Visionary Leadership for Psychiatric-Mental Health Nurses Around the World

INTERNATIONAL SOCIETY OF PSYCHIATRIC-MENTAL HEALTH NURSES

White Paper, June 2014

Youth Violence and Violence Prevention

I. Statement of Position

The Association of Child and Adolescent Psychiatric Nurses (ACAPN), a division of the International Society of Psychiatric Mental Health Nurses, is dedicated to the mental, social, and physical well-being of all children, adolescents and families. ACAPN strives to develop healthy youth, and to advocate for safe non-violent environments in which they may live, play and grow. As such, ACAPN is concerned with the increase in violent acts perpetuated by and towards youth. Youth violence has become a significant public health challenge and as such poses risk to youths, families, the community and society.

II. Purpose

This white paper is written to provide a current overview of youth violence and offer evidence-based recommendations for preventing violence towards and by youth.

III. Definition

Youth violence is the intentional use of physical force or power, threatened or actual, made towards or against another person, group or community, which has the likelihood of resulting in injury, death, and psychological harm including impaired development or deprivation. It also includes public or private interpersonal violence, including those in response to provocations, proactive measures, criminal or non-criminal acts (DHHS, 2001*;* Hall et al*. 2012).*

IV. Background

Prevalence

Violence, manifested in multiple ways, is at worrisome and epidemic proportions in youth (CDC, 2012a). Homicide has long been the second leading cause of death in young people ages 15-24. However, it disproportionately affects ethnic minority youth when compared to the white population in the United States, as it is the leading cause of death in African-American youth ages 10-24, the second leading cause of death in Latino youth, and the third leading cause of death in Native-Americans youth (CDC, 2013). In 2010, 150 youth ages 10-14 died from homicide and 1,832 ages 15-19 died from homicide (CDC, 2010). During the same reporting period, unintentional deaths in both age groups accounted for 5,422 deaths. Among youth, suicide ranks as the third cause of death. Annually, there are approximately 4600 youth suicides, with firearms, suffocation and poisoning the most frequently chosen methods (CDC, n.d.). Over 700,000 youth suffer violence related injuries annually requiring emergency room treatment. Youth violence associated care, treatment, property damage and loss of productivity is estimated to cost over 16 billion dollars annually (National Center for Injury Prevention and Control, 2011). Other forms of violence such as self-injurious (self-harm) behaviors and bullying are on the rise and quickly becoming significant quality of life issues. Stigma can also fuel violence against LGBT youth, youth with mental illness and developmental delays. Dating violence and coercion, internet or electronic acts of aggression are additional acts of force and cruelty experienced by youth.

In a recent issue of the *Journal of Pediatrics* (March 2014), a study of 4,297 children from grades 5 to 10 validated the American Academy of Child & Adolescent Psychiatry's (AACAP) policy statement on the prevention of bullying and outcomes. AACAP policy states that sequela of bullying includes depression, irritability, anxiety, sleep problems, psychosomatic complaints, eating disorders, school truancy, running away, substance use and abuse, self-inflicted, accidental injuries and suicidal behavior. Teens in the tenth grade were found to have worse physical (weight issues) and emotional health status (depression and self-worth) and quality of life if they had been bullied and the effects are both additive and cumulative. (AACAP; Bogart et al.)

School violence became a part of violence statistics beginning in 1999 with the Columbine shootings and more recently in 2012 with Sandy Hook. These events covered extensively in the media also served to highlight other acts occurring in schools. Schools have unfortunately continued to be a place where violence towards youth occurs, with fights, weapon carrying, gang infiltration and threats occurring, and threatening overall safety. On national surveillance survey measures such as the Youth Risk Behavioral Survey (YRBS) and the Olewus Bullying Prevention Program (OBPP), youth reported specific acts of violence occurring at school and absenteeism as a result of feeling unsafe there (CDC, 2012b; Limber, Olweus & Luxenberg, 2012). Data from the 2008 National Survey of Children's Exposure to Violence (NatSCEV) which looked at past year and life-time exposure, found that with advancing age, youth were exposed to more violent acts of violence, at least 10% were exposed to 5 or more acts of violence and 60% reported exposure within the last year (Finkelhor et al. 2009). Poly-victimization, or youth exposed to multiple acts of violence or different types of violence (Finkelhor et al. 2011) may be most at-risk for significant psychiatric symptomatology such as post-traumatic stress, depression, anxiety, self-harming behaviors, or are at risk for becoming a perpetrator of violence.

