SPECIAL SECTION

Forum on Youth Violence in Minority Communities: Setting the Agenda for Prevention

Summary of the Proceedings

December 10–12, 1990
Atlanta, GA

This forum came about because of the action and commitment of three health officers, Woodrow A. Myers, Jr., MD, Health Commissioner for the City of New York, Deborah Prothrow-Stith, MD, former Health Commissioner for Massachusetts and currently an Associate Dean of the Harvard University School of Public Health, and Reed Tuckson, MD, former Commissioner of Health of the District of Columbia and currently a Senior Vice President of the March of Dimes.

They met with James O. Mason, MD, DrPH, the Assistant Secretary for Health and head of the Public Health Service, and urged him to recognize youth violence in minority communities as a very important public health problem that required immediate attention. Dr. Mason then asked the Centers for Disease Control to devise a strategy to respond to this very important problem. This forum represents a first step in a strategy for moving from analysis to action in the field of violence prevention.

This forum was cosponsored by the Centers for Disease Control and the Minority Health Professions Foundation. The Morehouse School of Medicine, a member of the Minority Health Professions Foundation, served as the coordinating institution for the Forum.

To provide the 110 participants and observers with as much information as possible on the current status of interventions in the field of violence prevention, background papers for the conference were prepared by the Education Development Center, Inc. The development of these papers was supported with funds from the Centers for Disease Control and the Carnegie Corporation of New York. Summaries of these papers appear on pages 269–277.

This summary of the proceedings represents the thoughts and deliberations of the participants. The papers, reports, and abstracts do not necessarily reflect the policy or opinions of the Centers for Disease Control, the Public Health Service, or the Department of Health and Human Services. Nor do they necessarily reflect the policy or opinions of the Minority Health Professions Foundation or the Carnegie Corporation of New York.

The following employees of the Division of Injury Control, Center for Environmental Health and Injury Control, Centers for Disease Control, played key roles in the organization of this forum: James A. Mercy, PhD, Chief, Epidemiology Branch, and Timothy N. Thornton, Public Health Advisor, Program Development and Implementation Branch, had primary responsibility for organizing this forum and deserve the greatest credit for its success. Patrick W. O'Carroll, MD, MPH, Chief, Intentional Injury Section, Epidemiology Branch; Kenneth E. Powell, MD, MPH, Medical Epidemiologist, Intentional Injury Section, Epidemiology Branch; and Mark L. Rosenburg, MD, MPP, Director, Division of Injury Control, made fundamental contributions to the conceptualization of this forum and the preparation of the proceedings.

Many other people contributed to the success of the forum:

Renee Wilson-Brewer, Stu Cohen, and Cheryl Vince of the Education Development Center, Inc.; Elena Nightingale and David Hamburg of the Carnegie Corporation of New York; Dan Blumenthal, Meryl McNeal, Mary Davis, and Pauletta Graves of the Morehouse School of Medicine; Randall B. Hirschhorn of the Department of Health for the City of Philadelphia; Mary Ann Fenley of Fenley Communications; La Tanya Beale, Jackie Buckingham, Diana Curtis, Lisa Daily, Sandra Emrich, Juarlyn L. Gaiter, Marcella Hammett, Jacob A. Gayle, Denise Johnson, Robert J. Kingon, Marilyn L. Kirk, Tracy Little, Mark S. Long, William A. Murrain, Nancy Nowak, E. Chukwudi Onwuachi-Saunders, Mary Post, Ann Shields, Leisha Ware, and Rueben C. Warren of the Centers for Disease Control.

James A. Mercy and Mary Ann Fenley edited the conference proceedings.

Send requests for copies of the background papers and tearsheets of the Proceedings to Division of Injury Control, CEHIC, Mail Stop F36, Centers for Disease Control, Atlanta, GA 30333.

Foreword to the Proceedings

Vernon N. Houk, MD, Assistant Surgeon General, Director, Center for Environmental Health and Injury Control, Centers for Disease Control

Rueben C. Warren, DDS, DrPH, Assistant Director for Minority Health, Office of the Director, Centers for Disease Control

WHILE GREAT STRIDES have been made in improving the health of the American people, there is still a marked disparity in the burden of death and illness borne by ethnic and minority populations compared with the majority white population.

Homicide and nonfatal injuries resulting from interpersonal violence account for much of this disparity, particularly among African, Hispanic, and Native Americans. It is clear that if the benefits of good health are to be extended equitably to all who live in the United States, we must be as vigilant in our efforts to prevent injuries from violence as we have been in addressing infectious and chronic diseases.

We must specifically target ethnic and racial groups and low-income populations in our efforts. It is important to recognize, however, that minority status per se has little to do with an individual's violent behavior or risk of victimization. Rather, research suggests that minority status simply may be associated with other factors—such as socioeconomic status—that, in turn, influence violent behavior and the risk of victimization.

If preventing death and injuries from violence is to be addressed, we must consider simultaneously several extremely contentious political and social issues such as poverty, racism, unemployment, and lack of educational opportunity. In addressing these issues and continuing the search for effective strategies to prevent violence, we must avoid polemics and emphasize a scientific perspective.

