
Training Health Professionals in Youth Violence Prevention

Overview of Extant Efforts

Robert D. Sege, MD, PhD, Joan Serra Hoffman, PhD

This supplement to the *American Journal of Preventive Medicine* seeks to capitalize on the current state of the art to support the improvement of health practitioner training in youth violence prevention. To accomplish this objective, we have attempted to lay out the rationale for training in youth violence prevention, supply specific case examples from various sectors in the medical and public health world, with a focus on the efforts funded by the U.S. Department of Health and Human Services' National Academic Centers of Excellence (ACEs) on Youth Violence Prevention. Recognizing that youth violence transcends national borders, we have provided a global perspective by looking at one specific international example of violence prevention. This supplement, although it highlights and describes some programs, is by no means encyclopedic, and many other worthwhile programs including some described in Table 1, may be worthy models for replication.

Over the past dozen or so years, there has been a tremendous effort to address this epidemic, and the medical and public health communities have begun to develop systematic approaches to the prevention of violence-related injuries. Despite these advances, violence continues to be a major cause of morbidity and mortality for children and youth. In fact, intentional injuries remain among the leading causes of death and disability for American children, youth, and young adults.¹ Much work remains to be done.

A sustained call for a public health approach first began in the United States in the mid-1980s with attention by then-Surgeon General C. Everett Koop and subsequent publications calling for the development of a public health approach to youth violence prevention.² Among the efforts that ensued were improved surveillance³ and new, more integrated approaches to understanding the origins of youth vio-

lence. During the decade from 1983 to 1993, the country experienced an epidemic of violent and often lethal behavior that would affect many victims, perpetrators, their families, friends, and communities. By the early 1990s, pediatricians were seeing in their offices a substantial number of children injured in fights,⁴ and emergency rooms were seeing a greater number of adolescents and young adults injured and disabled as a result of violence.² Local violent-injury surveillance systems were established in several cities, and violent-injury surveillance was established through hospital emergency departments in Washington DC,⁵ Harlem, New York,⁶ and Boston, Massachusetts.⁷

Much of the early youth violence prevention work centered on the identification of risk factors for subsequent violence, and the development of responses to these risks. Research identified the clustering of risky behaviors,⁸ leading to the recognition that risk factors occur in every area of life, from the individual, family, school, peer group, and community, and that the greater number of risk factors a child or a young person is exposed to the greater the likelihood that they will experience violence. Health practitioners and researchers noted that teens who had been injured through fighting were at subsequent risk for further, often more serious, violence-related injuries⁹ as well as involvement in criminal violence.¹⁰ Situational factors such as access to firearms increased the lethality of adolescent violence and the risk of death.^{11,12} Early childhood risks for violence were also identified. Patterson et al.¹³ noted the relationship between early parenting practices and subsequent delinquency. Poor monitoring and supervision of children by parents and the use of harsh physical punishment, for example, are strong predictors of varied forms of violence during adolescence and adulthood.¹⁴ Health professionals underscored the potentially harmful effect of the growing, broad exposure to thousands of violent acts by children and youth, important consumers of the mass media, including entertainment and advertising.¹⁵⁻¹⁹ Research on the relationship between media violence and youth violence found conclusive evidence with respect to short-term increases in aggression and pointed to the need to examine the influence of the mass media (both the traditional and newer media, such as video games)

From the Department of Pediatrics (Sege), Tufts University School of Medicine, Tufts-New England Medical Center, Boston, Massachusetts, and the National Center for Injury Prevention and Control (Hoffman), Centers for Disease Control and Prevention, Atlanta, Georgia

Address correspondence and reprint requests to: Robert D. Sege, MD, PhD, Department of Pediatrics, Tufts University School of Medicine, Tufts-New England Medical Center, NEMC Box 351, 750 Washington Street, Boston MA 02111. E-mail: rsege@tufts-nemc.org.

