

RECOGNIZING & PREVENTING

**Youth
Violence**

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

**MASSACHUSETTS MEDICAL SOCIETY
COMMITTEE ON VIOLENCE**

PREFACE

This guidebook is the product of the Massachusetts Medical Society's Committee on Violence, Ylisabyth S. Bradshaw, D.O., M.S., Chair 1999-2001, Robert D. Sege, M.D., Ph.D., Vice Chair. Portions of this guidebook are based on the conference "Violence Prevention: New Approaches for Clinical Application" held at the Massachusetts Medical Society on May 1, 2000. The Committee would like to acknowledge Robert DuRant, Ph.D., Eli Newberger, M.D., John Rich, M.D., M.P.H., and Howard Spivak, M.D., who addressed the conference; Michael Cronin, M.P.H., Linda Grant, M.D., M.P.H., Barbara Herbert, M.D., Elliot Pittel, M.D., Stephen Porter, M.D., Nancy Rappaport, M.D., and Peter Stringham, M.D., who led the afternoon workshops; and many other professionals who contributed their thoughtful discussions at the conference. These discussions had the invaluable assistance of the following medical students who provided discussion guides and summaries for the participants: Jennifer Chen, Donna Greco, Jeffery Lazar, Ann Mullers, Rachel Salguero, Adam Saltzman, Serineh Voskanian, and Wei-Lien Wang.

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

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Robert D. Sege, M.D., Ph.D., Editor
Vincent G. Licenziato, Associate Editor

MASSACHUSETTS MEDICAL SOCIETY
COMMITTEE ON VIOLENCE

MASSACHUSETTS MEDICAL SOCIETY COMMITTEE ON VIOLENCE

Ylisabyth S. Bradshaw, D.O., M.S., Chair

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Eleanor T. Hobbs, M.D.	Margaret I. Bianchi, MMS Alliance
Judith N. Huizenga, M.D.	Jeanne K. Gaz, MMS Alliance

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MASSACHUSETTS MEDICAL SOCIETY STAFF

Marianne Barra
Gina DeDominici

Susan Webb
Laura Whipple

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please contact the Massachusetts Medical Society

Department of Public Health and Education
860 Winter Street

Waltham, Massachusetts 02451-1411

Telephone (781) 434-7373, (800) 322-2303

Fax (781) 434-7455, E-mail dph@mms.org

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Note to Readers:

Please note that the guidebook “Recognizing and Preventing Youth Violence” is intended as an informational resource, that the guidelines and suggestions in the guidebook should not be construed as standards of care, that treatment decisions must be made on the basis of the facts and circumstances of each individual case, that the guidebook should serve only as a starting point, and that 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.

INTRODUCTION

Violence is a leading cause of injury, death, and mental health problems for America's youth. Although physicians and other health care professionals have always been involved in treating the *results* of violence, recent research and practice suggest that we can also play a critical role in its *prevention*.

We have two opportunities for intervention and prevention: during a routine health care visit and when caring for a youth who has been injured. On these occasions we can provide preventive education, screening for risk, and linkages to intervention and follow-up services.

This guide was written to:

- provide basic information about youth violence
- describe risk factors and appropriate screening tools
- suggest approaches to violence prevention and intervention
- present ideas and resources for advocacy and research
- introduce the Massachusetts Medical Society's Committee on Violence's *Violence Prevention for Children and Youth Parent Education Cards (Tip Cards)*

The Medical Society's tip cards were developed through a process which included practicing physicians' and other professionals' input at every stage, along with parent involvement through professionally run focus groups. Studies performed on prototype cards demonstrated their effectiveness, and over 500,000 cards have been distributed throughout the United States and foreign countries. We hope that dissemination of knowledge about the risk and protective factors and about available resources will make a *difference* in the lives of our patients.

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

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

Ylisabyth S. Bradshaw, D.O., M.S., Chair of MMS Committee on Violence
Robert D. Sege, M.D., Ph.D., Vice Chair of MMS Committee on Violence



Some Sobering Facts

- On average, in 1997, there were 17 Americans between the ages of 15 and 24 murdered each day.^{1,2}
- Teens are 2¹/₂ times more likely than adults to be victims of violence.³
- 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.
- In a national survey of high school students,^{4,5} 36 percent had been in a physical fight more than once during the past year, with 4 percent requiring medical attention.
- 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. These 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.