Nowhere is the need for a scientific perspective greater than in considering the role of firearms in youth violence. Firearms injuries of all types take the lives of more than 30,000 people in the United States each year. Firearms injuries also disproportionately affect minority populations. African American males face more than twice the risk of dying from a gunshot wound as white males. Consequently, in addressing the issue of violence, we cannot and will not stray from a commitment to address firearms injuries as diligently as we have addressed, with measurable success, other threats to the public's health.

Violence has been established as an important public health problem. Now is the time for concrete actions to prevent youth violence in minority communities. We must directly confront the pervasive notion that nothing can be done to reduce the shamefully high toll of violence in poor and minority communities.

Taking action requires breaking the cycle of financial nonsupport. Violence prevention efforts have received little funding because of the perception that violence is primarily a criminal justice problem and that effective violence prevention strategies do not exist. Few funds, however, have been available to undertake the scientific and programmatic work needed to identify cost effective interventions. To break this cycle, people working in violence prevention must be willing to have their activities evaluated and to modify programs in accordance with evaluation results.

Four steps are of immediate importance in moving from analysis to action in the field of violence prevention.

1. We must develop guidelines for the design, implementation, and evaluation of community youth violence prevention programs. This forum has provided much information that will help to fill the current void in the availability of clear, concise, culturally sensitive, and culturally specific guidelines for targeted community action.
2. We need to establish partnerships between Federal, State, and local governments and communities, so government can assist communities better in designing and implementing community youth violence prevention programs.
3. We need to evaluate rigorously those interventions that hold the greatest promise and apply the results of these evaluations in community violence prevention programs.
4. We need to build the public health infrastructure for delivering violence prevention messages and interventions to those in greatest need. Such an infrastructure should include both material and human resources. We can begin this process by establishing fellowships and training programs to build a cadre of people who can lead and facilitate community efforts to prevent youth violence.

There is a plan. There is a diverse group of talented people committed to the goal of violence prevention. The time to act is now.

Background of the Forum

THE OMNIPRESENT threat of violence in the lives of many thousands of America's minority youth severely detracts from the quality of life in minority communities. Despite an urgent need, there is little guidance currently available for communities that wish to develop their own violence prevention programs. The absence of useful guidance is attributable to three factors.

First, we know less than we would like to about effectively preventing death and injuries from youth violence. Second, what is known about prevention—based on innovative efforts by a variety of communities as well as scientific research to date—has not been assembled in a clear, concise way for communities to use. Third, there has been no accepted locus of responsibility for helping communities to address the primary prevention of violent death and injuries. Although the myriad of social and environmental problems that engender violence might be amenable to a broad variety of interventions, our society has heretofore relied almost entirely on a criminal justice approach.

To begin addressing these issues, the Centers for Disease Control of the Public Health Service and the Minority Health Professions Foundation (with the Morehouse School of Medicine serving as the coordinating institution) sponsored The Forum on Youth Violence in Minority Communities: Setting the Agenda for Prevention.

Interpersonal violence is a public health problem that impacts all segments of American society. Each year, more than 20,000 people die and more than 2.2 million suffer nonfatal injuries from interpersonal violence (*1,2*). Young people from racial and ethnic minorities in particular are at an extraordinarily high risk of death and injury from interpersonal violence.

Homicide is the leading cause of death among both male and female African Americans, 15–34 years of age (*1*). In 1989, an African American male had a lifetime probability of being a murder victim of 1 in 27, compared to a white male's probability of 1 in 205, according to unpublished data from the Federal Bureau of Investigation.

Hispanic males and Native Americans are also at high risk of homicide victimization. In the Southwest, the homicide rate for Hispanic males has been found to be more than three times the rate for non-Hispanic white males in the region (*1*). The risk of homicide for American Indians and Alaska Natives is more than double that for all Americans (*3*).

Homicide, however, which represents the fatal level of interpersonal violence, is only the tip of the iceberg. Each year more than 450,000 African Americans and Hispanics suffer nonfatal injuries from nonviolent and abusive behavior (*2*). Rates of nonfatal injury from interpersonal violence, like homicide, are disproportionately high for young people, males, African Americans, and Hispanics (*2*). Assault, primarily in the context of marital or dating relationships, is also a major source of injury among African American females (*4*).

The purpose of the forum was to (*a*) summarize what is known about violence prevention so that this information can be applied immediately by minority communities and (*b*) determine priorities for the evaluation of violence prevention programs so that future research can be appropriately targeted. With this knowledge, the sponsoring groups, State and local health departments, and minority communities themselves will be better able to implement effective violence prevention programs and encourage research in the development of promising intervention strategies.

The forum focused on minority communities for several important reasons. First, people living in many minority communities face an extraordinarily high risk of death and injury from violent and abusive behavior. Because the need for action is greatest in these communities, they should be the first to receive resources available for the prevention of youth violence.

Second, the successful implementation of youth violence prevention programs will depend heavily on the development of effective working partnerships between minority communities and the public and private sectors. These partnerships must be developed in such a way as to respect each community's right of ownership of this problem and the means of resolving it. The information that emerges from this forum is intended to provide the knowledge base and establish the environment necessary to empower minority communities in their efforts to achieve the goal of prevention.