Table 1. National Academic Centers of Excellence on Youth Violence Prevention Health Professionals Training Summary Matrix

Centers	Center-specific initiatives	Broader professional and community initiatives
<p>University of California, Riverside Based in Criminal Justice, with contributions from Psychology, Sociology, Law, Education, Psychiatry, and Family Medicine</p>	<p>Development of annual summer institute for graduate students from the health and allied professions</p> <p>Development of curriculum for California Medical Training Center at UC Davis</p> <p>Development of training materials to improve informal care environments of immigrant children</p>	<p>Publication of Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals³⁶</p> <p>Development of training workshops on Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals³⁶ for USC Dept. of Family Medicine, Latino Health Access, and a workshop at 2003 APHA</p> <p>Translation into Spanish and adaptation of Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals³⁶ for Latino audiences in collaboration with the University of Puerto Rico ACE</p> <p>Evaluation of Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals³⁶</p> <p>Development of youth violence prevention workshops for community based health organizations</p>
<p>University of California, San Diego Based in School of Medicine, with contributions from Pediatrics, Family & Preventive Medicine, Trauma/ER, Anthropology, Psychology, Theater & Dance, Sociology, Ethnic Studies, Public Health, and Human Development</p>	<p>Development and implementation of training curricula for medical and public health professionals, including curricula for: (1) third- and fourth-year medical students at UCSD; (2) Pediatric residents at UCSD and the Naval Medical Center San Diego (NMCSD); and (3) Epidemiology, maternal and child health, health promotion, social work, criminal justice, and nursing graduate students at San Diego State University</p> <p>Evaluation of the effectiveness of an intervention to improve the identification and management of adolescent substance abuse, intimate partner violence, and disorders</p>	<p>Piloting a health communication initiative for community outreach and education with participation of health professionals</p>
<p>University of Michigan Based in Public Health (SPH) with collaboration from Psychology Emergency Medicine, Social Work, Communications, and Epidemiology</p>	<p>Training in youth violence prevention as a public health problem, development of courses and community-based training in violence prevention, and program evaluation for community health and allied professionals and lay workers</p> <p>The Center also works with SPH to train local Flint high school students and graduate students in the health professions</p>	<p>Development of web-based emergency room prevention module</p>
<p>University of Puerto Rico Based in Pediatrics with contributions from Epidemiology, Social Psychology, Education, Curriculum Development, and Public Health</p>	<p>Development of a semester course on youth violence prevention for undergraduate students in health-related professions taught in Spanish throughout the island university campuses</p>	<p>Development of youth violence prevention workshops for community-based health organizations on the island of Puerto Rico, including health workers from other parts of the Spanish-speaking Caribbean</p>

(continued on next page)

Table 1. National Academic Centers of Excellence on Youth Violence Prevention Health Professionals Training Summary Matrix (*continued*)

Centers	Center-specific initiatives	Broader professional and community initiatives
<p>Virginia Commonwealth University Based in Pediatrics with Epidemiology, Psychology, Theater, Mass Communications, Psychiatry, Education and Criminal Justice</p>	<p>Development of a two-week experiential training for pediatric residents, Cops & Docs</p> <p>Provided training in violence prevention including the development and implementation of courses in social sciences, public health and medicine, pre- and post-doctoral training, and development of mentoring opportunities</p>	
<p>Columbia University Based in Public Health with collaborations in Criminology, Anthropology, Sociology, Psychology, Social Policy, Law, Social Work, and Epidemiology</p>	<p>Conducted advanced seminars on youth violence prevention as a public health issue</p> <p>Developed module of courses and practicum on youth violence prevention for Columbia University graduate students</p> <p>Developed internship program for community-based research in youth violence prevention</p>	<p>Developed Zero Tolerance for Violence, focus group discussion guides for community group physicians</p>
<p>Harvard University Based in Public Health with collaborations in Medicine, Sociology, Psychology, Economics, and Criminal Justice</p>	<p>Developed the following courses and programs on youth violence prevention: American Violence: The Intersection of Home and Street; Principles of Injury Control; Child Abuse and Neglect; Practice of Preventing Intimate Partner Violence; Injury Epidemiology and Prevention; and Trauma and Injury Control, a popular elective course on violence prevention for first year medical students at the Harvard Medical School</p> <p>Pre- and post-doctoral fellow mentoring, including the Yerby Minority Post-doctoral Fellowship</p>	<p>Conducted community partner training (including community health partners) on asset mapping</p> <p>Conducted training for state health departments on youth suicide prevention</p> <p>Provided technical support for Massachusetts Medical Society Violence Prevention Project, which produced a booklet, Recognizing and Preventing Youth Violence: A Guide for Physicians and Other Health Care Professionals</p> <p>Developing case reports for a problem-based curriculum on youth violence at Tufts Medical School</p> <p>Conducted presentations for health care professionals at regional and national conferences and medical grand rounds</p> <p>Produced an online CME program and grand round slide set for the Massachusetts Medical Society</p> <p>Developed online workshops on suicide prevention</p>
<p>Johns Hopkins University Based in public health with collaborations in School of Nursing, Krieger School of Arts and Sciences, Graduate Schools of Education, Social Policy, School of Medicine</p>	<p>Established pre-doctoral and post-doctoral fellows mentoring program</p> <p>Supervised post doctoral fellows in community-based participatory research programs in youth violence prevention</p>	<p>Developed summer institute on school-based mental health and violence prevention, focusing on the translation of evidence-based practices</p> <p>Conducted statewide training program for state agencies in collaboration with Governor's Office</p>
<p>University of Alabama–Birmingham Based in Psychology, with collaboration from Medicine, Nursing, Social and Behavioral Sciences, Education, Public Health, and Health Related Professions</p>	<p>Graduate-level seminars in Psychology and Public Health including intentional injurious behaviors, adolescent development, epidemiology and intervention in youth violence, and child clinical psychology</p> <p>LEAH Grant in Adolescent Medicine funded five postdoctoral positions</p> <p>Mentoring honors students and McNair Scholars</p>	<p>Training school and school health counselors on school-based social-skills programming</p>

