

# Public Health Training on the Prevention of Youth Violence and Suicide

## An Overview

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**Abstract:** Although injury is the leading cause of death for Americans aged 40 and under, curricula in U.S. Schools of Public Health rarely include training on injury prevention or control. Domestically and internationally, when the topic of injury is addressed, the focus is often on unintentional injuries. Yet intentional injuries from violence and self-harm (apart from acts of war and terrorism) and the acute and chronic health problems associated with them take a large and often hidden toll on individuals, families, and communities worldwide. Adequate education on the prevention of violence and suicide by teenagers remains missing from public health and medical training. Public health and medical practitioners are confronted by violence-related injury but are provided little formal education on youth violence or suicide, effective responses, or prevention.

Adolescents' involvement in violence remains a serious public health problem. Involvement in aggression and self-harm by adolescents leaves them at immediate risk of injury and often has ongoing and negative effects on future development, involvement in community and family life, and risk of morbidity and mortality for self and others. Public health practitioners are at the nexus of health care and service provision at local, state, federal, and multinational levels, and are well suited to provide training and technical assistance on youth violence prevention across disciplines and settings. In this article, training resources, opportunities, and strategies for prevention of the high prevalence of youth violence and suicide in the U.S. are discussed and recommendations for a new public health training initiative are outlined.

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### Training on Injury Prevention in Schools of Public Health

Although injury is the leading cause of death for Americans under the age of 40, until recently, curriculum in Schools of Public Health (SPH) in the U.S. rarely included training on injury prevention or control. In their 2002–2003 survey, the Association of Schools of Public Health (ASPH) and the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control (CDC/NCIPC) found that, if occupational/industrial injury were excluded, training or research on injuries was minimal among accredited SPH.<sup>1</sup> Only a few U.S. schools (3 of 21 completing the survey) required an injury course on intentional or unintentional injuries in doctoral programs; no schools required training in

injury for a masters degrees. ASPH and CDC/NCIPC estimated that less than one quarter of all SPH graduates had taken even a general course on injuries during their formal training.

### Training on Intentional Injury (Violence and Suicide) in SPH

To the extent that injury is addressed at all in U.S. SPH, the traditional focus has been on unintentional injuries occurring in occupational/industrial settings or on in-home risks of unintentional injury to children, with an emphasis on very young children.<sup>1</sup> Although often confronted by violence-related injury once they become practitioners, most public health professionals never receive formal training on violence or its prevention. Yet intentional injuries (not including those resulting from acts of war and terrorism) and acute and chronic health problems associated with them take a constant and often hidden toll on individuals, families, and communities.<sup>2–4</sup> This burden falls especially heavily on vulnerable populations.<sup>5–7</sup> Given an increasingly resource-scarce environment in the U.S., training

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on early identification of and knowledgeable responses to suicide and interpersonal violence offers an opportunity to prevent ongoing trauma and significantly improve the health of Americans.<sup>8</sup>

### **Importance of Training on Youth Violence in SPH**

Despite long-standing concern in the medical and social service fields with the prevention of child abuse, education on violence and suicide prevention among teenage children remains missing from standard public health and medical training. Yet the consensus of scientific research indicates that injuries are preventable and can be reduced by informed preventions. Injuries as a result of interpersonal violence and suicide seem particularly preventable among children and adolescents. Public health professionals often are well-positioned to interact with children's and teens' welfare in school, home, and community settings and help determine policy responses and programming for children and their families across a range of health issues.<sup>9</sup> Public health practitioners also are at the nexus of health care and other service provision at local, state, and federal levels, and thus are well suited to provide training and technical assistance on youth violence and its prevention to those in other disciplines and settings.