- *Youth and Violence – Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence*

To obtain free copies, contact the American Medical Association at (312) 464-4520. 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/dvp/bestpractices.htm.



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, in the 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 heredity factors like temperament
- exposure to violence in the media
- use of drugs and/or alcohol
- presence of firearms in the home
- combination of stressful family and socioeconomic factors (poverty, severe deprivation, marital breakup, single parenting, ineffective parenting practices, unemployment, loss of support from extended family)
- brain damage from a head injury

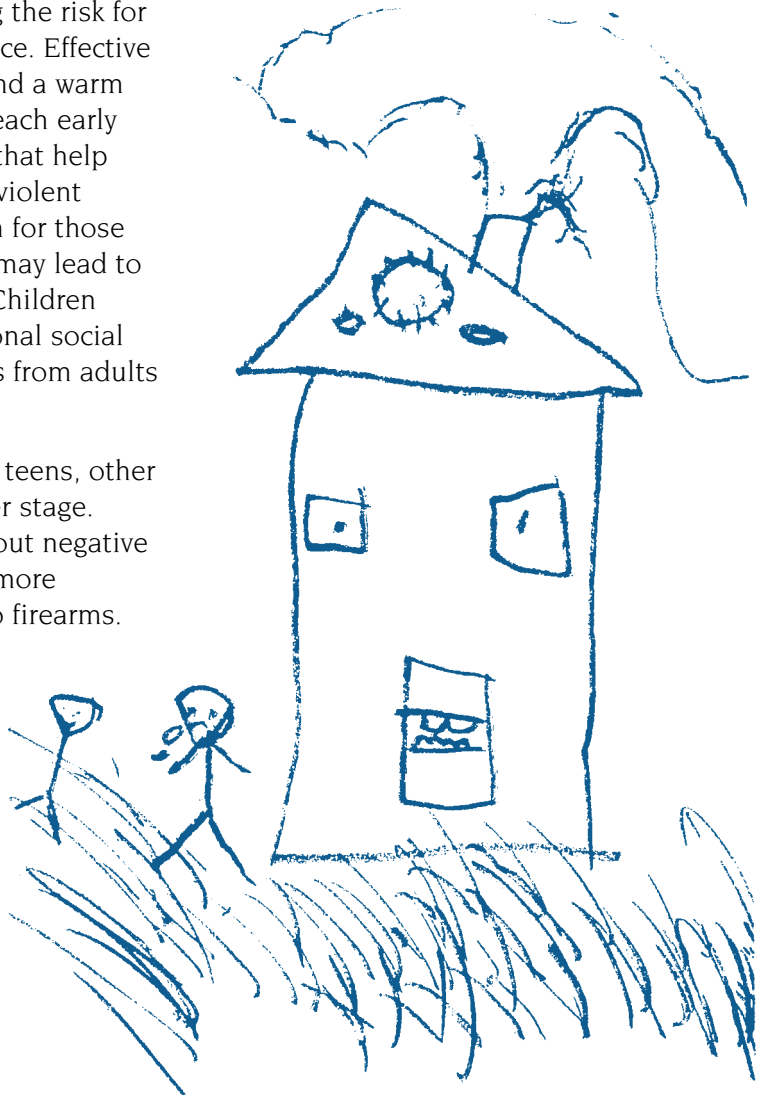


TIP CARD: When Children Witness Violence

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

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

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



Resiliency Factors

Even when confronted with the 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 conflict altogether or de-escalate a violent situation
- autonomy — self-control, taking responsibility for one's actions, and establishing a distinct identity
- sense of purpose/future — motivation, persistence and hardiness, goal-directed

Environmental influences on resiliency include the connections a youth has to the larger community. This includes involvement with athletic teams, adult mentoring, church and other religious groups, and neighborhood organizations. These activities promote meaningful connections with adults and friendships with peers who have positive pro-social personal values. Both organizational and individual connections promote resiliency.

