

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-07

Subject: Update on Youth and School Violence

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Referred to: Reference Committee K
(M. Leroy Sprang, MD, Chair)

1 Background

2
3 Resolution 608 (I-06), introduced by the American Association of Public Health Physicians
4 and adopted as amended, asked that our American Medical Association (AMA) continue to
5 study the timely issue of violence in our schools, including youth violence prevention and early
6 identification and intervention, and issue a report back to the House of Delegates. Resolution
7 610 (A-07), introduced by the American College of Obstetricians and Gynecologists and
8 adopted by the House of Delegates, asked our AMA to renew its commitment to combat family
9 and intimate partner violence and to recognize the importance of violence prevention and
10 education by including the issue in the strategic planning process.

11
12 Our AMA and this Council have been significantly involved in examining violence-related
13 issues and in developing educational resources. The AMA Policy Database contains no fewer
14 than 48 separate policies related to violence. Current AMA activities related to violence
15 include a Roadmap for Clinical Practice on Intimate Partner Violence; a Roadmap in
16 preparation on domestic and family violence; and the continued operation of the National
17 Advisory Council on Violence and Abuse, which is staffed by our AMA and comprised of
18 more than 35 state and medical specialty societies and allied health professional groups.

19
20 This Council has issued seven reports on violence since 1994 including reports on School
21 Violence in 1999, on Bullying Behaviors Among Children and Adolescents in 2002, and most
22 recently on the Diagnosis and Management of Family Violence in 2005. In 1999, our AMA
23 established the Commission for the Prevention of Youth Violence with funding from the
24 Robert Wood Johnson Foundation to apply the skills, scientific rigor, and insight of medical,
25 nursing, and public health professionals to the issue of youth and school violence. Several
26 medical specialty societies and allied health professional associations were represented on this
27 Commission, which in 2000 released its report, Youth and School Violence, and its
28 recommendations for addressing this problem. Subsequently, several other noteworthy
29 national reports have been issued, including the Surgeon General's report on youth violence; a
30 report from the National Academy of Sciences, "Deadly Lessons: Understanding Lethal School
31 Violence;" and a Presidential report issued by the Department of Health and Human Services
32 on issues raised by the Virginia Tech tragedy. Additionally, the General Accounting Office
33 (GAO) has released its preliminary findings and recommendations on the status of school
34 districts' planning and preparedness for emergency management.

35
36 The findings and conclusions of these reports remain relevant, therefore, the Council does not
37 believe a complete reexamination of youth and school violence is either needed or advisable.
38 Rather, the key points of the reports noted above are summarized to establish the current

1 framework for understanding and possibly preventing youth violence and its consequences.
2 Additionally, new findings about the effectiveness of prevention and intervention programs for
3 youth and school violence are briefly reviewed, and some emerging legal issues surrounding
4 school violence are discussed in order to inform a realistic course of action for our AMA. The
5 Council recognizes that the perpetration of violence has significant impacts on victims,
6 including those who observe, or are only present during the incident. School-aged children
7 exposed to violence may exhibit an array of acute as well as chronic symptoms for which
8 mental health interventions may be necessary. Discussion of this issue goes beyond the scope
9 of this report, but the availability of appropriate interventions and resources for victims should
10 not be neglected in addressing issues related to violence.

11 Methods

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13
14 To supplement the literature search from the previous Council reports and the reports noted
15 above, English-language studies on human subjects were selected from a MEDLINE search of
16 the literature from 1999 to August 2007 using the term “violence,” in combination with
17 “schools” or “school-based programs,” “children,” “adolescents,” or “prevention.” When high-
18 quality systematic reviews and meta-analyses were identified, they formed the basis for
19 evaluative statements about the efficacy of prevention or intervention programs. Additional
20 articles were identified by manual review of the references cited in these publications.

21 Current Understanding of Youth and School Violence

22
23
24 Based on reports issued by the AMA Commission, the Surgeon General, and the National
25 Academy of Sciences, several general points can be made, and some more recent concerns
26 identified.