Etiology

There are many factors that can result in violence perpetration. Some are included here but are by no means the only factors and it must be stated that the prognosis for youth who experience multiple risk factors is worrisome. These include genetic or biological risks, personal history of victimization, chronic stress exposure, environmental experiences, temperament and having a behavioral or psychiatric diagnosis. Neurotransmitters implicated in aggression include serotonin, dopamine and norepinephrine. Low serotonin levels in the prefrontal cortex or damage to that area of the brain predisposes the individual to violence (Siever, 2008). Chronic stress results in increased cortisol production with subsequent arousal and increased risk for impulsivity and reactivity. Youth with temperament styles characterized by hyperactivity, negativity, impulsivity and risk-taking are more at risk to engage in violence perpetration. In addition, youth who are victims themselves of child maltreatment (physical, sexual and / or emotional) or who witness violence and abuse in their homes or communities may resort to engaging in similar behaviors during their youth or later as adults. Research in media violence has shown that children who watch more violent programs on TV tend to favor using violence to resolve conflict (*AACAP, 2011*). In addition, violent video games and music lyrics have been shown to influence violent behavior in adolescents *(*Bajovic, 2013; Bushman & Gibson, 2010; Bushman, 2013; Ohio State University, 2013).

More recently, attention has focused on characteristics of neighborhoods and schools where youth live and learn as risk factors for aggression perpetration and victimization. Poor, overcrowded environments where there is a concentration of poverty, communities with high crime rates, poor housing and lack of resources/opportunities may also serve as catalysts to youth violence (Losel & Farrington, 2012). Positive peer relationships and positive attitudes and experiences (sense of safety and belonging) in school appear to be protective against engaging in violence (Henry et al. 2012). Lastly, youth diagnosed with conduct disorders, borderline personality disorders, attention deficit disorder,

substance use disorder and bipolar mania present more risk for violence engagement.

Prevention

While the 1979 U. S. Surgeon General's report on health prevention identified violence as one of 15 public health problems it was not until 1993 that the Bureau of Violence Prevention was established within the CDC paving the way for tracking patterns of violence and pursuing strategies to reduce the risk of violence in youth (Dahlberg & Mercy, 2009; USDHHS, 1980).

Intervention research has focused on numerous targets, using both the traditional 3 levels of public health prevention and the mental health intervention paradigm (IOM, 1994) of universal (for everyone), selective (for those at risk) and indicated (for those already showing high levels of aggression). Interventions focused on the prevention of abuse, identification and treatment of maternal mental health problems, early identification of conduct and mental health disorders in children, children subjected to abuse or who observe IP violence, interventions to increase social skills, and anti-bullying programs all exist but relatively few interventions have met the level of efficacy expected for government endorsement (Sullivan et al., 2008; US Department of Education, n.d.).

Communication and collaboration between U. S. government agencies, namely the CDC Office of Prevention of Youth Violence and Justice Department's Office of Juvenile Justice and Delinquency Prevention, have facilitated focused attention on collecting accurate statistics, educating the public and supporting programs that have demonstrated effectiveness in reducing violence. Established in 2010, the Academic Centers of Excellence (ACE) demonstration programs are now active in ten university-community partnerships funded to design, deliver and study effectiveness of evidence-based programs that target the root causes of violence at three ecological levels: individual, relationship and community (CDC, 2012b).

Among the well-established evidence-based programs that demonstrate high levels of effectiveness in preventing violence and are widely used is the *Nurse Visitation Program* (Eckenrode et al., 2010; Olds et al., 1998) to reduce maternal abuse and reduce child aggression and Olweus' (1994; 2003) program to prevent bullying. For children already determined to have emotional disturbances Webster Stratton's *Incredible Years* parenting program (2004) has been deemed highly effective (US Department of Education [DOE], 2011). Another promising intervention for sexual violence prevention has been bystander intervention programs that attempt to empower and engage community members to act when they learn about or witness violence toward a victim (Banyard et al., 2010).
As children proceed into the grade school years, most violence prevention efforts turn to more universal programs. School-based prevention has been a particular area of focus, such as drugs and alcohol use, anti-bullying and date rape awareness. These programs are generally designed to teach problem solving, conflict resolution and promote pro-social behaviors. Two school-wide interventions with medium to high effectiveness regarding character development and its effect on behavior (USDOE, n.d.) are *Positive Action* (improvement ratio +19 and a positive effectiveness rating) and *Caring School Community*™ (improvement ratio +8 and effectiveness rated as having potentially positive effects). While many other prevention intervention programs (Breitenstein et al., 2012; Farrell & Camu, 2006) have good levels of efficacy, the impact on the prevention of violence later in life has not been demonstrated (WHO, 2002).