A Developmental Approach

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



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

Adolescents can be screened for behaviors that place them at risk for mental health problems and future involvement in violence. An assessment by a health care provider begins with obtaining information from a number of sources: the adolescent, parent(s), significant 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, homicidality
- history of witnessed or experienced physical or sexual abuse
- emotional neglect
- history of running away from home
- marked change in physical health
- dramatic behavior change (e.g., withdrawal, aggression, petty theft, drunk driving, truancy, 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 many issues of typical child development, from sleeping and feeding schedules to language acquisition. Therefore, discussing family dynamics and positive parenting skills is both expected and accepted.

Clinical Suggestions

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

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

- Screen for family violence and substance abuse.
- Ask about parental views regarding spoiling and discipline.
- Suggest using nonphysical discipline such as natural/logical consequences and time-out strategies. The American Academy of Pediatrics (AAP) recommends that parents be encouraged and assisted in the development of methods other than spanking for managing undesired behavior.¹²
- 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.

TIP CARD: Raise Your Child with Praise

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



TIP CARD: Time-Out!

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

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 or 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.



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.

TIP CARD: Pulling the Plug on TV Violence

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



Adolescents

Adolescence is the time when the serious consequences of involvement in violence become apparent; youth between the ages of 15 and 24 have the highest incidence of homicide of any age group.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 most likely to get hurt in fights are those who are most likely to abuse drugs, be sexually precocious, and drop out of school.¹⁸ It follows that the discovery of risky behavior in any one of these domains should lead to gentle inquiries into all of them. From a community perspective, youth development programs that engage young people in meaningful activities typically protect them from multiple risk factors.

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 times, finding out if there is adult supervision, and getting to know the parents of the adolescent's friends.

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



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

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

Clinical Suggestions: Violence-Related History

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

(The FISTS mnemonic is adapted with permission from the Association of American Medical Colleges. Alpert, Elaine J., M.D., Bradshaw, Ylisabyth S., D.O., M.S., Sege, Robert D., M.D., Ph.D. Interpersonal Violence and the Education of Physicians, 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 that incident. Pay careful attention to how it started, what motivated this individual to fight, who else was there, and whether a weapon was involved. Explore whether there could have been a non-fighting resolution and assess this youth's ability to resolve a conflict easily.



Injuries

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

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

Sex

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

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

Threats

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

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

Self-Defense

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



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

After a history is obtained, providers can determine if the youth's risk for involvement in violence is low, moderate, or high. 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 fights
- are struggling with school work
- report other behavior that the health care professional identifies as risky

Intervention & Prevention Ideas

- Take time to discuss the most recent fight and the kinds of strategies that can be used to de-escalate future situations. This is the opportunity to discuss anger management strategies and offer information about community resources.
- Consider referring this patient to a counselor to further discuss the issues and risky behaviors identified.
- With the teen's consent, 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

While 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



TIP CARD: Teen Dating Violence

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

Violence!!!

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

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

PREVENTION OF REINJURY

In Boston, children and teenagers who are injured once in a fight, robbery, or assault — and require medical attention — are six times more likely to be injured again.²¹ Since professionals in the Emergency Department (ED) are the ones who often have contact with individuals immediately after a violent incident, the ED staff plays a critical role in identifying ways to prevent further injury.

Clinical Suggestions

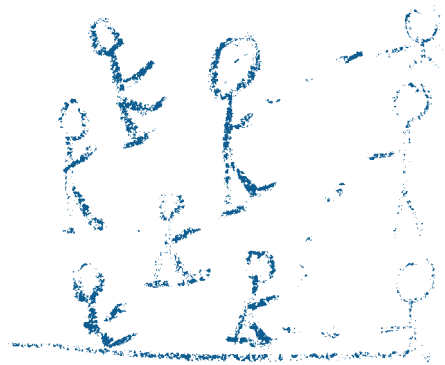
Evaluation and intervention need to happen as soon as the initial injury is stabilized and a medical treatment plan has been initiated. This is important, because the goal is to decrease the potential for any debilitating psychological sequelae such as depression and post-traumatic stress disorder. The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

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

- previous weapon use
- alcohol and drug abuse
- mental health history
- ongoing family violence
- life at school
- criminal history

