

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level

Task Force on Violence

Pediatrics 1999;103;173-181

This information is current as of May 31, 2006

The online version of this article, along with updated information and services, is
located on the World Wide Web at:

<http://www.pediatrics.org/cgi/content/full/103/1/173>

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 1999 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



AMERICAN ACADEMY OF PEDIATRICS

Task Force on Violence

The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level

ABSTRACT. Violence and violent injuries are a serious threat to the health of children and youth in the United States. It is crucial that pediatricians define their role and develop the appropriate skills to address this threat effectively. From a clinical perspective, pediatricians should incorporate into their practices preventive education, screening for risk, and linkages to necessary intervention and follow-up services. As advocates, pediatricians should become involved at the local and national levels to address key risk factors and assure adequacy of preventive and treatment programs. There are also educational and research needs central to the development of effective clinical strategies. This policy statement defines the emerging role of pediatricians in youth violence prevention and management. It reflects the importance of this issue in the strategic agenda of the American Academy of Pediatrics for promoting optimal child health and development.

ABBREVIATIONS. AAP, American Academy of Pediatrics; HELP, Handgun Epidemic Lowering Plan; TFOV, (AAP) Task Force on Violence; VIPP, Violence Intervention and Prevention Program.

BACKGROUND

Violence has become increasingly prominent in the lives of children in the United States, which has the highest youth homicide and suicide rates among the 26 wealthiest nations in the world and one of the highest rates of homicide worldwide.¹⁻³ Homicide and suicide have become the second and third leading causes of death of teenagers; homicide is the leading cause of death of black youth.^{3,4} Children and youth face serious short- and long-term physical and emotional consequences as victims, witnesses, and perpetrators of violence.^{5,6} Furthermore, violence is an issue that crosses all geographic (urban to rural) and socioeconomic boundaries.

Homicide rates for males 15 to 19 years of age increased 113% between 1985 and 1995, surpassing rates for males of all other age groups except those 20 to 24 years of age, with firearm-related homicides accounting for almost all of this increase.³ Teenagers are now more likely to die of gunshot wounds than all natural causes combined.^{7,8}

Data on nonfatal violent injuries are less available and reliable than those on homicide, in part, because many victims do not seek medical attention. It is estimated that for every homicide, there may be as many as 100 nonfatal violent assaults that receive treatment in an emergency department.⁹ In 1995, children and adolescents 17 years or younger had 517 000 hospital emergency department visits for as-

sault-related injuries.¹⁰ Health care workers in urban trauma centers have noted that assaultive trauma is recurrent, with hospital readmission rates for subsequent assaults noted to be as high as 44% and subsequent homicides as high as 20%.¹¹⁻¹⁵

As youth homicide rates have continued to rise, so have permanent physical disabilities attributable to assaults. One estimate is that during the early 1990s, the number of severe nonfatal central nervous system injuries attributable to gunshot wounds in Los Angeles, California, was equal to the number of fatalities.¹⁶ More than 15% of all spinal cord injuries are caused by intentional trauma,¹⁷ and an unknown, but presumably substantial, number of traumatic brain injuries are the result of violence. The number, specific injury cause, and degree of long-term disability of the victims remain poorly described in the literature because no surveillance system has been established to document these conditions, despite their prevalence.

The situations in which fatal and nonfatal adolescent assault injuries occur are similar.¹⁸ Violent injury and death result from altercations between family members and acquaintances far more often than from robberies or other criminal activity.¹⁹ National surveys indicate that large numbers of youth, male and female, are involved in violent altercations.²⁰ Furthermore, the risk of involvement with violence has been associated with many issues relevant to pediatric practice including disciplinary methods (such as corporal punishment), television viewing (particularly violent programming), exposure to domestic violence and child abuse, and handgun ownership.²¹⁻²⁸

A growing number of reports confirm that numerous children witness violence.²⁹⁻³² Although it is unclear how many children are exposed to domestic and other forms of violence, no doubt exists that children are harmed—cognitively, emotionally, and developmentally—when they witness violence.^{6,31,33-37} Exposures to violence and victimization are also strongly associated with subsequent acts of violence by the victim.³⁸⁻⁴⁰

THE ROLE OF PEDIATRICIANS

Pediatricians have a long and admirable history of addressing the major health issues of children in the United States by: promoting access to health care and the prevention of unintentional injury; recognizing and treating institutional injuries and child abuse; providing preventive care, such as immunizations;

and by fostering early care and education, such as quality child care and the Head Start program.

This statement outlines roles for pediatricians in the prevention and management of youth violence. It establishes an agenda for making this a routine part of pediatric practice in four major areas: clinical services, community advocacy, research, and education. This broad agenda builds on a still-evolving body of knowledge, but the urgency of youth violence prevention requires further and immediate action by pediatricians.

Clinical Care

The epidemiology of violent injury identifies contributing factors affecting risk for involvement with violence, and the influences of violence on children (short- and long-term).²¹⁻²⁸ Many of these risk factors are in areas traditionally and routinely addressed by pediatricians in their anticipatory guidance activities and so provide a familiar starting point for violence prevention efforts.⁴¹

Because many pediatricians encounter children and youth who are experiencing or are at risk for violence, pediatricians are well situated to intervene. Prevention of youth violence requires that pediatricians recognize violence-related risk factors and diagnose and treat violence-related problems at all stages of child development. See section on "Safety and Screening" below.