(continued on next page)

Table 1. National Academic Centers of Excellence on Youth Violence Prevention Health Professionals Training Summary Matrix (*continued*)

Centers	Center-specific initiatives	Broader professional and community initiatives
University of Hawaii–Manoa Based in psychiatry, with collaboration with medicine, criminology, sociology, public health, urban planning, political science, and ethnic studies.	Developed and implemented new medical school cases to address youth violence prevention Developed training in pediatrics on violence prevention education	Trained health professionals at an Asian/Pacific Islander community-based health clinic on youth violence Trained health professionals, lay and community members, students, and academics from the health professions on youth violence prevention and research

on interpersonal relations and on individual traits such as hostility, inability to identify or empathize with others, callousness, and indifference.²⁰

Insights from developmental research shed light on the complex interaction of individuals with their environment at particular times in their lives, enabling the identification of different life-course pathways to violence. Longitudinal studies examined the ways in which aggression can persist from childhood into adolescence and through to adulthood, showing the relationship between elementary school aggressiveness and subsequent criminal conduct. More recent longitudinal studies suggest that children learn to control their aggressive behavior beginning before age 18 months.²¹

A second pathway to violence, much less understood, began to be investigated more systematically. In this case, violence begins after puberty and has a different course, severity, and duration over the lifespan. Researchers and practitioners also began to examine the links between youth violence and other forms of violence. Links between a history of family violence, youth violence, dating violence, sexual violence, and suicide were uncovered. Child maltreatment was found to lead to later adolescent delinquent behavior, increased risk for dating violence, and suicide attempts during late adolescence and early adulthood.^{22–25}

Organized medicine began to adopt policies related to these issues. In the mid to late 1990s, physician attitudes gradually moved from an acceptance of harsh physical punishment²⁶ to acknowledgment of its deleterious effects.²⁷ By 1998, the American Academy of Pediatrics (AAP) began advising pediatricians to counsel parents to use alternatives to such punishment.²⁸ Similarly, physicians and organized medicine backed stronger firearms regulation.²⁹ Professional associations also joined parents in calling for restrictions on the content of television shows designed for children, and the AAP asked parents not to allow children under 2 years to watch any TV at all. Guidelines to treat violently injured adolescents in hospital-based pediatric emergency and trauma care were developed by the AAP in 1996 to address the unique needs of patients. The guidelines underscored the idea that the comprehensive care of violently injured adolescents must address

their psychosocial needs as well as their physical injuries via multidisciplinary care protocols, as in those used to treat victims of child abuse, suicide attempts, and sexual assault.³⁰

Over time, demand for healthcare- and public health-based violence prevention programs steadily increased with both healthcare professionals themselves and the general public increasingly taking the view that violence prevention is an important part of the routine health care of children. The National Survey of Early Childhood Health, for example, demonstrated that a majority of parents of young children want their healthcare provider to discuss community violence and that this desire is unmet.³¹ The unmet desire may reflect the poor training and support of physicians in practice, as demonstrated in surveys of pediatricians conducted by the AAP in 1998 and repeated in 2003. These surveys demonstrate increased physician demand for violence-prevention training, in the face of inadequate (self-assessed) training.³²

Creation of the National Academic Centers of Excellence on Youth Violence Prevention

By the late 1990s and early 2000s, cumulative findings from comprehensive reviews on youth violence contributed to a new level of assurance that youth violence is preventable.^{20,33–35} A number of effective prevention programs and strategies for both early- and late-onset youth violence prevention were identified with varied populations of youth ranging from the general youth population to high-risk youth and those who have already been victimized by, perpetrated, or witnessed violence.³³ Applying and disseminating this knowledge to effect change in health and other settings became a priority next step.