27
28 Commission for the Prevention of Youth Violence. The report issued by the Commission
29 advocated a public health approach to the prevention of youth violence. That is, youth
30 violence is not inevitable, but a social problem that can be prevented by applying some of the
31 same principles that have reduced the impact of drunk driving, increased the use of seat belts,
32 and reduced tobacco use. By applying community-based methods to identify sources of the
33 problem, and epidemiological data/analyses to identify patterns of risk and protective factors
34 (as well as ongoing surveillance and monitoring to establish trends), community-based
35 interventions can be designed to reduce risk factors and enhance protective factors. The studies
36 reviewed below evaluated and monitored the effectiveness of many of these interventions.
37 Accordingly, it should be possible to share information about effective and ineffective
38 programs to educate the public and allow for the more widespread adoption of model
39 programs.

40
41 Critical influences on youth violence can be divided into individual influences (particularly
42 preexisting emotional, cognitive, and developmental, and/or psychosocial problems),
43 environmental influences (family, friends, school and neighborhood), and societal influences
44 (media and public policy). Key risk factors include alcohol and other drug use, maltreatment
45 as a child, active gang affiliation, easy access to firearms, and exposure to violence among
46 intimates and peers and in the media. Various warning signs may be apparent.

47
48 Protective factors, including intact family structures, positive peer groups, and supportive
49 communities, can buffer the effects of violence. These protective factors (or assets) may be
50 external, focusing on support, empowerment, and the setting of boundaries and constructive
51 use of time, or they may be internal and involved with establishing a commitment to learning
52 or positive values, and developing social competencies and a positive identity.

1 Preventive interventions can be primary, directed to an entire population; secondary, involving
2 and serving specific populations at risk for violence; or tertiary, wherein treatment is aimed at
3 youth who have already demonstrated problem behaviors. The Commission report also
4 identified several model intervention programs, and the key attributes of successful programs.
5 Finally, several priorities for preventing youth violence were offered by the Commission
6 including: 1) support the development of healthy families; 2) promote healthy communities; 3)
7 enhance services for early identification and intervention for children, youth, and families at
8 risk for or involved in violence; 4) increase access to health and mental health services; 5)
9 reduce access to and risk from firearms for children and youth; 6) reduce exposure to media
10 violence; and 7) ensure national support and advocacy for solutions to violence through
11 research, public policy, legislation, and funding. Each priority includes several action steps,
12 and recommendations/action steps are offered separately for health professionals, schools,
13 business and civic leaders, law enforcement and criminal justice, media, families, faith-based
14 organizations, legislators, and youth themselves.¹
15

16 Youth Violence: A Report of the Surgeon General. The impetus for the Surgeon General's
17 report was the Columbine tragedy. The report examined the scope of youth and school
18 violence, its possible causes, and how to prevent it among school-aged children (through high
19 school). The report views violence from a developmental perspective and examines how
20 youth's personal characteristics interact over time with the social contexts in which they live.
21 The report concludes that two main trajectories or pathways to youth violence can be
22 identified, with violent behavior developing either before or after puberty. Early-onset youth
23 violence shows strong links between childhood factors and an eventual persistent involvement
24 in violent behaviors; therefore, early childhood programs may be more critical for preventing
25 the onset of a chronic, violent lifestyle.
26

27 As with the Commission's report, the Surgeon General advocates a public health approach to
28 the problem of youth violence by defining the problem; using epidemiological analyses that
29 identify associated risk and protective factors; designing, developing, and evaluating the
30 effectiveness and generalizability of interventions; and disseminating successful models as part
31 of a coordinated effort to educate and engage the public. Similarly, personal characteristics
32 and environmental conditions that either place children or adolescents at risk of violent
33 behavior or that seem to protect them from the effects of risk were examined in this report. As
34 noted above, the strongest risk factors involve the family and peer influences.
35

36 Although less is known about the genesis of later-onset violence, research demonstrates that
37 prevention programs and strategies can be effective against both early- and late-onset forms of
38 violence in general populations of youths, high-risk youths, and even youths who are already
39 violent or seriously delinquent (see below). Nevertheless, many programs are ineffective, and
40 some may cause harm. Effective intervention and prevention programs combine approaches to
41 address individual risks, as well as environmental conditions. School programs that seek to
42 change social context, and not individual attitudes, skills, and risk behaviors, may be more
43 effective. Interventions designed to specifically address gangs and delinquent peer influences
44 are notably lacking.²
45

46 Prevention and Interventions for School and Youth Violence

47

48 An array of intervention programs with well-documented effectiveness are now in place to
49 reduce and prevent school and youth violence. Multiple studies have identified and examined
50 specific risk factors and the personal and environmental features of young people's lives that
51 increase the probability of violence, as well as the protective factors that appear to buffer the

1 effects of violence. Recent systematic reviews highlight the existence of effective school-
2 based prevention programs and interventions in preventing violent behavior in youth.