The Academy encourages pediatricians to use a stepwise approach to promote a healthy nonviolent environment at all phases of child and adolescent development.

Early Nurturing

• *Infancy.* Children need loving and caring relationships early in life to develop skills for nonviolent behavior throughout life. Pediatricians can promote care and support systems for families to help them nurture children. Key elements include appropriate bonding and attachment between parents and the infant and identification of factors that threaten bonding and attachment (ie, postpartum and other family depression, family strife, and lack of support systems for parents).

• *Preschool.* During the preschool years, pediatricians can encourage parents to spend time with their children, read to them (starting in infancy), teach them positive social skills, and monitor and provide guidance for their television viewing. Pediatricians can educate parents on normal age-appropriate (see Table 1) behaviors and guide them in how to model nonviolent behavior and conflict resolution for their children.

• *School age.* During this time, children develop communication skills and problem-solving skills. Parents can teach and model nonviolent anger management and conflict resolution skills as well as foster appropriate empathy skills. Pediatricians should support and encourage parents in this process by identifying positive activities for children, such as supervised sports, music, theater, recreational, and

community life projects that are both socially acceptable and that build useful skills.

• *Adolescence.* As children mature, the pediatrician can encourage parents to foster independence, educate their children about the responsibilities of adulthood, but also maintain their attachment to and involvement with their children during this process.

Limit Setting

• *Infancy.* Limit setting during the infant's first year should center on educating parents about appropriate parenting and nurturing skills. Pediatricians can ask about parental views regarding spoiling and discipline. Parents must learn that corporal punishment is less effective than other limit-setting strategies.

• *Preschool.* Pediatricians can encourage the parents and other caregivers to avoid corporal punishment and use more effective nonviolent disciplinary restrictions to alter misbehavior such as natural and logical consequences and time-out strategies for specific behaviors.⁴³ Pediatricians can advise parents against disciplining a child for age-appropriate behavior, such as exploring their environment or spilling their milk. When children knowingly misbehave, parents and others must be as consistent as possible, and when children behave appropriately, they should be praised and encouraged. Pediatricians can provide advice on managing assertive and aggressive behaviors, as well as on supporting and reinforcing prosocial behaviors.

• *School age.* Pediatricians can help parents understand the child's need to assume greater responsibilities. They can help parents understand the importance of developing consistent, clearly articulated family rules and agreed-on consequences for breaking these rules. They can also encourage consistent discipline among different caregivers and nonviolent disciplinary strategies.

• *Adolescence.* Pediatricians can help parents establish family rules that address potential areas of conflict, such as driving privileges, curfews, substance abuse, and school and household responsibilities. Pediatricians can discuss with the adolescent what constitutes safe, appropriate dating and relationships, as well as strategies for avoiding or resolving interpersonal conflicts with friends and peers.

Safety and Screening

Pediatricians need to identify the risk factors for violence among their patients. Violence-related assessment and screening should focus on the following areas:

• history of mental illness, previous domestic violence, or substance abuse in the parents or other family members;

• family stresses that could lead to violence (eg, unemployment, divorce, or death);

• appropriate supervision and care and support systems (eg, child care arrangements, the family and social network);