In *Youth Violence: A Report of the Surgeon General*³³ then-Surgeon General David Satcher underscored the need for a national resolve to confront the problem of youth violence systematically, using research-based approaches and correcting damaging myths and stereotypes about youth and youth violence. Preparing well-trained staff, knowledgeable about the dynamics of

Table 2. The National Academic Centers of Excellence on Youth Violence Prevention

The goal of this program is to reduce the incidence of youth interpersonal violence by achieving the following objectives:

- Monitoring the magnitude and distribution of youth interpersonal violence
- Building the scientific infrastructure necessary to support the development and widespread application of effective youth interpersonal violence prevention interventions
- Promoting interdisciplinary research strategies to address the problem of youth interpersonal violence
- Fostering collaboration between academic researchers and communities
- Mobilizing and empowering communities to address the problem of youth interpersonal violence

For more information: www.safeyouth.org

youth violence and its prevention and the development, implementation, and evaluation of preventive interventions in health and other settings was identified as an integral part of this national effort.³³ Despite ample literature on research and services in the specialty journals of various disciplines, in professional articles, and increasingly on the World Wide Web, the lack of collaboration between academic centers and the community-based agencies responsible for providing medical services to adolescent victims or for implementing youth violence prevention programs continued to result in foregone improved prevention and intervention opportunities.

In 2000, recognizing these gaps, the Centers for Disease Control and Prevention (CDC) established 10 National Academic Centers of Excellence on Youth Violence Prevention (ACEs), to serve as national models for the prevention of youth interpersonal violence (Tables 1,2). The program provides a long-term and multidisciplinary focus on youth violence, fostering academic, practitioner, and community collaborations that can stimulate scientific creativity, speed new developments in youth violence prevention research and practice, and hasten the translation of knowledge. The program has created opportunities for cross-center projects, coming together to assemble a critical mass of professional and community capacity to address questions vital to the development of the youth violence prevention field as well as to local violence prevention efforts.

The centers were charged with developing curricula for the training of healthcare professionals and integrating the curricula into medical, nursing, and other health professional training programs. The examples of their work contained in this supplement encompass intramural activities as well as initiatives involving a broader professional and community audience and take place across different specialties and disciplines (for example, pediatricians, nurses); settings (such as

community-based clinics and other community settings, teaching hospitals, and schools); and target populations (including low- or high-risk children and adolescents, victims of violence, and gang-involved youth and families).

Recognizing that clinical assessment and intervention efforts can be strengthened through partnerships with community providers, including lay workers, advocates, and survivors groups, these ACE initiatives have involved community members in the development, testing, and implementation of a broad range of training materials and initiatives. Examples of the breadth of work include: the incorporation of youth perspectives in the training of high school youth in Flint, Michigan; as change agents in health and youth violence prevention initiatives in the larger community; encouraging the pursuit of a health career; and partnering with community in developing pediatric training for physicians to work with health disparities, systems issues, and community-oriented primary care in San Diego. The geographic locations of the Centers, as well as the demographic diversity of the communities they serve, provide opportunities to develop multicultural and culturally specific approaches to the training of health professionals. Recognizing that the U.S. youth population is becoming increasingly diverse, and responding to these changing demographics, the ACEs are translating and adapting *Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and other Health Professionals* for use in Latino communities in the U.S. and in Puerto Rico, and for Spanish-speaking Latin American and the Caribbean health professionals, working jointly with the American Medical Association, CDC, and the Pan American Health Organization in this effort.³⁶ A summary of the training activities for health professionals conducted by the ACEs is presented in Table 1.

How to Use This Supplement

The first section of the supplement lays the groundwork for violence prevention training. The articles by Drs. Rosenberg³⁷ and Knox and Spivak³⁸ lay out both the overall strategy for youth violence prevention as well as the core competencies required for trainees in the area of violence prevention. These two articles provide a basic description of the content of training programs around the country.

