia resources

- Center for Injury and Violence Prevention: www.vahealth.org/civp/preventviolenceva
- Prevent Child Abuse Virginia: www.preventchildabuseva.org
- Richmond Organization for Sexual Minority Youth: www.rosmy.org
- Virginia Best Practices Violence Prevention Tools: www.preventviolenceva.org
- Virginia Center for School Safety: vaschoolsafety.com
- Virginia Department of Education: http://www.safeanddrugfreeva.org/links.html#varesources
- Virginia Youth Violence Project: curry.edschool.virginia.edu/curry/centers/youthviolence
- Virginia State Police Crime Prevention: http://www.vsp.state.va.us/crime_prevention.htm
- Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

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NOTES

If family or sexual violence is indicated
two critical resources in Virginia are:

Family Violence & Sexual Assault Hotline
1-800-838-8238

Child Abuse & Neglect Hotline
1-800-552-7096

Virginia Department Of Health
www.vahealth.org/civp
1-800-732-8333