Adolescents are not only the victims of violence but are frequently the perpetrators. Although children aged 18 and under account for only 10% of arrests for homicide in the U.S. (and 10% of all murder victims in 2001),<sup>10</sup> adolescents' involvement in perpetration of nonlethal violence is a serious public health problem. The most comprehensive measure of youth violence among teens in the general U.S. population is the CDC Youth Risk Behavior Surveillance Survey (YRBSS), a nationally representative school-based survey conducted every 2 years. Findings from the 2003 survey indicate that well over one third of 9th- through 12th-grade boys (40.5%) and one fourth (25%) of 9th- through 12th-grade girls reported "being in a physical fight" in the 12 months before the survey.<sup>11</sup> Rates of aggression among those adolescents not attending school are assumed to be even higher. The YRBSS also gathers information on suicide ideation and attempts. According to data from 2003, 17% of 9th- through 12th-grade students seriously thought about suicide over the past 12 months, 17% made a suicide plan, and 8.5% made a suicide attempt.<sup>11</sup> These numbers underscore the need for a high-profile, intensive public health initiative. The following discussion focuses first on training in the area of interpersonal violence and then on training in the area of suicide prevention.

Involvement in perpetration of aggression by adolescents leaves them and their victims at immediate risk of injury and harm and often has ongoing and negative effects on future development and involvement in community and family life, effects that may last for

years. Yet responses to perpetration of youth violence typically take place only **after** significant incidents have occurred or a pattern of aggression has been established. Empirical studies of violence by teenagers and children indicate that the onset of most severe interpersonal aggression occurs during middle childhood, with persistence for boys throughout the teen years.<sup>12</sup> Informed interventions for adolescents and children are critical for prevention as well as for effective responses to early indicators and behaviors.

Diverse approaches have been proposed to prevent violent behavior by teenagers, including programs with both primary and secondary prevention aims such as school- and community-sponsored initiatives<sup>13,14</sup> (see Mytton et al.<sup>13</sup> for a comprehensive review of randomized controlled trials of violence-prevention programs). Based on the hypothesis that antecedents of violence may begin in infancy, many researchers stress the importance of couching the prevention of teenage violence in a life-course perspective.<sup>15,16</sup>

Although individual instances of youth violence are a frequent topic in the U.S. media, by the early 2000s nonjudicial prevention efforts still consisted mainly of scattered school- and community-based programming, much of it innovative but untested. Because theories of adolescent aggression were developed based on male behavior, male teenagers are the primary focus and the population for whom interventions and services are developed and implemented.<sup>13</sup> Until recently, lack of inquiry into the dynamics of girls' violence left practitioners and policymakers with a significant dearth of knowledge on which to base policies, programs, or prevention strategies for violence by girls,<sup>17,18</sup> an important gap in light of the 25% finding of 12-month involvement in physical aggression among girls found in the most recent YRBSS.

### **Public Health Training in Youth Violence Prevention**

Formalized training on youth violence and youth suicide prevention for public health professionals is in its infancy. In Appendix E of the ASPH and CDC/NCIPC 2002–2003 summary of curricula and training at U.S. accredited SPH, only a few schools listed any courses that mentioned youth violence specifically,<sup>1</sup> and only a small proportion of students took those courses as a part of their training. Despite its prevalence in the general population, no U.S. SPH reported training in youth violence prevention as a requirement for a masters' degree or doctorate. Training opportunities for practicing professionals are rare as well.

The CDC, National Institutes of Health, and other funders have been major supporters of expanding training opportunities available for public health students and practicing professionals. Beginning in 2000, CDC funded 10 national Academic Centers of Excellence on Youth Violence Prevention dedicated to ad-

vancing the science of youth violence prevention through partnerships between academic and community-based practitioners.<sup>19</sup> Also in 2000, the Robert Wood Johnson Foundation convened a commission of representatives from major professional associations in public health, medicine, and nursing to develop recommendations for health professionals in preventing youth violence. This group recommended priority actions for health professionals across disciplines.

As a follow up, in 2001, the Commission asked the Southern California Center of Academic Excellence for Youth Violence Prevention to prepare a report on competencies health professionals need in order to work effectively in preventing youth violence. This report, *Youth Violence and the Health Professions: Core Competencies for Effective Practice (November, 2001)*,<sup>20</sup> identifies core competencies that cut across disciplinary and specialty lines and professions in a wide variety of settings. Core competencies are outlined in knowledge, attitudes, communication, clinical intervention, practice management, work with communities, and policy/system/social change.<sup>21</sup> Practical strategies for promoting training on youth violence prevention also are presented. The National Training Initiative in Injury and Violence Prevention (NTI), a collaboration of the National Association of Injury Control Research Centers (NAICRC) and the State and Territorial Injury Prevention Directors' Association (STIPDA), also has developed core competencies to guide training programs for practitioners working with injury and violence prevention, including suicide prevention ([www.injured.org](http://www.injured.org)).