The second section, coordinated by Dean Sidelinger, provides a series of specific case examples of youth violence prevention. After the overview,³⁹ medical student training in Hawaii, the San Diego residency training program, nurse training in Puerto Rico, and the varied training of healthcare providers currently in practice are all discussed in a series of case examples. Each of these cases includes specific resources that can be used for training.⁴⁰⁻⁴⁵

Public health departments, as well as schools of public health, play an important role in the prevention of youth violence. The third section, coordinated by Aleta Meyer, looks at training at public health professionals in youth violence prevention. This section begins with an overview by Drs. Meyer and Browne⁴⁶ followed by a series of case examples⁴⁷⁻⁴⁹: a student curriculum on youth violence prevention, Internet-based training for practicing public health professionals in youth suicide, and national training initiatives on injury and violence prevention. Violence is not restricted to the United States; Dr. Meddings' article⁵⁰ describes how violence prevention experts from the Americas have collaborated with a network of global injury experts to develop training tools for develop violence prevention and injury infrastructure in low- and middle-income settings.

The fourth section centers on efforts that focus on specific types of violence.⁵¹⁻⁵⁴ Examining the detailed approach to specific problems provides guidance for the development of training programs not just in these areas, but in other related areas as well. Groves and Augustyn⁵¹ describe their model program for the care of children who witness violence. In the late 1990s spectacular episodes of school violence brought national attention to the problem of violence within schools, adding to the far more prevalent lower intensity interpersonal violence, including bullying. Keys and Leaf⁵² describe an example of cooperation between the public schools and public health professionals.

The relatives and friends who survive the homicide of a loved one offer a special perspective on the epidemic of violence in the United States. Feldman Hertz and Prothrow-Stith⁵³ describe their work with survivors of homicide to develop appropriate training materials both for professionals in dealing with this very vulnerable, difficult, tragic population.

Child abuse was first identified as a clinical syndrome in the late 1950s. Since then a substantial body of literature has developed concerning child abuse. Many training programs nationally have focused on training healthcare professionals in child abuse. Not only has child abuse been recognized as a part of the medical care system for a long time, but also the medical requirement is enforced through mandatory reporting laws in all 50 states. The final article in this section⁵⁴ provides an overview of the approach taken to healthcare professional training in child abuse, brought here as a mature model for comprehensive training that has been institutionalized in training programs throughout the United States.

Finally, Dr. Joseph Wright, an Emergency Physician in Washington DC, provides a perspective⁵⁵ from the field, to serve as an epilogue to this collection.

Youth violence is a preventable health challenge that mars and robs the transition to a healthy, safe, and

productive adulthood for many young people. We hope this supplement can strengthen existing efforts and foster new initiatives to promote the health, life, and safety of children and youth.

No financial conflict of interest was reported by the authors of this paper.