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

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



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

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

Since these youths are at a substantial risk for a recurrent violence-related injury, consider trying to connect them with the appropriate services prior to discharge from the hospital. When all involved — patient, referral agencies, and 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, recreation opportunities, and spiritual/religious support, play an important role as well. In many cases, these programs provide links to other services that prove to be influential in preventing youths from being injured again.²³

A history of abuse or neglect requires notification of the Department of Social Services. Note that even in those cases in which the youth denies a history of abuse or neglect, Massachusetts law requires health care professionals to notify the Department of Social Services when the health care professional has a reasonable belief that the youth has been subject to abuse or neglect.²⁴

Specific plans for revenge may call for police involvement, but only after attempts have been made to defuse the situation and only 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 and the undeveloped state of the law in Massachusetts concerning the duty to warn third parties, legal counsel should always be consulted before the police are contacted to protect a third party.

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

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

Suggestions for Clinical Documentation

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

GAY, LESBIAN, BISEXUAL, TRANSGENDER (GLBT) YOUTH

People who self-identify as gay, lesbian, bisexual, or transgender (GLBT), or who are perceived to be GLBT, are at increased risk for involvement in violence, usually as victims. A national study reported that in 1999 there were at least 2,000 attacks against GLBT individuals, many of whom were teenagers and young adults.²⁵ For the same year, there were 174 incidents in Massachusetts, with 12 percent of the victims under the age of 22.²⁶ Many of these attacks were hate crimes – the beating or murder of someone based upon beliefs, race, religion, or sexual orientation. Hate crimes may be particularly savage and include humiliation, rape, torture, and other unusually cruel acts. One case in Massachusetts involved a teenage boy having the word “homo” carved on his back in five-inch letters by two of his classmates using a pocketknife.²⁵

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.²⁷ These and other studies have shown that up to one-third of all GLBT youth have attempted suicide in a given year.^{28,29} They are more likely to experience depression and other psychosocial problems.³⁰ 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, an open and honest discussion can serve as a bridge to educating adolescents about violence prevention, which in turn will help them access care for more complex physical and mental health matters.

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.³¹ 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; however, a more important barrier is the *assumption of heterosexuality*.³²

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:

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

In Massachusetts, adolescents may seek medical advice without parental involvement if they qualify as “mature minors.” See page 38 for more information about the Mature Minor Rule for Massachusetts.

Advocacy

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



"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 — parenting, adoption, or abortion. However, pregnant teens are at high 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.

The Facts

- Some studies have found that up to 66 percent of pregnant teens report histories of sexual abuse.³³
- The majority of studies on the subject report that the prevalence of violence to women during pregnancy is between 3.9 and 8.3 percent.³⁴
- One study found that out of 535 pregnant teenagers, 44 percent had been raped, with 11 percent becoming pregnant as a result of the rape.³⁵ The girls' boyfriends, many of whom are up to 10 years older than the teens, perpetrate up to 30 percent of these rapes.³⁶

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.³⁷ Abused women are *twice as likely* as nonabused women to begin prenatal care during the third trimester.³⁸ Therefore, repeated questioning throughout the pregnancy, or asking patients about abuse later in the pregnancy, is likely to elicit a higher reporting rate.³⁹

It is a good idea for all pregnant and sexually active teenagers to have a complete 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.

Counseling

If the teen has not been referred to counseling, whenever possible, she should be connected with the proper social 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 the increased use of contraceptives, delay of a second pregnancy, and increased education and employment opportunities have positive outcomes in decreasing unintended teen 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.

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 and response strategies.

Two important facts:

- Less than 6 percent of serious child assaults occur in schools ⁴⁰
- 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 school. 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 for Community Action and Bullying at School: What We Know and What We Can Do”* by Dan Olweus (see the Referrals & 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.

TIP CARD: Bullying – It’s Not O.K.

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



Middle

In 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, high 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 of involvement in violence.⁴¹ 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.⁴² Several curricula have been developed and assessed; the most effective of these involve the extensive use of role-playing interactions to transform cognitive understanding into changed behaviors.