Finally, a focus on minority communities is justified because of the need to ground violence prevention programs in the particular cultural milieu of each community. African American, Hispanic, Native American, and Asian communities each have unique cultural traditions that must be respected and reflected in the development of prevention strategies. Strategies for violence prevention, as with other public health interventions,

must be culturally sensitive and culturally specific in order to achieve their maximum potential.

The conference consisted of a combination of plenary and working group sessions. After the opening plenary session, participants attended one of five working group discussions, which focused on the following areas:

1. principles of community intervention,
2. violence prevention strategies focused on minority youth in general,
3. violence prevention strategies targeted towards high-risk populations of minority youth,
4. weapons and youth violence, and
5. interventions in early childhood.

The Education Development Center, Inc. of Newton, MA, prepared background papers for each working group.

Panel discussions were held in plenary sessions on the afternoons of the first and second day of the forum. The first panel addressed the successes and setbacks of ongoing community violence prevention programs. The second panel shared information about how to develop a public-private partnership to facilitate a planned, long-term funding effort for violence prevention in minority communities.

The Centers for Disease Control will use the conference proceedings to develop guidelines for community violence prevention programs and priorities for evaluation research. The community guidelines and evaluation priorities will be based on information acquired through the forum deliberations, the background papers prepared for this forum, and other relevant sources.

References

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3. Injuries among American Indians and Alaskan Natives, 1990. Indian Health Service, Public Health Service, Rockville, MD, 1990.
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The Necessity of Social Change in Preventing Violence

MANY PARTICIPANTS in the forum shared the concern that while public health efforts to prevent deaths and injuries due to youth violence should be expanded, it is imperative to recognize the larger social context in which violence occurs.

Marked economic and social disparities among Americans contribute to the etiology of violence in fundamental ways. Poverty, joblessness, and the lack of real employment opportunities promote violence by generating a sense of frustration, low self-esteem, and hopelessness about the future.

Racism also contributes to violence, both directly—through the anger caused by the experience of racial discrimination—and indirectly, by depriving certain segments of society of the opportunities to be successful in school and work. The poor in our society, who are disproportionately African American, Hispanic, and Native American, do not have equal access to our criminal justice, health care, and educational systems. The tendency in this society to equate individual attainment with self-worth, without regard for equal opportunity, contributes to the frustration and anger associated with violence.

Faced with such bleak prospects, some minority youth have feelings of anger and hopelessness about the future. Many sense that it does not matter what they do because they do not believe they will live to see middle age.

In the final analysis, if we are to prevent deaths and injuries from interpersonal violence, fundamental societal issues must be addressed. These larger social problems, however, must be addressed at the same time that we take whatever immediate actions possible to prevent further injuries and deaths from violence. This parallel approach provides the best opportunity for both short- and long-term success in reducing the toll of violence in American society.

Opening Keynote Address

The Prevention of Minority Youth Violence Must Begin Despite Risks and Imperfect Understanding

William L. Roper, MD, MPH, Director, Centers for Disease Control, and Administrator, Agency for Toxic Substances and Disease Registry

I AM CAREFUL to call this a forum and not a conference because I know that your primary task during the next few days will not be to sit and listen to speakers such as myself, but to engage in critically important discussions among yourselves, to translate what is known about violence prevention and community organization into meaningful recommendations for prevention.

It is no exaggeration to say that the need for effective violence prevention measures—and thus the need for this forum—is critical. Homicide has become the tenth leading cause of death in the United States and the sixth leading cause of years of potential life lost. Among young people 15-24 years of age, homicide is the second leading cause of death, surpassed only by unintentional injuries. Youth homicide rates in the United States are not only unacceptably high, they represent a national disgrace: the homicide rate among young males in the United States is roughly 20 times higher than homicide rates in most other industrialized nations.

Minority Homicide

But if youth homicide rates in general are unacceptably high, homicide rates among the youth in our minority communities are even higher. Homicide rates among young black males are seven to eight times higher than among white males. Incredibly, homicide is the leading cause of death among black youth, both male and female, accounting for about 6,000 deaths each year. Young Hispanics and Native Americans are also at increased risk of homicide; homicide rates among young Hispanic males and among young Native American males are four to five times higher than among non-Hispanic white males. Homicide rates for Native American females are three times greater than among young white females.

All these numbers tell a story, but they do not tell the whole story. They do not tell us about the senseless killing of a young mother and her infant child, gunned down in apparently random violence. They do not tell us about the woman who is permanently paralyzed after being shot in the neck by her own husband in a fit of rage. And they do not tell us about another type of wasted life, the life of a man that will be spent in prison for killing two other men over the business of selling drugs. These terrible tragedies occurred right here in Atlanta—and all of these tragedies, and several more, occurred in just the past several weeks. This is not to single out Atlanta. This sort of violence is practically a daily occurrence in most cities throughout this country.

The high rate of homicide, and the disproportionate burden of homicide on minority communities, has been a concern for health professionals for some years now. In the late 1970s, a broad set of health objectives was developed for the nation, and a specific objective was included—to reduce the rate of homicide among 15- to 24-year-old black males.

