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FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

Policy Statement—Role of the Pediatrician in Youth Violence Prevention

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ABBREVIATION
AAP—American Academy of Pediatrics

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abstract

Youth violence continues to be a serious threat to the health of children and adolescents in the United States. It is crucial that pediatricians clearly define their role and develop the appropriate skills to address this threat effectively. From a clinical perspective, pediatricians should become familiar with *Connected Kids: Safe, Strong, Secure*, the American Academy of Pediatrics' primary care violence prevention protocol. Using this material, practices can incorporate preventive education, screening for risk, and linkages to community-based counseling and treatment resources. As advocates, pediatricians may bring newly developed information regarding key risk factors such as exposure to firearms, teen dating violence, and bullying to the attention of local and national policy makers. This policy statement refines the developing role of pediatricians in youth violence prevention and emphasizes the importance of this issue in the strategic agenda of the American Academy of Pediatrics. *Pediatrics* 2009;124:393–402

INTRODUCTION

A periodic survey of 1632 American Academy of Pediatrics (AAP) members administered by the AAP Task Force on Violence in the late 1990s indicated that injury as a result of violence is a substantial problem being confronted by pediatricians in practices across the country.[1] More than half of the respondents reported having recently seen a child who had sustained an intentional injury as a result of child maltreatment, and more than one third reported having recently treated a child with an injury resulting from domestic or community violence. Most pediatricians feel that they have an important role to play in the prevention of such injuries, and there is evidence to suggest that parents and community leaders also perceive a central role for pediatricians in the prevention of youth violence.[2–4] However, many pediatricians feel ill prepared to screen for and manage forms of violence other than child maltreatment.

In 1999, the AAP published a comprehensive policy statement outlining and defining the emerging role of pediatricians in the prevention of youth violence.[5] This statement represented the culmination of 3 years of focused, strategic thinking and outlined possible interventions that could be woven into routine health maintenance and preventive care practice. The 1999 statement also identified opportunities for pediatricians to assume leadership roles in violence prevention education and advocacy in community-based and out-of-office settings.

Although awareness of youth violence as a key issue in pediatrics has increased since publication of the 1999 statement, AAP periodic survey results have demonstrated a continued need for training and support for pediatricians.[6,7] In response, violent-injury prevention has assumed a higher priority within the AAP,[8] and several ongoing efforts have been initiated, such as the AAP Violence Prevention Symposium (2003); National Chapter Injury Prevention Conference (2005); appointment of a violence prevention subcommittee to the national Committee on Injury, Violence, and Poison Prevention (2005); and the publication of *Connected Kids: Safe, Strong, Secure* (2006).[8] At both the organizational policy and clinical practice levels, the AAP is striving to prepare and engage pediatricians in specific activities aimed at reducing the burden of intentional injuries borne by children in the United States.

This revised policy statement updates the evolving epidemiology of intentional injury, identifies important emerging issues related to violence prevention in children, and reaffirms the basic tenets that support the recommendations made in the original statement 10 years ago. Key new areas highlighted in this revised policy statement incorporate new information and resources concerning bullying and dating violence, and provide further specific counseling guidance for pediatricians

BACKGROUND

Over the last 2 decades of the 20th century, violence emerged as a major public health problem that disproportionately affects children, adolescents, and young adults. Despite recent declines in rates of violent deaths, nonfatal firearm injuries, and violence-related behaviors, such as fighting and weapon carrying,[9–15] homicide remains the second leading cause of death for all children 1 to 19 years of age.[16,17] Significant ethnic disparities in youth violence exposure persist. For example, homicide is the second leading cause of death in the United States for ages 15 to 19, but it is the leading cause of death among black 15- to 24-year-olds.[18]

Cross-national analyses have demonstrated similar rates of violence-related behaviors among adolescents in this country compared with international peers, yet the United States continues to lead the industrialized world in rates of youth homicide and suicide.[19–21] Approximately 3% of direct medical expenses in this country are related to interpersonal assault injuries, and the total cost to society of gun violence is approximately $100 billion, of which $15 billion is attributable to firearm injuries to children.[22–24]

The potential risks and behavioral consequences associated with early childhood exposure to violence in the home and/or witnessing violence in the community are profound. Over the past decade, there has been a great deal of scholarly attention devoted to elucidating those factors that confer risk or promote resilience.[25–28] It is recognized that there is a great deal of overlap among contextual factors, including family dynamics, community norms, and cultural beliefs and practices, that all play critically important roles in determining individual outcomes.[29] Primary care pediatricians routinely have access to young people involved in violence-related behaviors and are particularly well positioned to advise parents and caregivers.[30] Pediatricians are also likely to be aware of community-based resources such as prenatal and early intervention home visitation programs that have demonstrated promise in reducing the subsequent burden of intentional injury borne by young children.[31,32]