Recent training efforts have focused on in-person and interactive strategies. In 2003, the NCIPC at CDC funded PREVENT (Preventing Violence through Education, Networking, and Technical Assistance), a training project derived from a 3-year collaboration of the STIPDA and the NAIRC.<sup>22</sup> This program is designed to make violence prevention training more available nationally to practitioners working to prevent violence. Based at the University of North Carolina Injury Prevention Research Center, in collaboration with the North Carolina Institute of Public Health, PREVENT is developing regional workshops and an institute focused on violence prevention and techniques for program planning and evaluation ([www.prevent.unc.edu](http://www.prevent.unc.edu)).

A variety of other online resources and satellite training sessions also exist. Partnerships for Preventing Violence—a collaboration of the Harvard School of Public Health, the Prevention Institute in Oakland, California, and the Education Development Center in Massachusetts—has piloted a national training model that has reached over 14,000 participants by 2004 using satellite technology. This model consists of a seven-part series using a cross-disciplinary approach to the complexities of youth violence in schools and communities. Broadcasts include in-studio discussions with experts,

practitioners, members of the community, parents, and youth, as well as preproduced video segments featuring model prevention programs.

Other resources include the National Youth Violence Prevention Resource Center web site SafeYouth.org ([www.safeyouth.org](http://www.safeyouth.org)), developed by CDC and other federal partners, to provide a user-friendly single point of access for federal information on youth violence. Information on the site is intended for use by parents, youth, and other interested individuals, as well as professionals, students, and academics. Resources include fact sheets, best-practices documents, funding and conference announcements, research bulletins, surveillance reports, and profiles of promising programs. Executive summaries include such topics as "What Health Care Practitioners Can Do to Prevent Youth Violence," drawn from the *Report of the Commission for the Prevention of Youth Violence*, funded by Robert Wood Johnson.<sup>23</sup> In 2000, the CDC NCIPC Division of Violence Prevention also assembled a *Best Practices of Youth Violence Prevention* sourcebook intended for a general audience.<sup>24</sup> This sourcebook reviews principles of intervention and prevention planning, implementation and evaluation, and organizes prevention strategies into four basic categories: (1) parent- and family-based strategies, (2) home-visiting strategies, (3) social-cognitive strategies, and (4) mentoring strategies.

The 2000 Robert Wood Johnson Commission also funded the development of an outreach and training guide for health professionals, *Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals* (June, 2002),<sup>25</sup> based on the Commission report. This remarkably comprehensive 185-page guide is dedicated to assisting health professionals enhance the awareness of professional and community groups about the prevalence of and strategies for preventing youth violence. Techniques for preparing presentations and workshops for a wide range of professionals are outlined. Detailed lists of topics, prepared slide presentations, and sample handouts are offered. Sample speeches are included for health professional, youth, and community audiences, along with information on a wide range of special issues (e.g., bullying in schools, adolescent substance abuse, media violence, youth gangs) and references to articles on these topics. A concluding section on other resources is included as well.

The Massachusetts Medical Society, through its Committee on Violence, also has taken an active role in training in youth violence prevention. A handbook, *Recognizing and Preventing Youth Violence: A Guide for Physicians and Other Health Care Professionals*, sold out its first edition and the second edition was published in late 2004. The handbook, distributed by the Massachusetts Medical Society and reprinted by other states, is designed to assist physicians, other health professionals, and their patients or clients in understanding and

responding to youth violence. The handbook is accompanied by Parent Education Cards in English and Spanish covering nine violence-related topics as well as by an on-line CME program. Materials are available in print and are also available via the Massachusetts Medical Society's web page.<sup>26</sup>