I am sorry to report that, not only are we *not* going to achieve the targeted reduction in homicide rates, but the problem has actually been getting worse in recent years. An analysis of mortality data published in December 1990 by the Centers for Disease Control (CDC) in the Morbidity and Mortality Weekly Report presents some disheartening findings: from 1984 to 1987, the homicide rate among black males, ages 15-24, has risen 39 percent. It is now seven to eight times the rate of white males in the same age group, and 17 to 283 times the rate of males, ages 15-24, in other developed countries. Among young people, 15-24 years of age, the homicide rate for the younger half of the age group—15- to 19-year-olds—is rising particularly fast. Since 1984, the homicide rate among these adolescents has risen 53 percent.

Death by Firearms

A particularly striking finding in the analysis of recent trends in youth homicide is the prominence of guns. More than *95 percent* of the increase in homicide rates among young black males in recent years is attributable to firearms. Firearms account for 82 percent of the homicide deaths among black males, ages 15-24. In contrast, firearms account for 70 percent of homicide deaths among white males, 55 percent among black females, and 46 percent among white females in this age group. I know that one of the work groups for this forum will specifically address the issue of guns and violence,

and I applaud your determination to tackle this sometimes contentious issue.

Geographic Variation

Another important finding of the CDC analysis was the importance of geographic variation in youth homicide rates. Five States (New York, Florida, Michigan, Missouri, and California) and the District of Columbia have homicide rates among young black males that exceed 100 per 100,000 population. The homicide deaths in just these five States and the District account for *more than half* of all homicides among 15- to 24-year-old black males in this country. This information, while it does not tell us what to do to prevent homicides, certainly indicates where we must focus our limited prevention resources. And yet we should not assume homicide is a problem only in our big urban centers; our analysis indicates that homicide rates have increased in recent years in communities across the spectrum—from rural to urban.

That's the bad news. The good news is that the work you propose to do in the next few days is exactly what is needed, the first necessary step that will begin to move us forward toward real homicide prevention. While it is true that we have made little progress toward the homicide Health Objective I mentioned previously, it is also true that when that Objective was written in 1978, no one—in or out of the health sector—had any notion of how to proceed to work toward that objective.

That "notion" is what you will develop, and that is why this forum is so important. Ultimately, we need to be able to promulgate a program of scientifically proven homicide preventive interventions. But we will not reach that level of scientific certainty for a while, and the problem of homicide is too urgent to wait until all the answers are in. That is why the first thing we must do is get out there in the communities and develop programs that seem to make the most sense, given our current scientific understanding and real-life experience.

Three Themes

I would like to discuss three themes on which I have focused since coming to CDC last year, three themes that I think are all addressed at some level in this very forum on preventing youth violence. These themes are improving the health of children, improving the infrastructure of public health, and making prevention a practical reality in our health systems.

The health of children. As to the health of children, the statistics I have already cited speak only too clearly of the health impact of this problem on young people, and especially among minority youth. What they do not speak to is the genesis of violent behavior, which has its roots early in childhood, when children are physically abused, or witness violence in the family, or grow up in communities where violence is all around them. I am very pleased to see that one of the workshops will focus on preventing violence among adolescents and young adults by intervening much earlier—with young children.

Public health infrastructure. My second theme is strengthening the infrastructure of our public health system. What does this mean? Infrastructure in public health includes individuals and institutions that, when working together effectively, promote and protect the health of people. The public health infrastructure consists of strategies, facilities, material resources, but above all, the human resources committed to transforming our nation's health. The local public health agencies are at the heart of the public health infrastructure, but there is clearly room for contributions from voluntary health groups, community-based organizations, and agencies in other sectors whose work impinges on health. I believe that the infrastructure of public health in general is in need of improvement and must be strengthened. With regard to the delivery of services that will prevent violence, however, we are only now *beginning* the process of developing the necessary public health infrastructure. What it will finally look like will depend to a large extent on what particular actions we must take to prevent these violent injuries and deaths—and we are counting on each of you attending this forum to help us figure out what those actions will be.

Prevention. My final theme is making prevention a practical reality in our health system. We have done miracles with our advanced medical care system, and we can be justly proud of those accomplishments. But it is always better to prevent diseases and injuries than to treat them, however effective the treatment may be. When it comes to violent injuries, especially among otherwise healthy young people with many decades of life before them, prevention is and must be our primary emphasis. Again, this theme no doubt resonates

throughout this forum: How can we prevent violent injuries and deaths among the youth in minority communities? How can we reduce the toll of violence through prevention?

One critical component to making prevention a practical reality is convincing people that it works. Without this conviction, the best programs might never be implemented outside the communities where they are developed. It is for this reason that *evaluation* is so critical to the practice of public health. No, we should not and will not wait until all the answers are in before we act to prevent violence. But, having recognized the need for action, we should work in parallel with that action to rigorously determine which interventions are effective, and which are not. Of those that are effective, which are generalizable? Which are sensitive and appropriate to the culture of the community served? Which are least costly?

Answers to these questions will be the key to encouraging the development of violence prevention activities throughout the country, and they will be instrumental in attracting resources—human and otherwise—to this field. That is why one goal of this forum is to identify promising interventions to prevent violence that would be good candidates for evaluation research.

The challenge which you have taken up at this forum is large, and I applaud your courage in taking it up. Let me close with a quote from Harold Shapiro, President of Princeton University, who said,

> "The willingness to risk failure is an essential component of most successful initiatives. . . Successful change depends upon experimentation with uncertain results."