Myriad promising primary care interventions have been developed, but few have been evaluated in a scientifically controlled fashion.[33–35] To that end, several governmental health and organized medicine entities, including the Centers for Disease Control and Prevention, the Office of the Surgeon General, the American Medical Association, and the Agency for Healthcare Research and Quality, have sought to synthesize the burgeoning research literature in this area to help identify effective approaches.[36–39] The AAP has also developed and published a number of policy statements and other reports specifically related to addressing youth violence from an evidence-based, best-practices perspective.[40–43] However, the most comprehensive effort to date undertaken by the AAP is the primary care violence prevention protocol titled *Connected Kids: Safe, Strong, Secure*. Developed as a multiyear project supported in part by the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, *Connected Kids* is a carefully constructed resource aimed specifically at facilitating the primary health care professional's ability to incorporate intentional injury prevention tools and messages into everyday practice.

Another important recent development in the field of violence prevention has been the recognition of the primary importance of resilience factors that enable children and young adults to adapt successfully to stress, including exposures to violence. Scientific support for the crucial role of resilience stems from a number of sources, including analysis of data stemming from the National Longitudinal Study of Adolescent Health.[26,28] This statement discusses *Connected Kid*s, bullying prevention, and dating violence. The related key issues of firearms and media violence[42,43] are included in other AAP policy statements.

CONNECTED KIDS: SAFE, STRONG, SECURE

Connected Kids: Safe, Strong, Secure is a program launched by the AAP in 2005 that addresses violence prevention in the context of routine child health care. The development of *Connected Kids* involved the input of more than 100 experts as well as extensive input from parents and adolescents during a 3-year process.[8,44,45] The final AAP product consists of a clinical guide, 21 parent/patient information brochures, and supporting training materials (see Tables 1–3).

Because of the recent recognition of the primary importance of individual and family resilience discussed above, the *Connected Kids* program implements a strength-based approach to anticipatory guidance, helping parents and families raise resilient children. This approach results in a much broader approach to anticipatory guidance than previous, risk-based approaches. In addition, each topic area specifically addresses the social ecology of childhood by including information about the child's development, the parent's feelings and reactions in response to the child's development and behavior, and specific practical suggestions to help families connect to existing community resources.[46] Feasibility and qualitative field tests conducted in early 2005 yielded enthusiastic results, and rigorous program evaluation using existing practice-based networks is planned. The first randomized, controlled trial published to date of a primary care intervention designed to affect youth involvement in violent behavior demonstrated efficacy in the reduction of both fighting and fighting-related injuries.[47] The availability of an AAP tool like *Connected Kids* has great promise and potential to similarly affect children across the country as pediatricians become comfortable integrating its use into their practices. *Connected Kids* is coordinated with the third edition of *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*[48] and provides assistance in implementation of the *Bright Futures* psychosocial and safety themes. More detailed information is available from the AAP Web site (www.aap.org).

BULLYING

Bullying is a form of aggression in which 1 or more children repeatedly and intentionally intimidate, harass, or physically harm a victim who is perceived as unable to defend herself or himself.[49,50] An issue of emerging concern has been the association of bullying behavior, particularly among young school-aged children, with the subsequent development of serious

TABLE 1 Training Resource From AAP *Connected Kids: Safe, Strong, Secure*: Infancy and Early Childhood

INFANCY AND EARLY CHILDHOOD: PRENATAL TO 4-YEAR-OLD VISITS			
VISIT	**INTRODUCE**	**REINFORCE**	**BROCHURES**
2 Days to 4 Weeks	● What Babies Do ● Coping with parental Frustration ● Parent Mental Health ● Parent Support[79]		1. Welcome to the World of Parenting!
2 and 4 Months	● Child Care[80] ● Family[79] ● Safe Environment[81] ● Parenting Style[82] ● Bonding and Attachment	● Parent Mental Health ● Parent Support	2. Parenting Your Infant
6 and 9 Months	● Establishing Routines ● Discipline = Teaching[82] ● Reducing child access to firearms[42] ● Modeling Behavior	● Parent Support ● Child Care ● Safe Environment ● Bonding and Attachment	3. How Do Infants Learn? 4. Your Child Is On the Move: Reduce the Risk of Gun Injury
12 and 15 Months	● Child Development and Behavior[82]	● Parenting Style ● Reducing child access to firearms Modeling Behavior ● Safe Environment	5. Teaching Good Behavior: Tips on How to Discipline
18 Months and 2 Years	● Child's Assets ● Guided Participation ● Media[43,83]	● Parent Support ● Reducing child access to firearms Child Development and Behavior ● Establishing Routines	6. Playing Is How Toddlers Learn 7. Pulling the Plug on TV Violence
3 and 4 Years	● Peer Playing ● Safety in Others' Homes[42] ● Talking About Emotions ● Promoting Independence	● Modeling Behavior ● Guided Participation	8. Young Children Learn a Lot When They Play