### **Promising New Directions: Youth as Health Educators in Youth Violence Prevention**

A variety of "Teens Against Violence" programs have been organized around the idea of using adolescents as facilitators and outreach workers to their peers. Recently, the effectiveness of teens as violence prevention educators for adult professionals also has been explored. For example, in an evaluation of a violence prevention education program for healthcare personnel (based in an adolescent clinic of a tertiary care pediatric hospital), findings from a year-long randomized, controlled comparison study found that healthcare personnel who participated in a training program with teen health educators: (1) conducted more violence and risk screenings with adolescent patients, (2) attributed greater importance to conducting assessments for youth violence and violence risk counseling, (3) had better identification and management skills of youth's violence-related problems, and (4) demonstrated more effective interpersonal skills with their adolescent patients than did matched healthcare personnel who were informed by reading articles on youth violence and screening for violence.<sup>9</sup>

In this experiment, teen health educators used panel discussions and drama techniques to train health professionals about violence risk, high-risk behaviors, and prevention strategies for teens; did one-on-one roleplays of screening and disclosure response strategies with providers; and provided direct feedback on practitioners' approach and skills in assessing violence risk and making practical recommendations to teen patients. In many cases, adolescents offer the best suggestions for youth violence prevention or remediation and the best assessments of the effectiveness of communications and interventions. Evaluators concluded that teen health educators can be a valuable resource for training in youth violence prevention and can provide more memorable learning experiences than do less-direct training methods.

### **Training on Prevention of Suicide Among Youth**

Discussions of "youth violence" rarely include suicide attempts and completed suicides by youth; suicide is more typically treated as a separate topic and a rare event. Yet suicide, the 11th leading cause of death in the U.S. overall in 2002, was the third leading cause of death among young people aged 10 to 19 years and 20

to 24 years.<sup>27</sup> Between 1950 and 1990, the suicide rate among youth aged 10 to 19 years nearly tripled,<sup>28</sup> although it has declined since 1990 from 6.2/100,000 in 1992 to 4.3/100,000 in 2002.<sup>27</sup> Many risk factors for youth suicide are the same as those for interpersonal violence by youth, including a history of child maltreatment and alcohol/substance abuse,<sup>29</sup> strengthening potential gains in prevention of youth violence against self or others if these common risk factors and warning signs are understood and addressed.

### **History of Public Health Suicide-Prevention Efforts**

Despite the magnitude of the problem, relatively few resources have been devoted to suicide prevention and training compared with other public health problems. Although suicide has been reframed only recently as a preventable public health problem, public health-oriented suicide prevention in this country dates back to the late 1950s with the establishment of the Suicide Prevention Center in Los Angeles with funding from the U.S. Public Health Service. The next decade saw the growth of suicide crisis lines across the nation, the establishment of the National Institute of Mental Health's Center for Studies of Suicide Prevention in 1966, and the organization of the American Association of Suicidology in 1968. In the 1980s, the CDC established its first violence prevention unit, and the American Foundation for Suicide Prevention, a national nonprofit, was established to fund research, education, and treatment. It wasn't until 1985, however, when the Secretary's Task Force on Youth Suicide was established by the U.S. Department of Health and Human Services, that a coordinated public health effort began to address suicide. In 1989, this group published recommendations for suicide prevention including training health service providers in the diagnosis and treatment of suicide among youth and involving public and private sectors in youth suicide prevention.<sup>30</sup> Unfortunately, the recommendations were not disseminated widely and the plans were not carried out as intended.