Professor Shapiro was careful to note that he was not recommending failure; nor do I! But I do recommend that you approach your deliberations with the conviction that, although you are being called upon to make recommendations based on sometimes imperfect knowledge, they will represent the best, most carefully considered recommendations possible.

Violence is a Greater Killer of Children than Disease

Antonia C. Novello, MD, MPH, Surgeon General of the Public Health Service

I CONGRATULATE the Centers for Disease Control (CDC), the Minority Health Professions Foundation, and Morehouse School of Medicine for this fine meeting. Violence among young people in minority communities is an important topic.

As a pediatrician, I am struck by the efforts that have improved the health of children, the efforts to develop vaccinations and to monitor growth and development. Yet violence kills even more surely than pertussis, harms more often than measles. Our society has not responded with the intensity required to deal with such a menace to public health.

Injuries are the number one killer of children. The rate of homicides—let's be blunt, the rate of murders—is increasing faster among teenagers than among young adults. The sad thing is that violence is as lethal as the diseases being treated in clinical trials.

Young people, particularly those who are excluded from many of the opportunities that this country offers, are at high risk for violence. Many are immersed in violence in ways we can scarcely imagine.

A recent Morbidity and Mortality Weekly Report (MMWR) provided figures that give meaning to this meeting (*1*). MMWR reported that the homicide rate for black men, ages 15-24, has risen 40 percent since 1984. Firearms-related homicides accounted for 80 percent of the deaths and 96 percent of the increase in the homicide rate for young black men from 1984 through 1987. And this is today. Imagine that by the year 2000, the proportion of the nation's 18- to 24-year-olds will increase from one in four to one in three.

We know that homicide rates among young black men are seven to eight times higher than among white men. Homicide rates among black women are three to four times higher than among white women. The same pattern holds for Native American women; the rate for them is three times higher than among white women. Fatal and nonfatal assaults among blacks and other minority groups were three times the respective rates for whites.

The factors identified as important to homicide include immediate access to firearms, alcohol and

substance abuse, drug trafficking, poverty, racial discrimination, and, in some situations, cultural acceptance of violent behavior.

We must remember, however, that minority men are not naturally less caring or more violent. There is always a reason, sometimes many terrible reasons, for this behavior.

The roots of violence may extend as far back as before birth. Many children today are born into violence and never see any other way of expressing intense feelings except through violence. These children have either been subjected to violence in their cribs or neglected because of turmoil in their homes. And as a pediatrician, I can tell you that neglect is also a kind of violence that can kill. One study showed that in the United States each year 675,000 children are abused or neglected (*2*).

I attended a conference on homeless children and youth at Meharry College in October. There I learned that every day in this country, 30 children suffer gunshot wounds. Two Chicago researchers, C.C. Bell and E.J. Jenkins, reported in an unpublished paper that in Los Angeles County in 1982, 10 to 20 percent of the homicides in the city were witnessed by children, and in Chicago, virtually all the children in a public housing development had a first-hand encounter with a shooting by age 5. In 1985, children witnessed 17 percent of the homicides in Detroit, according to an unpublished City of Detroit study by Batchelor and Wicks. A study in a Chicago school found that 26 percent of the children had seen a person shot, and 29 percent had seen a stabbing (*3*). Do you wonder why when they are older, they want to get a gun? Children learn what they see. How can we ask these children to act differently? Have they ever known that there are different ways to express feelings and, if so, have they seen them work? Early experience has lifetime impact.

I am concerned about violence by and to women. Although homicide rates for men are higher, too many women are victims of intimate violence. Too many women eventually rebel or, as a price of association with a man, participate in violence. Too many women may be under the influence of substances that impair judgment and live in violent situations.

Last summer, I visited the Wind River Reservation in St. Stephens, WY, where a terrible series of suicides were occurring among teenage boys. Tribal members wept, and Indian Health Service professionals grew very quiet talking about these sad events. I was there in time for a crisis roundtable and review. Everyone was struggling to help. Some conventional ideas could not be put into practice. For example, telephone hotlines could not be used because people did not have telephones. Adolescents in trouble could not be reached when they lived too far from the clinics and there was no transportation.

Just as it is in our cities, these young Native American men were very demoralized without employment, a terrible problem in and out of reservations. Still, with ingenuity and great devotion to helping stem the continuing occurrence of the suicides, the elders of the tribe, the men, included the young men in an ancient ceremony that reinforced their tribal connections, and the series of suicides stopped.

I know that this sort of self-destructive behavior is not strictly part of your topic. But many of the principles apply. Self-destruction is only a hair away from violent attacks on others. Today we have lethal combinations of drugs, alcohol, and guns available in all our cities and suburbs, not just on our reservations.

I mention the Wind River episode because you have been asked to be creative in your working groups. I would urge you to be broad in scope as well. Think of old ways, think of any method that might be used to restrain violence. A number of new social philosophers such as the poet Robert Bly are suggesting that older men might play a major role in helping young men who have virtually given up. We may find that we need to go back to very old paths to find a new way to combat violence.

We all need to remember that working with teenagers requires sensitive judgment—one day they must be approached as adults, the next as children. We can work with parents, but teenagers must be consulted as well. I believe in telling teenagers the straight facts. This is not an easy task, but we cannot expect young people to do as we tell them if the concepts are abstract. Like any other human beings and in spite of their age, they need the truth.