High

In high 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 in Massachusetts includes the following:

- comprehensive health education curriculum
- school counseling and psychological services
- school health services
- coordination of school and community resources
- school climate/environment

For a successful comprehensive health education program, collaboration must exist among the school, the family, and the community.⁴³

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.

JUVENILE JUSTICE SYSTEM

One million minors come into contact with the juvenile justice system each year. While more than 90 percent of incarcerated youths are held for nonviolent offenses, youths are responsible for 19 percent of all violent crimes.⁴⁴

While the goal is for interventions to occur before a youth commits a crime, health care professionals can still help youths in the juvenile justice system. Since sentences are often open-ended, and can last for years, there is ample time for intervention.

This population is at high risk for morbidity and mortality. Youths in the juvenile justice system have a high rate of physical and mental health problems. The most common psychiatric disorders among youths in the juvenile justice system are conduct disorder, depression, attention deficit/hyperactivity disorder, learning disabilities, post-traumatic stress disorder (PTSD), and developmental disabilities.^{45, 46}

Some Statistics

- In one study, 46 percent of teens admitted to a detention center were diagnosed with medical problems.⁴⁷
- As many as 60 to 75 percent of incarcerated youths have a recognizable mental disorder, and 20 percent have a severe mental disorder.⁴⁸
- 50 to 75 percent of juvenile offenders also have substance abuse problems.⁴⁹
- 32 percent of juvenile offenders have PTSD (a higher proportion than seen in community samples) as a result from previous physical abuse, sexual abuse, and trauma.⁵⁰
- More than 80 percent of incarcerated youth with mental disorders suffer from conduct disorders.⁵¹

Delinquent youths display many high-risk behaviors. They report more aggressive behavior, poorer interpersonal skills, poorer academic performance, more drug and alcohol use, and higher rates of sexual activity than their nondelinquent peers. In addition, they report poorer perceived well-being and self-esteem, increased physical discomfort, increased acute, chronic, and psychosocial disorders, and decreased family involvement and physical activity.⁵²



Additionally, a majority of incarcerated youths have a history of exposure to family and neighborhood violence — as witnesses or victims — and consequently display high levels of depression. Clearly, poor present and future mental health is a major issue for this population. In fact, some of the youths involved in the juvenile justice system may have committed their offenses as a result of undiagnosed or untreated mental health problems.⁵³

For minority youths, the situation is even worse. They are disproportionately overdiagnosed for conduct disorders but receive fewer mental health services. Minority youths are more likely than nonminority youths to be prosecuted in an adult court and sent to an adult jail for the same offenses.⁴⁹ Developmentally appropriate mental health services are often not accessible in adult prisons.

Incarcerated children often get inadequate mental health treatment in juvenile justice centers. Judges, prosecutors, defense counsels, and probation officers are often ill-equipped to fully evaluate the needs of a child with mental illness, interpret mental health tests, and understand proper treatment. Compounding this problem further is a lack of standardization in research-based mental health assessment protocols.

Girls in the Juvenile Justice System

Despite falling crime rates, more adolescent girls are arrested and incarcerated in the U.S., with almost three-quarters of a million girls under 18 arrested in 1997, accounting for 26 percent of total juvenile arrests. Most girls are arrested for nonviolent offenses, usually drug-related crimes. Many are members of minorities, have significant academic problems, have been victims of abuse, come from families living in poor communities, and are substance abusers. Girls challenge the juvenile justice system to provide for complex health and mental health issues related to sexual behavior, substance abuse, trauma, and involvement in violence. Their problems can easily be exacerbated in this system, where they can be exposed to staff insensitivity, loss of privacy, seclusion, or retraumatization.⁵⁴

Incarcerated girls report high rates of physical and sexual abuse, with more than 70 percent reporting such experiences. There are high rates of witnessing violence. Nearly 50 percent meet criteria for PTSD.⁵⁵

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

Clinical Suggestions

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

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

A comprehensive violence history involves assessing the following:

- history of trauma and exposure to violence
- victimization
- aggression

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

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

These services are most effective when incorporated with other services provided by schools, child welfare agencies, and community organizations. In addition, family counseling can help families' ability to cope and care for the children at home.