3 School Violence. In 2007, a systematic review was conducted by the Task Force on
4 Community Preventive Services to assess the effectiveness of universal school-based programs
5 in preventing violent behavior.³ This review focused on school-based programs that assessed
6 violent outcomes or proxies for violent outcomes. Universal programs⁴ were defined as those
7 delivered to all children in a given school or grade, not only to those who had already
8 manifested violent or aggressive behavior or risk factors for these behaviors. Pre-kindergarten,
9 elementary, middle, junior high, and senior high schools were included. Fifty-three studies met
10 the inclusion criteria. For all grades combined, the median effect of universal school-based
11 programs was a 15% reduction in violent behavior among students who participated in the
12 program. The relative reduction rates in violent behavior were as follows: 32.4% pre-
13 kindergarten; 18% elementary; 7.3% middle school; and 29.2% high school. All school
14 antiviolence program strategies (eg, informational, cognitive/affective, and social skills
15 building) were associated with a reduction in violent behavior. All program foci (eg, disruptive
16 or antisocial behavior, bullying, or dating violence) similarly were associated with reduced
17 violent behavior. With the exception of programs administered by school administrators or
18 counselors, a reduction in violent behavior was reported in programs administered by all
19 personnel, including students and peers.

20
21 In 2006, a systematic review examined the effectiveness of school-based secondary prevention
22 programs for children identified as aggressive or at risk of being aggressive. Fifty-six studies
23 met the inclusion criteria, which included requirements that participants be comprised of
24 children in mandatory education identified as exhibiting, or at risk of, aggressive behavior and
25 that school-based interventions be designed to reduce aggression, violence, bullying, conflict,
26 or anger. In 34 of the 56 trials identified, aggressive behavior was significantly reduced in
27 intervention groups compared to no-intervention groups. In seven studies a 12-month follow-
28 up was conducted and reported that reduction in aggressive behavior was maintained.
29 Subgroup analyses suggested that interventions designed to improve relationship or social
30 skills may be more effective than interventions designed to teach skills of non-response to
31 provocative situations. However, the benefits were similar when delivered to children in
32 primary versus secondary school, and to groups of mixed sex versus boys alone. In conclusion,
33 school-based secondary prevention programs to reduce aggressive behavior appear to produce
34 improvements in behavior greater than would have been expected by chance.⁵

35
36 Youth Violence. In 2004, the National Institutes of Health held a State-of-the-Science
37 Conference to examine and assess adolescent violence and related health-risking social
38 behavior and to identify directions for future research. One of the key objectives was
39 identification of the commonalities that exist among effective interventions.⁶ These
40 commonalities are as follows: they are derived from sound theoretical rationales; they address
41 strong risk factors; they involve long-term treatments, often lasting a year and sometimes much
42 longer; they work intensively with those targeted for treatment and often use a clinical
43 approach; they follow a cognitive/behavioral strategy; they are multimodal and
44 multicontextual; they focus on improving social competency and other skill development
45 strategies for targeted youth and/or their families; they are developmentally appropriate; they
46 are not delivered in coercive institutional settings; and they have a realistic expectation of
47 implementing the program as designed. Unsuccessful programs include those that aggregate
48 high-risk youth in ways that facilitate contagion, fail to clearly articulate implementation
49 protocols, have staff that are not well-supervised or held accountable for outcomes, and are
50 limited to scare tactics or “toughness” strategies.

1 In 2007, a systematic review was conducted to identify effective interventions for preventing
 2 violent youth behavior and the commonalities of effective and ineffective interventions.
 3 Primary, secondary, and tertiary interventions were examined. Of the 41 studies evaluated,
 4 49% were found to be effective, meaning one or more violence outcome indicator(s) was
 5 reported as significantly different at the $p < 0.05$ level. Overall, interventions were more
 6 effective as the level of intervention increased from primary to tertiary. Programs effective at
 7 the primary level included “Responding in Peaceful and Positive Ways” (a skills-building and
 8 conflict resolution program) and the “Aban Aya Youth Project” (school development
 9 curriculum and school/community intervention). The “Moving to Opportunity” project
 10 (moving families from high to lower poverty neighborhoods), the “Early Community-Based
 11 Intervention Program” (prevention of substance abuse and other delinquent behaviors), and the
 12 “Child Haven’s Therapeutic Child-Care Program” (for abused, neglected, and at-risk infants
 13 and toddlers and their parents) were determined to be effective secondary intervention
 14 programs. The “Turning Point: Rethinking Violence” program (to educate male first-time
 15 violent crime offenders and their parents about the consequences of violence) and the
 16 “multisystematic therapy program” (for juvenile offenders meeting *Diagnostic and Statistical*
 17 *Manual of Mental Disorders* (DSM)-III-R criteria for substance abuse and dependence) were
 18 found to be effective tertiary intervention programs.⁷ This study could not determine
 19 differences among programs and within subpopulations due to inadequate data.