• disciplinary attitudes and practices of the par-

TABLE 1. Age-Appropriate Interventions*

| Category | Infancy/Early Childhood (0–2 Years) | Preschool (3–5 Years) | School Age (6–12 Years) | Early Adolescence (13–16 Years) | Late Adolescence (16 Years and Older) |
|------------------------|--|---|--|---|--|
| Early nurturing | <p>Pregnancy planned?</p> <p>Assess support system</p> <p>Assess bonding and attachment</p> <p>Parent education:</p> <ul style="list-style-type: none"> • bonding and attachment • reading to child <p>Assess child care arrangements</p> <p>Assess sibling issues</p> | <p>Ability to cope with stress</p> <p>Assess support system</p> <p>Assess bonding and attachment</p> <p>Parent education:</p> <ul style="list-style-type: none"> • reading to child • teaching social skills • knowing normal age-appropriate behavior • modeling age-appropriate behavior • spending time with children | <p>Assess ability to cope with stress</p> <p>Assess support system</p> <p>Parent education: (same as preschool plus):</p> <ul style="list-style-type: none"> • promote: <ul style="list-style-type: none"> – communication skills – empathy skills – anger-management skills – problem-solving skills – opportunities for positive activities (eg, sports) | <p>Continued parental involvement</p> <p>Parent education (same as school age)</p> | <p>Continued parental involvement</p> <p>Foster safe separation</p> <p>Support growth and development:</p> <ul style="list-style-type: none"> • education • recreation <p>Educate about:</p> <ul style="list-style-type: none"> • parenting • bonding and attachment |
| Limit setting | <p>Promote parenting skills that emphasize positive reinforcement</p> <p>Avoid corporal punishment</p> <p>Promote age-appropriate disciplinary practices, including praise for positive behavior</p> | <p>Promote appropriate parenting skills</p> <p>Avoid corporal punishment</p> <p>Consistency in discipline</p> <p>Appropriate time-outs</p> <p>Develop family rules</p> <p>Praise for positive behavior</p> | <p>Promote appropriate parenting skills</p> <p>Avoid corporal punishment</p> <p>Consistency in discipline</p> <p>Appropriate time-outs</p> <p>Expand family rules</p> <p>Include responsibility</p> <ul style="list-style-type: none"> • school • chores | <p>Promote appropriate parenting skills</p> <p>Avoid corporal punishment</p> <p>Consistency in discipline</p> <p>Appropriate restrictions</p> <ul style="list-style-type: none"> • driving • drugs • curfews <p>Establish boundaries for dating and relationship</p> <p>Establish conflict resolution techniques with friends and peers</p> | <p>Same as for early adolescence</p> |
| Safety and screening | <p>Assess family:</p> <ul style="list-style-type: none"> • child care • parental stress • treatment of mental illness or drug abuse • support system • gang involvement <p>Assess disciplinary attitudes and practices</p> <p>Assess for domestic violence</p> <p>Assess conflict resolution at home</p> <p>Assess for guns in the home</p> | <p>Assess family:</p> <ul style="list-style-type: none"> • child care • parental stress • treatment of mental illness or drug abuse • support system <p>Assess disciplinary attitudes and practices</p> <p>Assess for domestic violence</p> <p>Assess conflict resolution at home</p> <p>Assess for guns in the home</p> <p>Assess exposure to violence:</p> <ul style="list-style-type: none"> • media • community • school | <p>Assess family:</p> <ul style="list-style-type: none"> • child care • parental stress • treatment of mental illness or drug abuse • support system (plus inquire about situations that threaten the child; assess whether the child is victimized) <p>Assess disciplinary attitudes and practices</p> <p>Assess for domestic violence</p> <p>Assess conflict resolution at home</p> <p>Assess for guns in the home</p> <p>Assess for gang involvement</p> <p>Assess exposure to violence:</p> <ul style="list-style-type: none"> • media • community • school <p>Assess for substance abuse</p> | <p>Assess family:</p> <ul style="list-style-type: none"> • child care • parental stress • treatment of mental illness or drug abuse • support system <p>Assess disciplinary attitudes and practices</p> <p>Assess for domestic violence</p> <p>Assess conflict resolution at home</p> <p>Assess for guns in the home</p> <p>Assess for gang involvement</p> <p>Assess exposure to violence:</p> <ul style="list-style-type: none"> • media • community • school <p>Assess victimization risk factors</p> <p>Assess for substance abuse</p> | <p>Assess family:</p> <ul style="list-style-type: none"> • child care • parental stress • treatment of mental illness or drug abuse • support system <p>Assess disciplinary attitudes and practices</p> <p>Assess for domestic violence</p> <p>Assess conflict resolution at home</p> <p>Assess for guns in the home</p> <p>Assess for gang involvement</p> <p>Assess exposure to violence:</p> <ul style="list-style-type: none"> • media • community • school <p>Assess victimization risk factors (Use HEADS to further access risk factors)</p> <p>Assess for substance abuse</p> |
| Treatment and referral | <p>Make referrals for problems identified.</p> <p>Refer to:</p> <ul style="list-style-type: none"> • parenting programs • services for domestic violence • drug treatment program • mental illness treatment <p>Provide counseling on the dangers of guns in the home</p> | <p>Make referrals for problems identified.</p> <p>Refer to counseling if the child:</p> <ul style="list-style-type: none"> • witnesses violence • is excessively aggressive • has been victimized <p>Provide counseling on the dangers of guns in the home</p> <p>Case management for high-risk youth</p> | <p>Make referrals for problems identified.</p> <p>Refer to counseling if the child:</p> <ul style="list-style-type: none"> • witnesses violence • is excessively aggressive • has been victimized <p>Provide counseling on the dangers of guns in the home</p> <p>Case management for high-risk youth</p> | <p>Make referrals for problems identified.</p> <p>Refer to counseling if the child:</p> <ul style="list-style-type: none"> • witnesses violence • is excessively aggressive • has been victimized <p>Provide counseling on the dangers of guns in the home</p> <p>Case management for high-risk youth</p> | <p>Make referrals for problems identified.</p> <p>Refer to counseling if the child:</p> <ul style="list-style-type: none"> • witnesses violence • is excessively aggressive • has been victimized <p>Provide counseling on the dangers of guns in the home</p> <p>Case management for high-risk youth</p> |

ents or caregivers (particularly about corporal punishment and physical/emotional abuse);

- exposure to violence in the home (domestic violence⁴⁴ or child abuse), school, or community;
- degree of exposure to media violence;
- access to firearms (especially handguns) in their or a neighbor's home, or the community;
- gang involvement or gang exposure in family, school, or neighborhood;
- situations in which a child or adolescent experiences physical assault or sexual victimization from anyone;
- presence of signs of poor self-esteem, or depression; and
- other factors affecting risk, such as poor school performance and physical, emotional, or developmental disabilities.