A comprehensive community approach to treating serious and violent criminal behavior in adolescents that has substantial empirical support is called Multi-systemic Treatment (MST).⁵⁶ Psychiatrists serve as part of a treatment team which works with adolescents involved in violence and their families to directly address cognitive, familial, and extra-familial (e.g., peer, school, neighborhood) factors that contribute to violent and antisocial behavior. Studies have found that adolescents in MST had significantly fewer re-arrests and shorter incarceration periods than youths in traditional services.⁵⁶

Advocacy

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



ACUTELY VIOLENT PATIENT

One of the greatest concerns of practitioners is encountering a violent patient. These patient encounters are infrequent, but the establishment of policies and procedures will prepare both you and your staff in advance.

When faced with a patient with a history of violent behavior or a recent violent act, a health care professional's role is first to ensure safety:

- for the patient
- for those in the immediate area

Approaching this patient with the view that violence is a symptom of a larger difficulty is essential for maintaining a perspective that can uncover underlying etiology and direct this patient toward the appropriate care.

In an acute situation, rule out medical conditions that result in aggression or irritability and may require emergent therapy. The **WHIMPS** mnemonic is a helpful place to begin this process. (**W**: Wernicke's or withdrawal — **H**: hypoxia, hypoperfusion, hypertensive crisis, hypoglycemia, hyper/hypothermia — **I**: intracranial bleed/mass, intoxication — **M**: meningitis — **P**: poisoning — **S**: status epilepticus). In addition, for children, consider lead poisoning, iron poisoning, iron deficiency, evidence of abuse from a skin or x-ray examination, and drug intoxication.

When assessing a violent patient, be mindful of the interview space. All potentially dangerous materials should be removed, the area should allow for escape and visibility, and quick backup help should be available.

The examiner needs to pay attention not only to the verbal communication of the patient but also the patient's body language. A general Mental Status Exam is essential for an adequate assessment; it should include a sense of the patient's sensorium to rule out delirium and screen for affective disorders, thought disorders, and anxiety disorders. An assessment of the level of cognitive function frequently can uncover deficits in communication as well as the patient's ability to respond to challenging situations in a mature manner.

Questions regarding past violence are extremely important, since the best predictor of violence is past violence. In assessing violence, get the specifics about current and past episodes, including the beginning or precipitants, the nature of the violence, and the conclusion or consequence. There are screening questionnaires available (e.g., the VASA: Violence and Suicide Assessment) that are helpful in assessing risk.⁵⁷ It is also important to obtain information from collateral sources — school and family. Since abuse and neglect are the most common contributors to violent behavior, the collaboration with social workers and state social service agencies is frequently required.

Clinical Suggestions

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

- learn how to control and express anger and frustration in appropriate ways
- improve social skills — interpersonal issues, communication, relationship-building and maintenance, problem-solving, conflict resolution
- take responsibility for actions and accept consequences

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

In addition, family conflicts, school problems, and community issues must be addressed. Management of the at-risk adolescent often necessitates a multidisciplinary approach, because complex and time-consuming issues are commonly involved. Involvement of social and mental health services is essential, as emotional issues that affect teens are complex and beyond the scope of the general pediatrician. Therapy and management can be individual, family, school, and community-based.

The family interventions that have proven to be successful involve building skills in communication, behavior monitoring, and effective discipline. Family therapy also focuses on building cohesion and emotional warmth within the family, strengthening adaptive behavior in the adolescent, and minimizing marital problems that interfere with the parents' ability to function effectively. Community-based interventions include Big Brother and Big Sister programs and other mentorship programs that often involve community leaders and educators. Utilization of Family Stabilization Teams are frequently helpful in intensely supporting families in crisis as well as aiding in the coordination and setup of treatment plans with the family.

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



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. Therefore, 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}

Physicians and other professionals can help prevent these tragedies by educating and explaining the risks and dangers of gun ownership. Parents can be encouraged to utilize safety mechanisms such as trigger locks and loaded chamber indicators, or simply to remove guns from the home. Health care professionals can also advocate for stricter gun control laws and for gun safety and support groups that lobby for increased safety mechanisms.