TABLE 2 Training Resource From AAP *Connected Kids: Safe, Strong, Secure*: Middle Childhood

MIDDLE CHILDHOOD: 5- TO 10-YEAR-OLD VISITS			
VISIT	**INTRODUCE**	**REINFORCE**	**BROCHURES**
5 Years	● Establishing Routines and Setting Limits[82]	● Child Development and Behavior ● Child's Assets ● Safety in Others' Homes ● Promoting Independence	9. Growing Independence: Tips for Parents of Young Children
6 Years	● Teaching Behavior ● Bullying Prevention ● Out-of-School Time	● Modeling Behavior ● Establishing Routines and Setting Limits	10. Bullying: It's Not OK
8 Years	● School Connections ● Alcohol and Drug abuse prevention[84] ● Interpersonal Skills	● Reducing child access to firearms ● Promoting Independence ● Establishing Routines and Setting Limits ● Bullying	11. Drug Abuse Prevention Starts With Parents 12. Friends Are Important: Tips for Parents
10 Years	● Child Mental Health ● School Performance	● Media ● Out-of-School Time	13. Everybody Gets Mad: Helping Your Child Cope with Conflict

TABLE 3 Training Resource From AAP *Connected Kids: Safe, Strong, Secure*: Adolescence

ADOLESCENCE			
VISIT	**INTRODUCE**	**REINFORCE**	**BROCHURES**
Early:	● Family Time Together	● Reducing youth access to firearms Establishing Routines and Setting Limits	14. Talking With Your Teen: Tips for Parents
11 to 14 Years	● Peer Relationships ● Support System ● Staying Safe ● Teen Mental Health ● Conflict Resolution Skills ● Healthy Dating ● Gaining Independence	● Alcohol and Drug abuse prevention ● School Performance	15. Staying Cool When Things Heat Up 16. Expect Respect: Healthy Relationships 17. Teen Dating Violence: Tips for Parents
Middle:	● Plans for the Future	● Alcohol and Drug abuse prevention	18. Teen Suicide and Guns
15 to 17 Years	● Firearms and Suicide Prevention, including reducing child access to firearms[42,85] ● Depression prevention[85] ● Resiliency	● Peer Relationships ● Healthy Dating ● Gaining Independence	19. Next Stop—Adulthood: Tips for Parents
Late:	● Transition to Independence	● Peer Relationships	20. Help Stop Teenage Suicide
18 to 21 Years	● Negotiating a New Environment (Post-High School)	● Plans for the Future ● Depression prevention	21. Connecting With Your Community

assault behaviors. A comprehensive analysis stimulated by the rare but high-profile, multiple-casualty, school-based events in Pearl, Mississippi; West Paducah, Kentucky; Jonesboro, Arkansas; Springfield, Oregon; and Littleton, Colorado in the late 1990s brought into acute focus just how serious a precursor bullying may be.[51] Several professional medical organizations, including the American Medical Association and the Society for Adolescent Medicine, have directed specific attention by way of formal policy or resolution to the issue of youth bullying, often within the context of the broader problem of youth violence.[52,53] Also, the Health Resources and Services Administration of the US Department of Health and Human Services recently launched phase II of a major multiyear awareness campaign thematically titled "Take a Stand, Lend a Hand: Stop Bullying Now."[54]

Although bullying among school-aged children has been well described in other parts of the world, until recently, epidemiologic characterization of the depth and extent of the problem in the United States has been lacking. Nansel et al[55] at the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health have created a bullying epidemiology working group and are comparatively analyzing both domestic and international data sets. They have established a prevalence baseline of 30% for children either bullying and/or being bullied on the basis of a large sample of 6th- to 10th-graders.[56] They have also begun to critically analyze the true associations of bullying with some of the traditional violence-related behavioral markers, including weapon carrying and frequent fighting. Bullying and being bul-

lied are both associated with higher rates of weapon carriage and fighting serious enough to result in injury.[57,58] These associations seem to be stronger for bullies than for targets. Also of great concern are the more subtle psychosocial consequences that can be associated with bullying behavior, including the subsequent development of depression and suicidal ideation.[59,60] These problems are more likely to result from the indirect, relational bullying behaviors that are more typically engaged in by young girls and that can be notoriously elusive to identify.[61]

A growing literature has also begun to explore bullying's relationship with somatic conditions, disease morbidity, and the development of long-term behavioral exposures and outcomes manifesting in adulthood.[62–65] The emergence of portable technologies, such as cellular telephones, digital cameras, and personal digital assistants and ready accessibility to social networking Internet sites has led to the advent of technology-assisted bullying behavior—a phenomenon known as "cyberbullying."[66,67]