We could debate whether it is poverty or race that so intensifies patterns of morbidity and mortality, that so darkens the picture for violence, but at this point in time, suffice it to say that they do overlap and are real issues. We say in Spanish that one cannot hold one's hand up to block the sun. We must face the facts to make a difference. The facts tell us that more than half of all African American and Hispanic children in this country live in cities. In 1987, nearly 40 percent of New York City children were poor and as a consequence

dejected; of these, 86 percent were African American or Latino. New York has 43,000 children in foster care and 6,000 in shelters for the homeless. Each night more than 100,000 American children do not have a place to sleep. We know that more than 20 million Americans are hungry—a form of severe deprivation, weakening all controls and increasing a sense of helplessness.

It may be necessary to sensitize ourselves to violence to stop accepting it! As a country, we are fatalistic about violence and injuries until it affects our lives. Abbie Hoffman said that "Violence is as American as apple pie." Maybe we need to make it un-American. Judging by our movies and television, we idolize the reckless and the violent. Perhaps we must point out to our children that these fictional stories use stunt men, highly trained and very fit. Perhaps we have to break the illusion that guns do not really hurt, or that dying is only part of a plot.

We barely understand what happens to a child raised in a violent environment. We have learned a great deal about post-traumatic syndromes. We know that women are caught in cycles of family abuse and violence. We are learning that being abused weakens one's ability to resist abuse, a concept that is very difficult to understand.

We need culturally sensitive programs. We must know Harlem to design a program for Harlem; we must know the barrios of Texas to be able to work there. Programs must be in the language of the people who will hear them. Parts of Appalachia can be as desolate as any inner city slum. In spite of problems and stereotypes, no one has a higher opinion of America than a minority group member. We see the American dream, but it is much harder to do the best when there are so many stumbling blocks and so much negativism along the way. America has been known to solve problems; I am certain that America can solve the problem of violence, can save its young people from becoming violent or being exposed to danger and injury. Americans love their children and will protect them.

I am glad your emphasis at this meeting is on prevention of violence. Your second objective is to determine priorities for the evaluation of programs to prevent violence so that future research can be targeted appropriately. I applaud this.

As the Surgeon General, I want all Americans to be healthy and safe, to have the best out of life and to bring the best to life. Your forum goes to the heart of a very serious issue. Prevention of violence is ultimately our only road to success, and many lives depend on this. As you work with this subject, remember that our young people are our future, yours and mine. We must come up with solutions before it is too late. I know we can. There is not a moment to waste.

References

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Charge to the Participants: From Analysis to Action

Mark L. Rosenberg, MD, MPP, Director, Division of Injury Control, Center for Environmental Health and Injury Control, Centers for Disease Control

THIS CONFERENCE will be a turning point in the prevention of violence among youth at highest risk, young people in minority communities. We are ready to turn analysis into action. We are now familiar with the analysis, having heard at many conferences how serious the problem is. This message has been repeated so many times that it has taken its toll on us. In fact, there are people who chose not to come to this Forum because they have attended at least one conference too many. We are ready to move on and we are counting on the participants of this Forum to help make that transition.

To get something done, we must proceed differently, and I would like to outline six steps that will be important.

1. We must continue to expand our scientific knowledge. The actions we decide to take should flow from scientific analysis, from the scientific generation of policy options, and from evaluation. We must find out what works. We have to evaluate our activities first of all for the decision makers who fund us, but more importantly, we must evaluate them for ourselves. People will ask us what works; they need to know what to do. Therefore, we need to know the answers to many questions.

'We have to start to make a difference today. Achievement will take a while and 10 years is probably a reasonable target date, but we must start now.'

What are the risk factors? Who is at highest risk? What difference does it make if you have access to firearms? What difference does it make if you are poor? How does science help to answer this last question? We usually think of homicide as a problem which disproportionately affects blacks. We know, as well, that if you control for socioeconomic status, the difference in homicide rates between blacks and whites almost goes away; violence is a problem that disproportionately affects poor people. On the basis of our science then, we can say that homicide is a "problem of poverty." As we continue to gather scientific knowledge, we will improve our understanding of a wide range of risk factors like race and poverty.

2. We must inform and educate the public, decision makers, and targeted risk groups. Consider what was done to inform and educate people about the other "H" problem. The other "H" problem, as many of you know, has also decreased the life expectancy of black men. The other "H" problem is HIV infection and AIDS. For HIV-AIDS, the 11th leading cause of death, there was an AIDS information and education campaign launched with a $7 million initial effort. That campaign included a brochure that was mailed to every household in this country—107 million households. It was a tremendous effort which I believe had a large effect. It was not cheap; the cost of that mailing was at least $17 million. So the campaign to address the 11th leading cause of death began with a $24 million effort. Can we do anything less for homicide, the 10th leading cause of death?

It is also important to note that the AIDS campaign was begun without a "magic bullet." There was no simple, cheap, and proven effective way to stop the virus. In fact, at the start, probably less was known about how an infectious agent causes that problem than we know about violence. So even though we do not have all the answers, it is time to start an education campaign.