Facts About Guns

- Half of all households in the United States have a gun.⁶⁰
- 59 percent of parents who acknowledged having a gun in the home do not lock the gun away from their children, putting children at a high risk for handgun-assisted suicide and accidental death.⁶¹
- Persons with a history of at least one handgun purchase in the family have an increased risk of suicide or homicide.⁶²
- A handgun in the home is 43 times more likely to be used for murder or suicide than for self-defense.⁶³
- Gunshot wounds to children aged 16 and under have increased 300 percent in major urban areas since 1986.⁶⁴
- An estimated 2.6 million American youths aged 11 to 18 carried a gun “for protection or as a weapon” in 1999.⁶⁵
- Firearms are the most common method of completed suicide.⁶⁶
- As a result of guns, every day in the United States about:
 - one child under the age of 10 is killed and two are accidentally injured.
 - eight adolescents between the ages of 15 and 19 are killed, and 38 are injured.⁶⁶

Mature Minor Rule

In Massachusetts, adolescents may seek medical advice without parental involvement if they qualify as “mature minors.” In order to determine that an adolescent is a “mature minor” within the meaning of Massachusetts law, a health care professional must determine that:

1. The best interests of the minor will not be served by seeking consent from a parent, and
2. The minor must be capable of giving “informed consent” before providing treatment without parental consent.⁶⁷

If the health care professional does not believe that a youth is capable of giving informed consent for any reason, the legal situation becomes much more complicated, and advice of counsel should be sought before care is provided without parental consent.⁶⁸

Reporting Youth Violence and Child Abuse

Massachusetts civil laws, or statutes, describe the circumstances and conditions that obligate mandated reporters to report known or suspected cases of abuse and provide definitions necessary for juvenile and family courts to take custody of a child alleged to have been maltreated. Criminal statutes specify the forms of maltreatment that are criminally punishable. Failure to report suspected child abuse could result in criminal liability, although the liability is typically a misdemeanor punishable by a fine. A report must be made to the Department of Social Services. Reporting to a parent or relative will not satisfy the reporter’s legal duty under the statutes.

The Massachusetts statute maintains that “...who, in his professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering physical or emotional injury resulting from abuse inflicted upon him which causes harm or substantial risk of harm to the child’s health or welfare including sexual abuse, or from neglect, including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition to the department by oral communication and by making a written report within forty-eight hours after such oral communication...”

For the complete text of this statute, go to: www.state.ma.us/legis/laws/mgl/119-51A.htm.²⁴ Over time, statutes are revised. So if there is any question about the reporting of youth violence or a violence-related injury, consult your organization’s legal resources or personal legal counsel.



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

Teach Your Peers

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

Teach the Public

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

Get Involved in the Community

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

Advocate

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

Local City/town Hall: _____

Commonwealth of Massachusetts: Governor's Office – (617) 727-3600

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

National: US Senate – (202) 224-3121, US House of Representatives – (202) 224-3121

REFERRALS & RESOURCES

Highly Recommended Publications

- *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/dvp/bestpractices.htm.

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

- *Youth and Violence – Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence*

To obtain free copies, contact the American Medical Association at (312) 464-4520. Fax: (312) 464-5842.

This can also be downloaded via the Internet at www.ama-assn.org/violence.

National Resources

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

Primary Prevention – Preteens

- Department of Social Services: (617) 748-2000, www.state.ma.us/dss



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

Primary Prevention – Adolescents

- Center for the Study of Sport in Society (Northeastern University, Boston, MA): The mission of the Center is to increase awareness of sport and its relation to society and to develop programs that identify problems, offer solutions, and promote the benefits of sport. (617) 373-4025, www.sportinsociety.org
- National Youth Sports Safety Foundation, Inc.: NYSSF is a national nonprofit, educational organization dedicated to reducing the number and severity of injuries youth sustain in sports and fitness activities. NYSSF with the Governor’s Committee on Physical Fitness and Sports developed a Sport Parent’s Code of Conduct to promote sportsmanship. (617) 277-1171, www.nyssf.org
- Massachusetts Department of Public Health — Violence Prevention Services for Adolescent Services: (617) 624-5433