Treatment and Referral

When pediatricians identify risk factors for violence or actual violence-related problems during the screening process, appropriate treatment or referral should occur. Some of the problems can be handled by the pediatrician through follow-up visits and office-based counseling, particularly when the issues are television viewing, removal of handguns, and nonurgent behavioral issues. The issue of gun ownership is a particularly frustrating and difficult one. Pediatricians should be prepared for resistance. Maintaining a focus specifically on the risks of handgun ownership can help keep the message clear and reduce controversy.

Some problems require referral for additional services to child welfare agencies (eg, for suspected child abuse), mental health services (eg, for victims of and witnesses to violence), emergency shelters and other domestic violence counseling and legal services, substance abuse treatment, or high-risk youth services. Repeated referral efforts may be required to achieve linkage to services.

Advocacy

Pediatricians should apply their proven professional influence to violence-prevention efforts. Pediatricians can advocate at patient, community, or broader public policy levels.

The first level of advocacy focuses on individual patients and families who present in the pediatrician's office. Individual advocacy might involve interventions and interactions with patients' insurance companies, schools, hospitals, mental health services, and other specific programs.

The second level of advocacy focuses on the community where pediatricians can partner with others to increase services, promote prevention activities, and influence community attitudes that affect risk and incidence of violence. Examples include reducing corporal punishment in schools and homes, participating in child death review teams, reducing or eliminating access to handguns, working with hospitals to develop protocols for treatment of victims and witnesses of violence (eg, using the American Academy of Pediatrics' [AAP] Adolescent Assault Victim statement⁴⁵), and educating the local media.

The third level of advocacy focuses on public policy. Pediatrician involvement can influence legislation and regulation.²¹ Laws and regulations pertinent to violence prevention include those that require safe gun storage, trigger locks, and other gun control measures, (particularly the reduction or elimination of handguns); prohibition of corporal punishment in schools; programs to provide home visitation for new parents, after-school care and recreational opportunities for youth, quality child care, and programs that educate parents and children.

Advocacy is an integral activity of the Academy, its state chapters, and other state medical societies. By working with the AAP individual pediatricians can achieve more than any single individual. Other organization collaborators include education groups (the state and local parent-teacher associations, state and local teacher associations, local chapters of the National Association for the Education of Young Children), youth service programs (Girl Scouts and Boy Scouts, girls and boys clubs, YMCA, YWCA), public health associations, community service organizations (Lions, Jaycees, Junior League), law enforcement agencies and organizations, religious institutions, organizations of child care providers, gun control organizations (eg, the Handgun Epidemic Lowering Plan [HELP] Network), and groups of local business leaders and associations. The AAP Department of Government Liaison and Division of State Government and Chapter Affairs can help pediatricians plan advocacy at the federal and state levels.

Education

Pediatricians need comfort and familiarity with the issues and the strategies related to violence prevention. Education on the issue should occur at all levels for trainees, from undergraduate to residency and fellowship programs, and for practicing clinicians through continuing medical education.

Research

Although the literature includes substantial data on risks and causes of violence, little published research addresses the effectiveness of prevention and treatment strategies.

Practicing pediatricians can be involved directly in violence-related research through practice-based research projects. Practicing pediatricians are crucial in this work because they bring direct clinical experience to choosing the right questions that will lead to useful interventions.

Pediatricians also need to advocate for resources to support research activities. Ongoing public health tracking of violent injuries should be a cornerstone for monitoring trends and characteristics of violence, as well as for measuring the effectiveness of prevention and intervention programs. To do this, the public and private sectors should invest in research on youth violence prevention. Investing in understanding youth violence and how to reduce it should match the level of concern about the issue. In particular, further research should explore what can be

done early in the lives of children, given the research on early brain and child development.⁴⁶

RECOMMENDATIONS

Clinical Practice

Clinical practice guidelines for the prevention and management of youth violence need to be established that include:

- promoting a healthy environment for all children, in the family and in the community;
- assessing for high-risk situations and behaviors;
- responding to problems identified with appropriate treatment and referrals;
- violence-prevention counseling and screening as early as the pediatric prenatal visit and continuing into adulthood; and
- maintaining familiarity with the relevant and appropriate counseling and treatment services in communities.

Advocacy

Pediatricians should advocate for:

- provision of affordable, quality child care for all families who require it, as well as other family support programs, such as postnatal home visitation;
- elimination of corporal punishment as a recommended form of child discipline in all settings;
- reduction of violence and expanded reporting of healthful activities in the media;
- reduced availability or elimination of handguns in all communities through handgun regulation and public education;
- increased treatment resources and services for substance abuse and domestic violence in all communities; and
- increased recreational, therapeutic, and occupational services and programs for children and youth, particularly in low-income communities.

Pediatricians should work as a group to strengthen such efforts and should link with other disciplines and advocacy groups to maximize effectiveness in these efforts.

Education

Many pediatricians lack education to acquire the skills and comfort they need to participate effectively in violence prevention. To remedy this situation:

- Medical schools and pediatric residency programs should develop and institute appropriate curricula on prevention and management of youth violence.
- Practicing pediatricians should enhance their knowledge and comfort in violence prevention and management through continuing medical education.