V. Implications for Nurses

For almost twenty years, psychiatric nurses have developed excellent primary and secondary programs. Several child and adolescent psychiatric nurses have developed promising, indicated and selective intervention programs using many of the strategies outlined by the CDC (2012). Gross et al. (2009) and Breitenstein et al. (2012) used a parenting (relationship) strategy and have demonstrated that parent training can improve how mothers interact with their difficult toddlers, addressing risk factors for aggressive behaviors (CDC, 2002). Similarly, the

social cognitive intervention exemplified by Puskar (Lamb et al., 1998; Puskar et al., 2009) was designed to increase adolescent coping skills to reduce potential for violence. The problem solving skills taught to individuals in this community-based program have demonstrated effectiveness in decreasing adolescents' aggressive responses to volatile situations (Puskar et al., 2009).
Child and adolescent psychiatric nurses are in a prime position to intervene early to strengthen family ties and identify children at risk. By virtue of their work in schools, primary care, health care clinics, and community health centers, they are in contact with children who are at risk for developing and continuing aggression. Because child and adolescent psychiatric nurses understand psychological, developmental, sociological, and psychiatric aspects of behavior, they can evaluate the potential efficacy of interventions or population based programs.

Another area in which psychiatric nurses must participate is in the area of advocacy. This need has been heightened by recent episodes of indiscriminate violence toward others by individuals with histories of mental illness exemplified by the killing of moviegoers in Colorado, school children and teachers in Connecticut, and college students and teachers in Virginia. All have provoked serious concerns about the adequacy of mental health services provided to youth and young adults with established psychiatric disorders; an area mandating improved, indicated and selective prevention intervention strategies offered at the individual and community level. Similarly, while it is known that observed violence puts individuals at risk for violent behavior (Gil-Gonzalez, 2008) and that college bystanders can be deterrents to sexual violence on campus (McMahon & Banyard, 2012), there is a gap in the empirical literature detailing preventive interventions for these groups.

Psychiatric nurses who work with children, adolescents, young adults, their families and communities can be essential in developing and providing evidence based post-violence interventions, conducting research and advocating for

needed resources.

VI. Resources for violence prevention information and interventions

Agencies/Programs	Websites
Center for Disease Control and Prevention, Center for Prevention of Injury and Violence, Division of Violence Prevention	http://www.cdc.gov/violenceprevention/youthviolence/index.html
Programs	
STRYE	http://www.cdc.gov/violenceprevention/stryve/index.html
Dating Matters	http://www.cdc.gov/violenceprevention/datingmatters/index.htm
DELTA (IPV)	http://www.cdc.gov/violenceprevention/delta/index.html
Department of Justice, Office of Juvenile Justice & Delinquency Prevention	http://www.ojjdp.gov/
Model Programs Guide	http://www.ojjdp.gov/mpg
Dept. of Education, Institute of Education Sciences	http://ies.ed.gov/ncee/wwc/
What Works	http://ies.ed.gov/ncee/wwc/findwhatworks.aspx
World Health Association	http://www.who.int/topics/violence/en/
Violence	http://www.who.int/violence_injury_prevention/violence/4th_mile

	Prevention: The Evidence	stones_meeting/publications/en/

VII. Call to Action

1. Support early assessment and intervention in primary care with both victims and perpetrators of violence.

2. Implement early home and family intervention services for children at risk for violent behaviors towards self and/or others.
3. Provide accessible and affordable early intervention services for developmentally delayed, neurologically impaired, and/or drug exposed young children (0-5) and their families.
4. Implement empirically validated psycho-educational programs for parents of children at risk for violent behavior towards self and/or others.
5. Support community education and social media programs, which teach pro-social behaviors, such as anti-bullying; offer mentoring, and promote resilient children.
6. Promote empirically supported pro-social education programs in the schools to teach anger management, conflict resolution, and problem-solving.
7. Promote community development of social support networks, and resources for services, including victims of violence; recreation, and employment
8. Participate in multi-disciplinary collaborative research to develop and rigorously evaluate culturally sensitive interventions aimed at reducing risk factors associated with violent and aggressive behavior towards self and / or others.
9. Develop and use assessment measures and interventions that are culturally appropriate for children and families from all ethnic and socioeconomic backgrounds.
10. Participate in policy initiatives that support development of healthier communities.

11. Develop, teach and evaluate mental health literacy modules for children, adolescents and parents that focus on violence prevention strategies.
12. Make timely referrals to licensed mental health professionals to evaluate and treat conditions associated with violent or antisocial behavior, including:

- Attention Deficit/Hyperactivity Disorder
- Childhood depression
- Oppositional Defiant Disorder
- Conduct Disorder
- Attachment Disorder
- Domestic violence
- Substance Use Disorder
- Family Dysfunction
- Difficult temperament style
- Mood Dysregulation
- Bullying
- Date rape
- Trauma and/or PTSD

13. Promote involvement in social movements aimed to:
    - Eliminate tolerance for racism, bigotry, hate crimes, child abuse/neglect, sexual harassment and exploitation of girls and women
    - Expect tolerance of diversity of race, gender, ethnicity and sexual orientation
    - Legislate and enforce more restrictive access to guns and stronger consequences for driving while impaired by alcohol/drugs and distracted driving as a result of electronic equipment (use of cell phones and texting)
    - Enforce strict adherence to legal drinking age
    - Advocate for a decrease in violence-oriented media (television,

movies, music, and radio) that is easily accessible to children.

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