Boston Area

- Boston Public Health Commission, Adolescent Wellness Program: (617) 534-5196, www.bphc.org/AWP/AWP.HTM
- Teens Against Gang Violence: A teen peer-leadership program that is not against gangs, but against gang violence: (617) 282-9659, www.tagv.org
- Boston Housing Authority’s Youth on the Rise — Drug Intervention Workers and Peer Leaders: main community number, (617) 988-4333; family services, (617) 988-5101; drug intervention, (617) 988-5349
- Boston Asian Youth Essential Services: (617) 482-4243
- Vietnamese Youth Task Force (Dorchester, MA): (617) 825-0110 x428
- Tree of Life/Arbol de Vida, Jamaica Plain Coalition (Jamaica Plain, MA): (617) 522-4832. Provides workshops for parents and youth on violence risk behavior.



- Mattapan 2006 Faith In-Action Initiative (Mattapan, MA): (617) 296-6789. Collaborative effort that encourages faith-based leaders in Mattapan to meet with law enforcement, human service providers, and the school system to increase awareness about the risk factors affecting Mattapan's youth.
- Project Free (Roxbury, MA): (617) 427-3556. This is a violence intervention program for at-risk youth in the Franklin Hill and Franklin Field communities.

Outside the Boston Area

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

Gay, Lesbian, Bisexual, Transgender (GLBT) Youth

- Stop The Hate (MA Governor's Task Force) — Receives reports of hate crimes, provides information and resources to students, educators, law enforcement officers, and communities: www.stophate.org
- GLBT Health Access Project: (617) 988-2605
- Fenway Community Health Center, Boston, MA. General information, (617) 927-6000. GLBT Help-Line, (617) 267-9001. Peer Listening Line: 1-800-399-PEER
- Northampton Community Health and Safety Advisory Committee (Northampton, MA): (413) 587-1361. School-based program that educates at-risk youths on conflict resolution, community service, substance abuse, homophobia, and gang involvement. As a referral program, it has extensive services for GLBT youth.
- Sidney Borum Jr. Health Center: general (617) 457-8140; GLBT (617)988-2605. This center provides primary medical care, substance abuse and mental health counseling, general psychiatric services, and HIV case management for adolescents and young adults, as well as specialized services for gay, lesbian, bisexual, and transgender youth, street youth, and people living with HIV/AIDS.



Schools

- Department of Education - Safe Schools Initiative: (781) 338-6300 or (781) 338-6309
- Lexington Public Schools, Health Protection Advisory Council (Lexington, MA): (781) 861-2348. An activity-based after-school program for eighth grade students that focuses on teaching conflict resolution, reducing opportunities for risky behavior, and encouraging a successful transition to high school.
- Marblehead Public Schools: Health Protection Advisory Committee (Marblehead, MA): (781) 639-3147. Program designed to increase community involvement in violence prevention efforts; services are offered within the schools.
- Northampton Community Health and Safety Advisory Committee (Northampton, MA): (413) 587-1361. School-based program that educates at-risk youths on conflict resolution, community service, substance abuse, homophobia, and gang involvement. As a referral program, it has extensive services for GLBT youth.

Juvenile Justice System

- Children's Law Center of Massachusetts: (781) 581-1977
- Committee for Public Counsel Services: (617) 482-6212. Arranges for public defenders and private counsel. The Youth Advocacy Project deals with juvenile delinquency and youthful offenders, and the Children and Family Law Program deals with civil family cases.
- Haverhill Police Department (Haverhill, MA): (978) 373-1212 x148. Provides violence education to police, health care workers, and educators and will implement community program on violence.

Boston Area

- Boston Community Centers' Street Worker Program: (617) 635-4920 x2215
- Boston Juvenile Probation: (617) 788-8571
- Boston Police, Gang Unit: (617) 343-4246; General: (617) 343-4200
- Community Justice Partners (Roslindale, MA): (617) 288-9100. A program that helps juvenile offenders adjust back to the community.
- ROCA — Restorative Justice groups: street workers involved with gangs and/or the courts; Alternatives with Work Program; Leadership Programs: (617) 889-5210

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**MASSACHUSETTS MEDICAL SOCIETY
COMMITTEE ON VIOLENCE**

**Department of Public Health and Education
860 Winter Street
Waltham, Massachusetts 02451-1411**