21 Lethal School Violence

23 Between 1992 and 2001, 35 incidents occurred in which students came to their school or a
 24 school-sponsored event with firearms, resulting in 35 dead and 144 injured.⁸ Between 2002
 25 and 2007 (prior to the Virginia Tech tragedy), another 8 incidents occurred involving students
 26 at U.S. schools, leaving at least 12 dead. Other high profile cases occurred in Canada,
 27 Germany, and Argentina during this period, as did other incidents at U.S. schools involving
 28 adult perpetrators. These incidents created long-lasting harm and trauma to individuals and the
 29 communities involved.

31 In examining “case histories” of events that occurred between 1992 and 2001, the Committee
 32 to Study Youth Violence within the National Academy of Sciences developed some hypotheses
 33 on the antecedents of school violence in urban, suburban, and rural schools, and on the
 34 prospects for prevention of such behavior. First, the genesis of lethal school violence differs
 35 between the inner city and suburban/rural districts. Inner city school violence has not been
 36 marked by the “rampages” exhibited in suburban or rural settings. Rather, it is an extension of
 37 gun violence in the neighborhood, fueled by poverty, racial segregation, and illicit drug
 38 trafficking. It usually is based on specific grievances among individuals, although innocent
 39 bystanders may be harmed. In suburban and rural communities, grievances are more general,
 40 abstract, and aggravated, leading to rampage violence. Many risk factors have been identified
 41 in the gunmen, but protective factors also have been present in many cases.⁹

43 School and community environments certainly play a role, as does easy access to firearms. In
 44 urban/inner city schools, social disruptions are paramount, whereas in suburban schools, the
 45 existence of numerous informal and exclusive student groups in which membership determines
 46 social status, coupled with an unappreciated gulf between the community’s youth culture and
 47 adults, was more important. Nevertheless, the Committee concluded that it is virtually
 48 impossible to identify likely offenders in advance and no foolproof (or even accurate) way
 49 exists to develop a profile and predict which students at high risk will commit these kinds of
 50 acts. Areas for further research include the need to better understand the factors that might
 51 influence school shootings, including precursors (ie, nonlethal violence and bullying); signs
 52 and symptoms of developing mental health problems in grades 6-10; and the effects of rapid

1 change in increasingly affluent rural and suburban communities on youth development,
2 socialization, and violence. The Committee also called for more studies to assess security
3 measures and police response to school emergencies.

4 Emergency Management Plans

5
6 The recent Virginia Tech tragedy has reinvigorated discussion on lethal school violence and its
7 antecedents, and led to a reexamination of the challenges encountered in planning for
8 emergencies, coordinating responses, and communicating with parents and students, as well as
9 the various legal issues that complicate prevention of lethal school violence, particularly in the
10 college environment. The GAO recently completed a preliminary review of the emergency
11 management plans of school districts. In this context, planning for response to lethal school
12 violence is part of an all-hazards approach to emergency management. While no federal laws
13 require school districts to have emergency management plans, at least 32 states currently have
14 laws or policies requiring school districts to have such plans.¹⁰ An estimated 95% of all school
15 districts have emergency management plans in place and most districts practice their
16 emergency management plans annually within the school community. However, more than
17 25% have never trained with first responders and more than two-thirds do not regularly train
18 with community partners. Other challenges include lack of equipment, training for staff,
19 personnel with expertise in emergency planning, partnerships, time, and funding. Ensuring that
20 parents receive consistent information during an emergency is also of concern to school
21 officials.