Research

Pediatricians can contribute to needed research by:

- participating in violence-related practice-based research projects;
- advocating for resources to:
 - enhance the level of violent injury tracking activities;

— enhance the level of public and private funding for violence prevention and management research.

TASK FORCE ON VIOLENCE, 1997–1998

Howard Spivak, MD, Chairperson
Katherine Kaufer Christoffel, MD, MPH
Herman B. Gray, Jr, MD
Maxine Hayes, MD
Renee Jenkins, MD
Luis Montes, MD
C. Damon Moore, MD

LIAISON REPRESENTATIVES

Stephanie Bryn, MPH
Maternal and Child Health Bureau
Alex Crosby, MD
Centers for Disease Control and Prevention

CONSULTANT

Carl Bell, MD
Community Medical Health Center

REFERENCES

1. Centers for Disease Control and Prevention. Rates of homicide, suicide, and firearm-related death among children: 26 industrialized countries. *MMWR Morb Mortal Wkly Rep.* 1997;46:101–105
2. Krug EG, Dahlberg LL, Powell KE. Childhood homicide, suicide, and firearm deaths: an international comparison. *World Health Stat Q.* 1996; 49:230–235
3. Anderson RN, Kochanek KD, Murphy SL. Report of final mortality statistics: 1995. *Mon Vital Stat Rep.* 1997;45(suppl 2):1–80
4. Centers for Disease Control and Prevention. Homicide among young black males: United States, 1978–1987. *MMWR Morb Mortal Wkly Rep.* 1990;39:869–873
5. Prothrow-Stith D. *Deadly Consequences.* New York, NY: HarperCollins; 1991
6. Osofsky JD, ed. *Children in a Violent Society.* New York, NY: Guilford Press; 1997
7. Centers for Disease Control and Prevention. Homicides among 15–19 year-old males: United States, 1963–1991. *MMWR Morb Mortal Wkly Rep.* 1994;43:725–727
8. Fingerhut LA, Kleinman JC, Godfrey E, Rosenberg H. Firearm mortality among children, youth and young adults, 1–34 years, trends and current status: United States, 1979–88. *Mon Vital Stat Rep.* 1991;39(suppl):1–16
9. Barancik JI, Chatterjee BF, Greene YC, Michenzi EM, Fife D. Northeastern Ohio trauma study, I: magnitude of the problem. *Am J Public Health.* 1983;73:746–751
10. Stussman BJ. *National Ambulatory Medical Care Survey: 1995 Emergency Department Summary.* Advance Data From Vital and Health Statistics, No. 285. Hyattsville, MD: National Center for Health Statistics; 1997
11. Sims DW, Bivins BA, Obeid FN, Horst HM, Sorensen VJ, Fath JJ. Urban trauma: a chronic recurrent disease. *J Trauma.* 1989;29:940–947
12. Poole GV, Griswold JA, Thaggard VK, Rhodes RS. Trauma is a recurrent disease. *Surgery.* 1993;113:608–611
13. Goins WA, Thompson J, Simpkins C. Recurrent intentional injury. *J Natl Med Assoc.* 1992;84:431–435
14. Morrissey TB, Byrd CR, Deitch EA. The incidence of recurrent penetrating trauma in an urban trauma center. *J Trauma.* 1991;31:1536–1538
15. Reiner DS, Pastena JA, Swan KG, Lindenthal JJ, Tischler CD. Trauma recidivism. *Am Surg.* 1990;56:556–560
16. Montes L. Physical morbidity. Presented at the Annual Meeting of the Handgun Epidemic Lowering Plan; October 18–19, 1993; Chicago, IL
17. Stover SL, Fine PR. *Spinal Cord Injury: The Facts and Figures.* Birmingham, AL: University of Alabama at Birmingham; 1986
18. Hausman AJ, Spivak H, Roeber JF, Prothrow-Stith D. Adolescent interpersonal assault injury admissions in an urban municipal hospital. *Pediatr Emerg Care.* 1989;5:275–280
19. Federal Bureau of Investigation. *Crime in the United States, 1996: Uniform Crime Reports.* Washington, DC: Government Printing Office; 1997
20. Centers for Disease Control and Prevention. Behaviors related to unintentional and intentional injuries among high school students: United States, 1991. *MMWR Morb Mortal Wkly Rep.* 1992;41:760–762:771–772
21. Spivak H, Harvey B, eds. The role of the pediatrician in violence prevention: proceedings of a conference: Chantilly, Virginia, March 4–5, 1994. *Pediatrics.* 1994;94:576–651