An editorial in the New York Times, titled "The Shame of Measles," said that we cannot accept deaths attributed to measles in this country. There were 40 deaths of children last year from measles because our nation eased up on our immunization campaign. The editorial stated "for our country, this is a disgrace." Well, that *is* a disgrace, but we are here to look not at 40 deaths, not 400, not 4,000, but 40,000 deaths from violence. This is a disgrace. The Times editorial said that people are not supposed to die from measles, but are people supposed to die from violence? Professor Darnell Hawkins, of the University of Illinois at Chicago, said that this toll, this cost of violence, is one that this society finds acceptable. Otherwise, society would have acted to prevent it. It *is* clear, however, that *we* do not find it acceptable and I think once Americans understand the problem, they will not find it acceptable either.

3. We need to reach beyond our own professional disciplines. As we have progressed in the analysis of the violence problem, we have been working with groups that traditionally have not been considered public health partners. The traditional range of occupations that have been thought to work for the public's health goes beyond health care professionals to include sanitation workers who pick up our garbage and the restaurant inspectors who check out where we eat.

But the new team working on the public health approach to violence includes the social workers who look after reportedly abused children and the police who arrest the husbands of battered wives. It's a large team now, but is it coordinated? Or is it a team that looks like it is in a three-legged race? This team can come together, but it will take a lot of work, and the work required from us will be different as we go from analysis to action.

4. We cannot wait for perfect knowledge. People in public health never wait for perfect knowledge; that is part of what makes us different. An example of this approach is the decline in rates of tuberculosis. The rates for respiratory tuberculosis started to fall in England and Wales more than 100 years before we developed either a vaccine or effective drug treatment for TB. The public health team did not have perfect knowledge, but they did not wait. They understood that tuberculosis is spread by conditions that are unsanitary, by poor housing, poor hygiene, and poor nutrition. They saw these patterns by analyzing their data, by scientific analysis, and they did something to change those conditions. They started 100 years

before they had that perfect knowledge, 100 years before they had an effective vaccine or antibiotic.

I think we can do no less to prevent violence. We did the same thing for AIDS when a campaign was started to change those behaviors that put people at risk. We did not have perfect knowledge—and we still don't—but the campaign to prevent AIDS continues at full strength.

5. We need to empower communities. Communities are the key to success in this effort. Bill Foege, a former Director of CDC, says that the first step is to empower ourselves with two simple concepts. First, we must realize that we live in a cause and effect world. Things happen for a reason; cause and effect, not fate, is the reason. We can understand the world better if we understand those reasons. Secondly, we, as individuals, can change the way things happen. We can change the effect by influencing the cause, we *can* influence the outcomes. Psychologists tell us this is a very important concept. We have all experienced days when we felt powerless and discouraged. But the sun comes out when hopelessness is replaced by a sense of being in control, and the sense that we *can* do something. This is empowerment.

We can make the difference; we can have an impact on violence. We can change things. First, we need to empower ourselves and then transfer that power to communities. There are many examples where this has been done, but we need to bring the message to communities. We cannot do the work without them.

6. We need to take charge and start now. As I was preparing for this conference, I thought about the slogans of the 1960s. In the mid 60s when we camped in Washington, the slogan was "Peace Now!" The slogan was not "Peace by the year 2000." The Year 2000 health objectives are good, but our slogan must be "Peace Now." We have to start to make a difference today. Achievement will take a while and 10 years is probably a reasonable target date, but we must start now. A better slogan for the 1990s might be the Nike slogan "Just do it." Get out there and do it.

During this meeting, the most important activities will happen in the work groups. In these groups, each person has something to contribute, even if they have not worked directly on the problem of violence. Many are here because of what they know about other public health approaches and problems such as health education, AIDS, tuberculosis, sexually transmitted diseases, or community organization. We need to use the knowledge gained from those areas to make a difference in the prevention of violence. We need your help as we figure out what will make a difference. Each work group has been asked to develop two short lists, one citing what communities can do now to prevent youth violence and the second, listing what we need to evaluate if we are to determine what works.

The first work group is going to look at strategies for the general population of minority youth. This group may apply some of the lessons we learned from the behavioral sciences. For example, knowledge alone is not enough to change behavior, and once behavior is changed, it must be maintained. The fact that a young man was not violent at age 16 will not save him from the consequences of violent behavior at age 25. The behavioral sciences have also taught us that some people are harder to change, and we are limited in applying what we know about one group to another. For example, we cannot apply what we learn about the upper-middle class population to some lower-socioeconomic status groups, particularly when we consider different racial or ethnic groups. Credible sources must give the message, and the message has to be reinforced by group norms.

Dennis Tolsma, an international expert in health education, coined the phrase that describes this approach as "multiple channels, multiple times," that is, say the message many times, many ways, over and over and over.

Another principle this group may consider is that perceived risk often differs from the true risk. People on our most crowded urban streets may have an unbelievably high risk of homicide, but people get used to it, and they believe that their risk is not very high, particularly if they, like most teenagers, think they will never die. Therefore, their *true* risk may not affect their behavior.

The second work group will look at prevention strategies for high-risk groups. Why do we pick high-risk groups? Because we can get the "biggest bang for the buck" if we reach this high-risk group, the group that may pull the trigger or take a knife to school. If we can concentrate scarce prevention resources where we can have a bigger impact, we may get more results faster.

Targeting high-risk groups is tough. How do you develop credible and effective messages for them? Taking on the groups at highest risk may be the hardest task, but we have confidence that this work group will solve the problem.