A second wave of suicide prevention began in the late 1990s. This effort broadened suicide prevention from a predominantly mental health focus on preventing suicide among individuals to a public health focus on preventing suicide in the population, particularly among youth. In 1996, the World Health Organization published *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies*.<sup>31</sup> Suicide prevention efforts in the U.S. were energized by the emergence of a grassroots movement composed largely of family members of suicide victims, which led to the formation of the Suicide Prevention Action Network (SPAN USA) in 1996. SPAN USA pressed for immediate action on the part of the federal government. As a result, in 1998, the first National Conference on Suicide Prevention was held in Reno, Nevada. This was an

historic and galvanizing event that brought together public and private organizations and proved instrumental in inspiring the office of the U.S. Surgeon General to take an active role in suicide prevention. The Surgeon General's *Call to Action to Prevent Suicide* was published in 1999,<sup>29</sup> and the *National Strategy for Suicide Prevention* was published in 2001.<sup>32</sup> The Institute of Medicine weighed in on the issue in 2002 as well with the publication of *Reducing Suicide: A National Imperative*.<sup>33</sup> Championed by Senator Harry Reid, suicide prevention research and training efforts began receiving enhanced support and federal funding in the late 1990s and early 2000s. States responded to the Surgeon General's call to action; to date, virtually all have established or are in the process of establishing statewide planning groups to chart a course for reducing suicide.<sup>34</sup>

### Training in Suicide-Prevention Efforts

During the first and second waves of the suicide-prevention movement, little was happening to train nonpsychiatric health professionals and activists either in clinical skills (recognizing, responding to, and treating potentially suicidal individuals and their loved ones) or in public health and public policy skills (understanding the epidemiology of self-harm, developing and evaluating population-based interventions, and broadly implementing evidence-based interventions to reduce rates of self-harm).

In terms of clinical training, studies indicate that most health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients and clients, or to refer them properly for specialized care. For example, according to Bongar and Harmatz,<sup>35</sup> less than one half of clinical psychology programs offer training in suicide prevention. Similarly, Berman<sup>36</sup> found that, among mental health professionals, the total average time of formal didactic training in suicide prevention was 2 hours. More recently, a survey of 598 past and current master's-level social work students found that 70% reported having 2 or fewer hours of class time devoted to suicide.<sup>37</sup> Hodgman and Roberts<sup>38</sup> found that only 21% of a sample of pediatricians routinely inquired about suicidal behaviors. It wasn't until the publication of the *National Strategy for Suicide Prevention* in 2001<sup>32</sup> and the Institute of Medicine's *Reducing Suicide* in 2002<sup>33</sup> that goals for training needs for suicide prevention were outlined for the U.S. Goal 7 in the *National Strategy* was to "Develop and promote effective clinical and professional practice" among mental health, healthcare, and emergency-response personnel.<sup>32</sup>

Public health training has lagged even more. In the ASPH and CDC/NCIPC 2002–2003 inventory of accredited SPH in the U.S., of 163 courses on nonoccupational injury prevention reported by the schools, only

one mentioned suicide in its title and none focused exclusively on suicide.<sup>1</sup> Opportunities for professional training are equally limited. A national needs assessment completed in 1997 by the CDC found that state health department officials needed assistance with strategic planning, program evaluation, and program implementation for suicide prevention. Three years later, in 2000, the Children's Safety Network (CSN), a project of the Health Resources Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), conducted interviews with staff from 25 state health departments and found that training in suicide prevention was one of the most pressing needs identified. Public health training has not kept pace with the rapid emergence of suicide prevention coalitions at the local level, coalitions composed of individuals eager to better understand suicide and learn a population-based approach to its reduction.

Informed and knowledgeable training in youth suicide prevention is critical. Unlike many areas of public health, in which funds spent on ineffective interventions simply waste scarce resources, in the suicide-prevention field there is the potential to do demonstrable harm. For example, interventions that focus dramatic, communal attention on an individual tragedy (such as a large school assembly after a student's suicide) sometimes unintentionally contribute to a suicide "contagion" effect. Given these risks, training needs are all the more pressing.

### Resources for Training in Suicide Prevention

In response to the urgent training needs, and in recognition of the recent groundswell in grassroots-level suicide prevention groups, the federal government has begun funding some training initiatives. These include the National Center for Suicide Prevention Training, funded by the MCHB, providing Internet-based courses (highlighted in a separate article in this volume)<sup>39</sup> and the Suicide Prevention Resource Center, a major new resource in the field funded by the Substance Abuse and Mental Health Services Administration, which provides training, internet and multimedia resources, and technical assistance.