22. Kann L, Warren CW, Harris WA, et al. Youth risk behavior surveillance: United States, 1993. *MMWR CDC Surveill Summ.* 1995;44:1-56
23. DuRant RH, Cadenhead C, Pendergrast RA, Slavens G, Linda CW. Factors associated with the use of violence among urban black adolescents. *Am J Public Health.* 1994;84:612-617
24. Webster DW, Gainer PS, Champion HR. Weapon carrying among inner-city junior high school students: defensive behavior vs aggressive delinquency. *Am J Public Health.* 1993;83:1604-1608
25. Sosin DM, Koepsell TB, Rivara FP, Mercy JA. Fighting as a marker for multiple problem behaviors in adolescents. *J Adolesc Health.* 1995;16:209-215
26. Valois RF, McKeown RE, Garrison CZ, Vincent ML. Correlates of aggressive and violent behaviors among public high school adolescents. *J Adolesc Health.* 1995;16:26-34
27. Callahan CM, Rivara FP. Urban high school youth and handguns: a school-based survey. *JAMA.* 1992;267:3038-3042
28. Cotten NU, Resnick J, Browne DC, Martin SL, McCarraher DR, Woods J. Aggression and fighting behavior among African-American adolescents: individual and family factors. *Am J Public Health.* 1994;84:618-622
29. Hutson HR, Angling D, Pratts MJ Jr. Adolescents and children injured or killed in drive-by shootings in Los Angeles. *N Engl J Med.* 1994;330:324-327
30. Dowd MD, Knapp JF, Fitzmaurice LS. Pediatric firearm injuries, Kansas City, 1992: a population-based study. *Pediatrics.* 1994;94:867-873
31. Osofsky JD, Wewers S, Hann DM, Fick AC. Chronic community violence: what is happening to our children? *Psychiatry.* 1993;56:36-45
32. Pynoos RS, Eth S. Children traumatized by witnessing acts of personal violence: homicide, rape, or suicide behavior. In: Eth S, Pynoos RS, eds. *Post-Traumatic Stress Disorder in Children.* Washington, DC: American Psychiatric Press;1985:19-43. Spiegel D, series ed. *The Progress in Psychiatry Series*
33. American Bar Association. *The Impact of Domestic Violence on Children: A Report to the President of the American Bar Association.* Chicago, IL: American Bar Association; 1994
34. Shakoor BH, Chalmers D. Co-victimization of African-American children who witness violence: effects on cognitive, emotional, and behavioral development. *J Natl Med Assoc.* 1991;83:233-238
35. Jenkins EJ, Bell CC. Violence among inner city high school students and post-traumatic stress disorder. In: Friedman S, ed. *Anxiety Disorders in African Americans.* New York, NY: Springer Publishing Co; 1994:76-88
36. Fitzpatrick KM, Boldizar JP. The prevalence and consequences of exposure to violence among African-American youth. *J Am Acad Child Adolesc Psychiatry.* 1993;32:424-430
37. Groves B. The child witness to violence project. *Discharge Plann Update.* 1994:14-18
38. Durant RH, Pendergrast RA, Cadenhead C. Exposure to violence and victimization and fighting behavior by urban black adolescents. *J Adolesc Health.* 1994;15:311-318
39. Widom CS. The cycle of violence. *Science.* 1989;244: 160-166
40. Miller TR, Cohen MA, Rossman SB. Victim costs of violent crime and resulting injuries. *Health Aff (Millwood).* 1993;12:186-197
41. Bass JL, Christoffel KK, Widome MD, et al. Childhood injury prevention counseling in primary care settings: a critical review of the literature. *Pediatrics.* 1993;92:544-550
42. American Academy of Pediatrics. *Guidelines for Health Supervision III.* 3rd ed. 1997
43. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. Guidelines for effective discipline. *Pediatrics.* 1998;101:723-728
44. American Academy of Pediatrics, Committee on Child Abuse and Neglect. The role of the pediatrician in recognizing and intervening on behalf of abused women. *Pediatrics.* 1998;101:1091-1092
45. American Academy of Pediatrics, Task Force on Adolescent Assault Victim Needs. Adolescent assault victim needs: a review of issues and a model protocol. *Pediatrics.* 1996;98:991-1001
46. Shore R. *Rethinking the Brain: New Insights Into Early Development.* New York, NY: Families and Work Institute; 1997

REPORT TO THE AAP BOARD OF DIRECTORS FROM THE TASK FORCE ON VIOLENCE

INTRODUCTION

Violence and violent injuries are a serious threat to the health of children and youth in the United States. It is crucial that pediatricians define their role and develop the appropriate skills to effectively address this threat. From a clinical perspective, pediatricians should incorporate into their practices: preventive education, screening for risk, and linkages to necessary intervention/follow-up services. As advocates, pediatricians should become involved at the local and national levels to address key risk factors and assure adequacy of preventive and treatment programs. There are also educational and research needs central to the development of effective clinical strategies.

BACKGROUND

Violence has become increasingly prominent in the lives of children in the United States, which has the highest youth homicide and suicide rates among the 26 wealthiest nations in the world and one of the highest rates of homicide worldwide. Homicide and suicide have become the second the third leading causes of death of teenagers; homicide is the leading cause of death of black youth. Children and youth face serious short- and long-term physical and emotional consequences as victims, witnesses, and perpetrators of violence. Furthermore, violence is an issue that crosses all geographic (urban to rural) and socioeconomic boundaries.