European researchers have been active for more than 30 years in developing interventions around bullying prevention. The most successful programs have been implemented in Scandinavia on the basis of the model developed by Norwegian investigator Dan Olweus.[68] The Olweus Bullying Prevention Program is a school-based model that has been replicated, refined, and evaluated many times internationally. Olweus proposes specific programmatic interventions at the school-wide, classroom, and individual levels on the basis of the insight that each bullying episode involves 3 groups of children: bullies and their acolytes, victims, and bystanders. However, there is a paucity of published reports in the peer-reviewed literature describing implementation and controlled evaluation of the Olweus Bullying Prevention Program in the United States.[69] It is clear that in this country, it must first be accepted that bullying behaviors cannot be considered a normative rite of passage and that they can be precursors for more serious downstream consequences. In terms of primary prevention, early parenting behaviors such as cognitive stimulation and emotional support have been shown to confer resilience against the future development of bullying behaviors in elementary-aged schoolchildren.[70] Promotion and reinforcement of such parenting skills plus recognition, screening, and appropriate referral as secondary prevention strategies are essential ways that pediatricians can collectively contribute to this aspect of youth violence prevention.

DATING VIOLENCE

The past decade has also seen more attention focused on relationship violence in adolescence, specifically teen dating violence. Depending on case definition and reporting methodology, estimates of the prevalence of teen dating violence have been reported to range from 9% to 46%.[71–73] With most US teenagers dating by middle adolescence,[74,75] it is important that pediatricians be aware of the precursors, symptoms, and behaviors associated with teen dating violence. Appropriate from a developmental standpoint, nascent prevention efforts in this area have focused primarily on peer-group–targeted interventions. One such school-based program that used a randomized, controlled methodology demonstrated efficacy for reducing self-reported teen dating violence victimization and perpetration rates at intervals up to 4 years after intervention.[76–78]

Because routine care-oriented intervention opportunities are more limited in adolescence and preadolescence, it is important that pediatricians avail and extend themselves as community resources to those entities that most influence the development of teen behavior. These would almost certainly include middle and high schools and, depending on the specific constitution of a given community, might also include faith-based organizations, local Boys and Girls Clubs, and/or other prosocial organizations. Most critical, however, is the role of the pediatrician as an information repository for parents and families. Early anticipatory guidance about adolescent cognitive and social development, relationship dynamics, and the risks of teen dating violence is paramount as part of a primary prevention strategy. The *Connected Kids: Safe, Strong, Secure* set of resource materials for early adolescence includes a "tips for parents" brochure on teen dating violence (see Tables 1–3). These materials and associated prompts are available in structured electronic formats to facilitate incorporation in electronic health records and associated decision-support tools.

THE ROLE OF THE PEDIATRICIAN: RECOMMENDATIONS

There are 4 domains in which pediatricians should be expected to employ their skills and influence in the implementation of youth violence prevention strategies: clinical practice, advocacy, education, and research.

Clinical Practice

Clinical practice for intervention, management, and prevention of youth violence should include:

- a working familiarity with the *Connected Kids: Safe, Strong, Secure* primary care violence prevention protocol;
- use of a comprehensive approach, exemplified by the *Connected Kids*

protocol for anticipatory guidance, screening, and counseling of children and families during the course of routine health maintenance (key elements of the protocol should be built into the practice flow sheets or electronic health record age-based prompts; parent and youth education materials should be readily accessible, either as printed material or printed at the time of visit);

- appropriate and timely treatment and/or referral for violence-related problems identified; and
- maintenance of an accurate database of community-based counseling and treatment resources. Whenever applicable, this database should be available through the practice's electronic health record system or linked to the practice's internal and external Web sites.

Advocacy

Pediatricians should advocate for:

- adequate publicly supported community-based behavioral health services;
- protection of children from exposure to firearms;
- bullying awareness by teachers, educational administrators, parents, and children coupled with adoption of evidence-based prevention programs;
- responsible programming on television, video, cable, the Internet, and video game formats that minimizes youth exposure to violent images, messages, and themes;
- the role of health professionals as appropriate public health messengers through print, electronic, or online media; and
- incorporation of content related to youth violence prevention in electronic health records, including screening prompts and links to parent education materials.

Education

Pediatricians should exercise every available opportunity to learn more about violence prevention through:

- formal continuing medical education or professional development programs;
- learning about community resources for children and adolescents; and
- elective course or rotation work in either medical school or postgraduate training.

Research

Pediatricians can contribute to needed research by:

- participating in practice-based research in the area of youth violence prevention;
- contributing data to existing intentional injury surveillance systems; and
- advocating for municipally supported, legislatively mandated active local injury surveillance systems.

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