References

1. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Web-based injury statistics query and reporting system. Centers for Disease Control and Prevention, 2004.
2. Spivak H, Prothrow-Stith D, Hausman AJ. Dying is no accident. Adolescents, violence, and intentional injury. *Pediatr Clin North Am* 1988;35:1339-47.
3. Stone DA, Kharasch SJ, Perron C, Wilson K, Jacklin B, Sege RD. Comparing pediatric intentional injury surveillance data with data from publicly available sources: consequences for a public health response to violence. *Inj Prev* 1999;5:136-41.
4. Sege R, Stigol LC, Perry C, Goldstein R, Spivak H. Intentional injury surveillance in a primary care pediatric setting. *Arch Pediatr Adolesc Med* 1996;150:277-83.
5. Cheng TL, Wright JL, Fields CB, Brenner RA, O'Donnell RB, Schwarz D, et al. Violent injury among adolescents: declining morbidity and mortality in an urban population. *Ann Emerg Med* 2001;29:292-300.
6. Durkin M, Kuhn L, Davidson L, Laraque D, Barlow B. Epidemiology and prevention of severe assault and gun injuries to children in an urban community. *Trauma* 1996;41:667-73.
7. Sege RD, Kharasch S, Perron C, Supran S, O'Malley P, Li W, Stone D. Pediatric violence-related injuries in Boston: results of a city-wide emergency department surveillance program. *Arch Pediatr Adolesc Med* 2002;156:73-6.
8. DuRant RH, Cadenhead C, Pendergrast RA, Slavens G, Linder CW. Factors associated with the use of violence among urban black adolescents. *Am J Public Health* 1994;84:612-6.
9. Sege R, Stringham P, Short S, Griffith J. Ten years after: examination of adolescent screening questions that predict future violence-related injury. *J Adolesc Health* 1999;24:395-402.
10. Rivara FP, Shepherd JP, Farrington DP, Richmond PW, Cannon P. Victim as offender in youth violence. *Ann Emerg Med* 1995;26:609-14.
11. Kellermann AL, Rivara FP, Lee RK, Banton JG, Cummings P, Hackman BB, Somes G. Injuries due to firearms in three cities. *N Engl J Med* 1996;335:1438-44.
12. Kellermann AL, Rivara FP, Rushforth NB, Banton JG, Reay DT, Francisco JT, Locci AB, Prodzinski J, Hackman BB, Somes G. Gun ownership as a risk factor for homicide in the home. *N Engl J Med* 1993;329:1084-91.
13. Patterson GR, DeBaryshe D, Ramsey E. A developmental perspective on antisocial behavior. *Am Psychol* 1989;44:331.
14. Gershoff ET. Corporal punishment by parents and associated child behavior experiences: a meta-analytic and theoretical review. *Psychol Bull* 2002;128:539-79.
15. Surgeon General's Scientific Advisory Committee on Television and Social Behavior. Television and growing up: the impact of televised violence. Washington, DC: US Government Printing Office, 1972.
16. Centerwall BS. Television and violence: the scale of the problem and where to go from here. *JAMA* 1992;267:3059-63.
17. Sege R, Dietz W. Television viewing and violence in children: the pediatrician as agent for change. *Pediatrics* 1994;94:600-7.
18. Singer JL, Singer DG. Television, imagination, and aggression: a study of pre-schoolers. Hillsdale, NJ: Lawrence Erlbaum Associates, 1981.
19. American Academy of Pediatrics Committee on Public Education. Children, adolescents and television (RE0043). *Pediatrics* 2001;107:423-26.
20. World Health Organization. World report on violence and health. Geneva, Switzerland: WHO, 2002.
21. Tremblay RE, Nagin DS, Seguin JR, Zoccolillo M, Zelazo PD, Boivin M, Perusse D, Japel C. Physical aggression during early childhood: trajectories and predictors. *Pediatrics* 2004;115:43-50.
22. Lansford JE, Dodge KA, Pettit GS, Bates JE, Crozier J, Kaplow J. A 12-year prospective study of the long-term effects of early child physical maltreatment on psychological, behavioral, and academic problems in adolescence. *Arch Pediatr Adolesc Med* 2002;156:824-30.