Homicide rates for males 15 to 19 years of age increased 113% between 1985 and 1995, surpassing rates for males of all other age groups except those 20 to 24 years of ages, with firearm-related homicides accounting for almost all of this increase. Teenagers are now more likely to die of gunshot wounds than all natural causes combined. Data on nonfatal violent injuries are less available and reliable than those on homicide, in part, because many victims do not seek medical attention. It is estimated that for every homicide, there may be as many as 100 nonfatal violent assaults that receive treatment in an emergency department. In 1995, children and adolescents ages 17 years or younger had 517 000 hospital emergency department visits for assault-related injuries. Health care workers in urban trauma centers have noted that assaultive trauma is recurrent, with hospital readmission rates for subsequent assaults noted to be as high as 44% and subsequent homicides as high as 20%.

As youth homicide rates have continued to rise, so have permanent physical disabilities attributable to assaults. One estimate is that in the early 1990s, the number of severe central nervous system injuries from gunshots in Los Angeles was equal to the number of fatalities. Over 15% of all spinal cord injuries are caused by intentional trauma, and an unknown, but presumably significant, number of traumatic brain injuries are the result of violence. These victims remain poorly described in the literature—in terms of

the number, specific injury cause, and degree of long-term disability—because no surveillance system has been established to document these conditions, despite their prevalence.

The situations in which fatal and nonfatal adolescent assault injuries occur are similar. Violent injury and death result from altercations between family members and acquaintances far more often than they are related to robberies or other criminal activity. National surveys indicate that large numbers of youth, male and female, are involved in violent altercations. Furthermore, risk of involvement with violence has been associated with many issues relevant to pediatric practice including disciplinary methods such as corporal punishment, television viewing (particularly violent programming), exposure to domestic violence and child abuse, and handgun ownership.

A growing number of reports confirm that numerous children witness violence. Although it is unclear how many children are exposed to domestic and other forms of violence, no doubt exists that children are harmed when they witness violence—cognitively, emotionally, and developmentally. Exposure to violence and victimization are also strongly associated with subsequent acts of violence by the victim.

HISTORY OF THE AAP TASK FORCE ON VIOLENCE

The Task Force on Violence (TFOV) was established in June 1996 and included seven members, two governmental agency liaison representatives, and a consultant from the field of community psychiatry. The Task Force held four meetings that primarily focused on the following activities:

a) the development of a policy statement on the role of the pediatrician in violence prevention that is broken down into the following categories: clinical care, advocacy, research, and education and training;

b) the development of a report to the Board of Directors recommending strategies and action steps for the organization to take related to violence prevention in each of the four categories listed above; and

c) consideration of goals/objectives for the possible convening of an interorganizational council on youth/peer violence including an assessment of more than 20 select health- and education-related national organizations to determine interest in participating on this council.

OTHER HIGHLIGHTS/ACTIVITIES OF THE TASK FORCE

- The Task Force worked very closely with staff from the Division of Child Health Research on the development and fielding of a Periodic Survey on violence and violence prevention. The survey is currently underway.
- The Task Force served as a reviewing body and resource for the development of an ACQIP exercise on violence/violence prevention that was distributed to ACQIP subscribers in January 1998.
- The Task Force developed questions on violence

prevention for inclusion in a survey on managed care and children with special health care needs that was disseminated to major managed care organizations (by the Division of Physician Payment Systems); survey results have been analyzed by staff and will be written up for a possible article in *AAP News*.

- The Task Force submitted program proposal recommendations to the Committee on Scientific Meetings for consideration at the 1998 Spring Session (not approved) and the 1998 Annual Meeting (approved as a Plenary Session—Howard Spivak, MD, Faculty).
- Staff developed an AAP violence prevention resource compendium that is available in hard copy format and on the Academy's Website (Advocacy Page).
- The Task Force outlined ideas for the components to be included in a Violence Intervention and Prevention Program (VIPPP) anticipatory guidance program if funding is secured for its development, implementation, and evaluation.
- The Task Force has encouraged other Academy committees to develop policy statements on specific areas of violence prevention that relate to issues that fall under their purview.
- The Task Force encouraged staff involvement throughout the process of the development of the policy statement, recommendations to the Board of Directors, and in educational issues.

RECOMMENDATIONS TO THE AAP BOARD

Clinical Care

1. That the Academy undertake the development of a VIPPP anticipatory guidance program.

Action Necessary:

- Identify resources for the development and evaluation of the program and subsequent training of pediatricians and other health professionals in its use.
- Inventory current Academy patient education materials to determine what might be repackaged to be utilized as part of the program.

2. That in its meetings with representatives of several of the major managed care organizations, the Academy leadership discuss violence prevention programs and initiatives as a priority issue especially as it relates to the impact on Medicaid managed care systems.

Action Necessary:

- Identify lead staff and AAP members to assist in the development of key messages to be shared with managed care organizations related to violence prevention.

Advocacy and Policy

1. That the Academy continue and intensify its focus on violence prevention in its goals and objectives.
- Action Necessary: That the Academy promote and enhance, where possible, its involvement in handgun regulatory activities.