The CDC-funded PREVENT training program mentioned earlier includes youth suicide prevention training in its violence prevention efforts. In addition, gatekeeper training, a population-based prevention strategy designed to help people identify those at risk for suicide, is being used increasingly by statewide suicide-prevention coalitions and other groups to train front-line personnel who work with youth such as teachers, health providers, and police.<sup>32,40,41</sup> These important endeavors scratch only the surface. To accelerate the pace of progress in youth suicide prevention, resources need to be devoted to attract faculty and researchers to the field, develop graduate-level training in SPH, and develop more

opportunities for in-person and distance learning for professionals and grassroots activists.

### **Faculty Development in Youth Violence and Suicide Prevention**

One of the most effective ways to increase the prevalence of training on youth violence prevention in SPH is to increase the number of faculty with expertise and competency in this area. Yet almost no sites offer faculty development in youth violence and youth suicide prevention. To address these important and pervasive health problems, SPH must prioritize hiring faculty with training and interest in youth violence/injury and prevention, seek cultural diversity and competency in this faculty, and include and integrate youth violence prevention topics in required courses in SPH.

### **Personal Process of Educating and Learning About Violence and Suicide**

The very nature of violence and suicide can make teaching, thinking, and learning about it and its prevention difficult. In-depth discussions of acts of violence and their outcomes may trigger unresolved personal experiences (e.g., of racism, child abuse, dating violence, experiences with bullying, and witnessed aggression) in both learners and educators, grief and anger related to family experiences or losses because of other- or self-directed violence, and awareness of personal misuses of power and privilege. The intensity of responses to topics of violence often catches educators and learners off-guard and may lead to resistance or denial. Youth violence educators need to prepare for potentially intense reactions and have an already-vetted referral list of supportive resources and knowledgeable mental health professionals available, tailored as much as possible to the type of learner receiving the information. An emphasis on the widespread prevalence of child maltreatment and youth violence in the general population and on strength-based perspectives with which to view victims as well as teen perpetrators is critical in placing individual experiences in a larger and more positive context. Finally, a focus on the desired endpoint—enhanced health, well-being, and safety—combined with an emphasis on best-practice responses and practical next steps balances the possible negative impact of the topic with motivation and forward momentum for improvement.

### **Recommendations for Public Health Training in Youth Violence and Suicide Prevention**

Effective training on violence and suicide prevention among teens must be based on the latest empirical findings of risk and protective factors for youth, coupled with culturally appropriate and community-based

applicability. Results of recent empirical inquiries suggest that **a much stronger emphasis on safety for children and adolescents in their families and communities will yield a significant reduction in youth violence overall.**<sup>3,12,16–18,42–44</sup>

Recommendations for a new Public Health Initiative include:

1. Establishing training in intentional injury prevention, including suicide, as a **requirement** for accreditation in SPH;
2. Integrating intentional injury concentrations, specialization, and injury degree programs into SPH curricula and into trainings internationally;
3. Including self-directed violence by youth into all trainings on youth violence and youth violence prevention;
4. Including trainings on youth violence and suicide prevention in SPH, medical schools, and international injury prevention curricula and modules;
5. Establishing academic–practitioner partnerships and practice opportunities in community and medical settings focused on youth and violence prevention as a part of public health training;
6. Encouraging the consideration of youth violence and suicide and its prevention within the broader context of health disparities and the need for culturally sensitive prevention strategies that include resilience as well as risk;
7. Extending of systematic and ongoing training on youth violence prevention to professional, community, and state health department settings in rural as well as urban areas;
8. Funding empirical evaluations of the effectiveness of youth violence prevention and intervention strategies;
9. Developing distance-learning opportunities for practitioners, other professionals, and the public on youth violence and youth violence prevention; and
10. Utilizing teens as youth violence prevention educators.

Societal responses to violence among adolescents over the past 20 years have been predominantly reactive and punitive. As the *Report of the Commission for the Prevention of Youth Violence* noted, “more school suspensions and more prisons are not the answer. The answer, rooted in public health, is prevention.”<sup>23</sup>

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