23. Stouthamer-Loeber M, Loeber R, Homish DL, Wei E. Maltreatment of boys and the development of disruptive and delinquent behavior. *Dev Psychopathol* 2001;13:941-55.
24. Wolfe DA, Skott K, Wekerle C, Pittman AL. Child maltreatment: risk of adjustment problems and dating violence in adolescence. *J Am Acad Child Adolesc Psychiatry* 2001;40:282-9.
25. Johnson JG, Cohen P, Gould MS, Kasen S, Brown J, Brook JS. Childhood adversities, interpersonal difficulties, and risk for suicide attempts during late adolescence and early adulthood. *Arch Gen Psychiatry* 2002;59:741-9.
26. McCormick KF. Attitudes of primary care physicians toward corporal punishment. *JAMA* 1992;267:3161-5.
27. AAP. The short and long-term consequences of corporal punishment. *Pediatrics* 1996;4(suppl):803-60.
28. Stein MT, Perrin EL. Guidance for effective discipline. *Pediatrics* 1998;101:723-8.
29. American Academy of Pediatrics. Firearm-related injuries affecting the pediatric population (RE9926). *Pediatrics* 2000;105:888-95.
30. American Academy of Pediatrics. Adolescent assault victim needs: a review of issues and a model protocol. American Academy of Pediatrics Task Force on Adolescent Assault Victim Needs. *Pediatrics* 1996;98:991-1001.
31. Kogan MD, Schuster MA, Yu SM, Park CH, Olson LM, Inkelas M, Bethell C, Chung PJ, Halfon N. Routine assessment of family and community health risks: parent views and what they receive. *Pediatrics* 2004;113(suppl):1934-43.
32. Trowbridge MJ, Sege RD, Olson L, et al. Intentional injury prevention and management in pediatric practice: results from 1998 and 2003 American Academy of Pediatrics periodic surveys. *Pediatrics* 2005;116:996-1000.
33. Satcher D. Youth violence: a report from the Surgeon General. Washington DC, United States Government Printing Office, 2001. Available at: www.surgeongeneral.gov/library/youthviolence/. Accessed October 13, 2005.
34. Thornton TN, Craft CA, Dahlberg LL, Lynch BS, Baer K. Best practices of youth violence prevention: a sourcebook for community action (Rev.). Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2002. Available at: www.cdc.gov/ncipc/dvp/bestpractices.htm. Accessed October 13, 2005.
35. Center for the Study and Prevention of Violence. Blueprints for violence prevention. Available at: www.colorado.edu/cspv/blueprints. Accessed October 13, 2005.
36. Commission for the Prevention of Youth Violence. Connecting the dots to prevent youth violence: a training and outreach guide for physicians and other health professionals. Chicago, IL: American Medical Association, 2000.
37. Rosenberg M, Knox LM. The Matrix comes to youth violence prevention: a strengths-based, ecologic, and development framework. *Am J Prev Med* 2005;29:185-90.
38. Knox LM, Spivak H. What health professionals should know: core competencies for effective practice in youth violence prevention. *Am J Prev Med* 2005;29:191-9.
39. Sidelinger DE, Guerrero APS, Rodriguez-Frau MV, Mirabal-Colón B. Training health care professionals in youth violence prevention: an overview. *Am J Prev Med* 2005;29(suppl):200-5.
40. Guerrero APS. Youth violence prevention in a problem-based clerkship curriculum. *Am J Prev Med* 2005;29:206-10.
41. Rodriguez-Frau MV, Mirabal-Colón B. A youth violence prevention curriculum for undergraduate nursing and allied health students. *Am J Prev Med* 2005;29(suppl):211-14.
42. Sege R, Flanigan E, Levin-Goodman R, Licenziato V, DeVos E, Spivak H. Case study: the American Academy of Pediatrics' Connected Kids Program. *Am J Prev Med* 2005;29(suppl):215-19.
43. Cunningham R, Vaidya RS, Maio RF. Training emergency medicine nurses and physicians in youth violence prevention. *Am J Prev Med* 2005;29(suppl):220-5.
44. Knox L, Lomonaco C, Elster A. The American Medical Association's Youth Violence Prevention Training and Outreach Guide. *Am J Prev Med* 2005;29(suppl):226-9.
45. Sege R, Webb S. Bringing violence prevention into the clinic: The Massachusetts Medical Society Violence Prevention Project. *Am J Prev Med* 2005;29(suppl):230-2.
46. Browne A, Barber CW, Stone DM, Meyer AL. Public health training on the prevention of youth violence and suicide. *Am J Prev Med* 2005;29(suppl):233-9.
47. Meyer AL, Masho SW. A youth violence prevention curriculum for public health students. *Am J Prev Med* 2005;29(suppl):240-6.
48. Stone DM, Barber CW, Potter L. Public health training online: The National Center for Suicide Prevention Training. *Am J Prev Med* 2005;29(suppl):247-51.
49. Runyan CW, Gunther-Mohr C, Orton S, Umble K, Martin SL, Coyne-Beasley T. PREVENT: a program of the National Training Initiative on Injury and Violence Prevention. *Am J Prev Med* 2005;29(suppl):252-8.
50. Meddings DR. The World Health Organizations' TEACH-VIP. *Am J Prev Med* 2005;29(suppl):259-65.
51. Augustyn M, Groves B. Training clinicians to identify the hidden victims: children and adolescents who witness violence. *Am J Prev Med* 2005;29(suppl):272-8.
52. Leaf PJ, Keys SG. Collaborating across sectors: training health professionals to work with schools on issues of violence. *Am J Prev Med* 2005;29:279-87.
53. Hertz MF, Prothrow-Stith D, Chery C. Homicide survivors: research and practice implications. *Am J Prev Med* 2005;29(suppl):288-95.
54. Reece RM, Jenny C. Training child maltreatment specialists. *Am J Prev Med* 2005;29(suppl):266-71.
55. Wright JL. Training healthcare professionals in youth violence prevention: closing the gap. *Am J Prev Med* 2005;29(suppl):296-8.