- That the Academy promote and enhance, where possible, its involvement in child death investigations at the federal and state levels including working with the American Bar Association and others, and to promote the AAP model state legislation on this issue.
 - That the Academy advocate for additional funding for research on the aforementioned topics.
 - That the Committee on Adolescence and the Department of Government Liaison expedite and prioritize the development of Academy policy on juvenile justice issues.
 - That the Department of Communications continue to emphasize messages regarding preventing media violence via the Academy's Media Matters campaign.
 - That the Academy continue to prioritize its efforts in the area of media education specifically related to combatting media violence.
 - That the Academy's leadership take a strong stand against corporal punishment in the home as they have done with respect to other settings such as schools.
2. That the Academy focus on the development of materials for use in education and training of pediatricians as advocates in the area of violence prevention.

Action Necessary:

- That a public speaking and media training session specifically focused on violence prevention be coordinated and facilitated by the Division of Public Relations.
- That the Division of Public Relations develop and promote speaking points and key media messages on violence prevention specifically focusing on positive images of youth in ways that emphasize nonviolence, resilience, and special accomplishments of youth.
- That the Division of Member Communications continue to prioritize articles on violence, and that a feature article be included in a future issue of *AAP News* that discusses the root causes of violence, encourages members to become involved in local/community-based coalitions and efforts related to violence prevention, and includes a section on additional resources.
- That the Violence Prevention Resources pages on the Academy's Website be promoted to the membership and others via *AAP News* and other publications.

3. That the Academy provide a nominal amount of funds to be used for the replication of the AAP violence prevention resource folder/packet so that an offer of the materials to the membership can be included in a future issue of *AAP News* as well as other Academy publications.

Action Necessary:

- That the Academy allocate funds for the production and distribution of the violence prevention resource folder/packet so that an offer of the materials can be made to the full Academy membership via *AAP News* and other publications.

4. That the Academy take the lead in convening an interorganizational council on youth/peer violence to enhance communication, collaboration, and public policy initiatives of several health and education organizations in an effort to coordinate clinical care messages, intervention and prevention strategies, and other activities.

Action Necessary:

- That the Academy allocate a nominal amount of funding for planning and convening a preliminary meeting of an interorganizational council on youth/peer violence. (Funds for AAP representatives' travel and expenses and for the council members' meals are being requested).
- That lead staff and AAP members be identified to coordinate and plan this activity.

Research

1. That the Academy identify opportunities to promote expanded attention to research in the area of violence prevention.

Action Necessary:

- That the Academy leadership promote violence prevention as a topic to be addressed by the soon-to-be established Child Health Research Center.
- That the Academy's Department of Research place emphasis on pediatric practice-based research projects on violence prevention via ongoing AAP research programs.

2. That the Academy via its Departments of Government Liaison and Research advocate for violence-related research funding from public and private sector sources.

Action Necessary:

- Work with appropriate staff from Centers for Disease Control and Prevention, the Department of Health and Human Services, the Maternal and Child Health Bureau, and the Department of Justice to identify opportunities to support violence prevention research in the budget process.

3. That the Academy, via the Councils on Pediatric Practice and Pediatric Research and the Department of Government Liaison, prioritize its advocacy efforts related to enhanced surveillance of violence-related injuries and deaths.

Action Necessary:

- Work with the Centers for Disease Control and Prevention to identify opportunities for funding of surveillance in the budget process.

4. That the results of the recently undertaken Periodic Survey on violence prevention be promoted earnestly to the membership and to other health care professionals and organizations in both the public and private sectors.

Action Necessary:

- Upon completion of the fielding of the Periodic Survey on violence prevention and tabulation of

the results, the Division of Child Health Research will write up the results and submit an article(s) for publication in a peer-reviewed journal. Information about the results also will be published in *AAP News*.

Education and Training

1. That the Academy recommend the development of enhanced continuing medical education programming, enhanced undergraduate medical education, and enhanced medical school education in the area of violence prevention.

Action Necessary:

- That the Board of Directors encourage the Section and Committee on Injury and Poison Prevention to make efforts to submit program proposals on violence prevention to the Committee on Scientific Meetings for consideration.

- That the Section on Injury and Poison Prevention focus at least one session on this topic at each national meeting as part of its educational programming.
- That the Practical Pediatrics Course Workgroup include violence prevention training in their future program planning.
- That the Committee on Scientific Meetings include the topic of violence prevention as part of their curriculum.
- That the PREP Planning Group consider including one article per year on violence prevention in *Pediatrics in Review*.

That the Council on Pediatric Education discuss violence prevention at their next meeting and determine an appropriate course of action for future endeavors in pediatric education and training related to same.

**The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice
and at the Community Level**

Task Force on Violence
Pediatrics 1999;103:173-181

This information is current as of May 31, 2006

**Updated Information
& Services**

including high-resolution figures, can be found at:
<http://www.pediatrics.org/cgi/content/full/103/1/173>

References

This article cites 33 articles, 13 of which you can access for free
at:
<http://www.pediatrics.org/cgi/content/full/103/1/173#BIBL>

Citations

This article has been cited by 32 HighWire-hosted articles:
<http://www.pediatrics.org/cgi/content/full/103/1/173#otherarticles>

Permissions & Licensing

Information about reproducing this article in parts (figures,
tables) or in its entirety can be found online at:
<http://www.pediatrics.org/misc/Permissions.shtml>

Reprints

Information about ordering reprints can be found online:
<http://www.pediatrics.org/misc/reprints.shtml>

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