22
23 Privacy Laws and Policies. In the wake of the Virginia Tech tragedy, the need to balance the
24 fundamental interests of individual freedoms, privacy and confidentiality, safety and security
25 of students, and assisting those with mental health needs to receive appropriate care became
26 apparent. The key findings in a report commissioned by President Bush following this tragedy
27 were as follows: 1) Critical information sharing faces substantial obstacles; 2) accurate and
28 complete information on individuals prohibited from possessing firearms is essential to keep
29 guns out of the wrong hands; 3) improved awareness and communication are key to
30 prevention; 4) it is critical to ensure that people with mental illness receive the services they
31 need; and 5) “where we know what to do, we have to be better at doing it.”

32
33 One of the substantial obstacles in critical information sharing is differing interpretations
34 regarding legal restrictions on the ability to share information about persons who may be a
35 threat to themselves or others.¹¹ On the federal level, the Health Insurance Portability and
36 Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA)
37 affect information sharing. However, state laws and regulations, which may be more
38 restrictive than federal laws, also impact information sharing at the state level.

39
40 FERPA was designed to protect the privacy of student educational records. The law applies to
41 all schools that receive funds under applicable U.S. Department of Education (DOE) programs.
42 A recent DOE Memo clarifies that under FERPA, schools may release any and all information
43 to parents, without the consent of the eligible student, if the eligible student is a dependent for
44 tax purposes under Internal Revenue Service rules. FERPA also permits schools to disclose
45 information from educational records to parents if a health or safety emergency involves their
46 son or daughter. Additionally, schools may disclose information from “law enforcement unit
47 records” to anyone, including parents and federal, state, or local law enforcement agencies,
48 without the consent of the student.

49
50 While FERPA applies to educational records, HIPAA applies to medical records, specifically
51 all information, written or oral, gained in the course of treatment. However, records

1 maintained by campus health clinics are considered educational records “because they directly
2 relate to a student and are maintained by the institution or by a party acting for the institution”;
3 therefore, they are covered under FERPA rather than HIPAA.¹² Disclosures are permitted
4 under HIPAA in certain situations, including when a person presents an imminent threat to the
5 health and safety of individuals and the public.¹³ The report of the Virginia Tech Review Panel
6 highlighted the confusion about the application of FERPA to treatment records from university
7 clinics and suggested that the law be amended to provide clarification.¹⁴

8
9 Access to Firearms. The report of the Virginia Tech Review Panel also highlighted the fact
10 that Cho Seung-Hui, the Virginia Tech shooter, was able to purchase handguns despite not
11 being legally authorized to do so. Under the federal Firearm Owners’ Protection Act, which
12 amended the Gun Control Act of 1968, a person who has been adjudicated as “a mental
13 defective or who has been committed to a mental institution” is disqualified from purchasing a
14 gun in the United States.¹⁵ “Adjudicated as a mental defective” is defined to include those
15 instances where a court, board, commission, or other lawful authority has determined that as a
16 result of mental illness a person is a “danger to himself or to others.”¹⁶ In 2005, Cho was
17 found to be a danger to himself by a special justice of the Montgomery County General District
18 Court. However, this information was not forwarded to federal authorities and therefore was
19 not in the federal National Instant Check System (NICS). State laws differ from federal laws
20 in defining who is disqualified from purchasing firearms. However, purchasers need to be
21 eligible under both state and federal law. The Review Panel recommended that all states report
22 information required to conduct federal background checks on gun purchases. However,
23 consensus is lacking on the types of mental health data that should be reported for inclusion in
24 gun background check databases.

25 26 Summary and Conclusion

27
28 As the many reports and studies summarized above suggest, schools are making progress in
29 violence prevention. Many schools have already adopted emergency management and
30 violence prevention plans; however, these plans need to be fully implemented and practiced.
31 The Virginia Tech tragedy has also brought several legal and policy issues to the forefront.
32 Privacy laws need to be further clarified to ensure that critical information is shared. In
33 addition, state and federal laws related to the reporting of mental health data for gun
34 background checks must be enforced.

35 36 RECOMMENDATIONS

37
38 The Council on Science and Public Health recommends that the following statement be
39 adopted and that the remainder of this report be filed:

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41 That our American Medical Association re-examine its role in implementing current
42 AMA policies related to violence prevention, and include such issues in a strategic
43 issue paper. (Directive to Take Action)

Fiscal Note: \$15,000

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- 45 ¹⁴ Mass Shootings at Virginia Tech: Report of the Review Panel Presented to Governor Kaine,
46 Commonwealth of Virginia; August, 2007.
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