The third work group will look at weapons, a very important problem. We have all seen and heard through many channels that increasingly, it is the youngest age groups that have the highest rate of increase of homicide. While the rates are leveling off for older people, they are increasing rapidly for younger people. Dr. Novello said that we do not know whether to call them young adults or children. As I get older, they look more and more like children. It is a problem of children; it's a problem of *our* children. It's a problem of children as victims and children as perpetrators.

From 80 to 95 percent of the homicides among minority youth are related to guns. People shoot the people they know, and they shoot the people in their own age group. Perhaps the youngest potential perpetrator was the 3-year-old who went to nursery school in New York City. He rode to school in a truck and there was a gun on the seat. He thought the gun was a toy, picked it up, put it inside his pants, and walked into the nursery school with a real gun. The rates are going up; the problem is getting worse. Increasingly, it is a problem of children shooting children.

We cannot be credible if we ignore the problem of guns. In public health we have tried to ignore guns for a long time because we thought there were other important things to do, and we would be stopped if we tried to address this problem. Politically, to deal with this issue is very difficult. Certainly, people will argue that they have the right to have guns, but there are many ways we can begin to address this problem without a total ban on firearms. To start with, it is illegal for children to have guns, and we need to do something about it. We need to proceed with developing an objective and scientific basis for prevention.We do not know what works best in this area and we need desperately to find that out so that we can empower communities and help them meet the challenge.

The next group will cover early childhood interventions. Why start young? Because people develop lifelong attitudes and habits when they are young. As a psychiatrist in training, I was told many times, that by a very young age, people's lives are determined and there is little chance of change. I am more optimistic about the power of people to change themselves, perhaps because there are so many ways I need to improve myself. I don't believe that our lives are so determined. We cannot ignore the fact, however, that early experience has a lifetime impact.

To work effectively in this area, we have to start with the very young and continue those messages through multiple channels, multiple times, reinforcing behavior through childhood and adolescence to adulthood. It takes a long time and much effort. To conduct this type of intervention and evaluate it takes a very long time. For example, you may start at a preschool level, at age 2 or 3, and repeat an intervention many times at least until age 15. Then, if you want to see whether or not you had any impact, you have to evaluate your program when these youth reach the high-risk ages between 15 and 25. Adding several years to design the intervention project and get it started, there is a 25-year time line for this project. Who has ever worked on a project that took 25 years to start and complete? Who wants to undertake such a project in the government? Who wants to undertake that in a foundation? Who wants to undertake that when we need to publish papers now? How can we get government to work with foundations and nongovernmental organizations to support the kind of sustained effort that is required? These are hard questions that must be answered.

The last work group will talk about principles of community intervention. These are the questions that need answers: what can a community do? Where does a community start? If there are only a few dollars and a few people, what should they do first? How can they do it? What resources do they need? How can they make programs culturally specific and culturally sensitive? How does a community become empowered to deal with the problem of violence?

Finally, let me share with you a closing line that comes from the film, "Dead Poets' Society." Robin Williams is a teacher who takes a group of young men to look into a trophy case where there are pictures of old teams that brought home "the gold," the trophies they won for the school. He had the students crowd around and put their noses against the glass and instructed them to look closely, because "those people who won these trophies were just like you. Just like you, they were bright-eyed and had shiny, smooth faces. In fact, lads, there is only one difference: they are dead!"

Carpe diem—Seize the day. Go out and do it. Peace now.

The purpose of the first panel discussion of the Forum was to inform participants about the successes and setbacks of ongoing community violence prevention programs so that they could apply these lessons in working group discussions. The following abstracts are adapted from the presentations given to this panel.

The Kansas City Project

Mark Mitchell, MD, MPH, Kansas City (MO) Health Department, (now at the Hartford, CT, Health Department)

IN 1988, THE KANSAS CITY HEALTH Department was funded for a 3-year violence control study by the Centers for Disease Control, Public Health Service. The project provides training in conflict resolution and anger control skills to violent young people to try to interrupt the cycle of violence before homicide occurs. This is done through a 12-year-old grassroots community organization, the Ad Hoc Group Against Crime, whose mission is to reduce crime, violence, and substance abuse. In the beginning, the project also involved municipal and juvenile courts, schools, and other agencies serving youth as referral agencies and, to assist in implementation and evaluation, police, psychologists, emergency room data base personnel, and evaluators. The majority of the representives of these entities are African Americans.

The 200 plus participants in the case-control study are young people with a history of violence. They were referred by youth-serving agencies, schools, and the juvenile court system. The training consists of five 2-hour sessions held at the Ad Hoc Group's offices. The project is in the evalution stage.

We have learned that people are very interested in homicide prevention (much more so than violence reduction or injury control efforts which are not as focused). We have also learned the importance of raising community and agency awareness and personalizing the problem of homicide, along with providing suggestions on reducing personal and community risk of victimization. The process of raising awareness must be from a victimization point of view, without critical overtones, and must continue throughout the intervention phase.

An intervention takes a minimum of 1 year to become operational, depending on the complexity of the system from which intervention takes place. Interventionists must be present in the system to provide training, establish trust, change attitudes toward violence, learn the system, decide how best to change the system to accommodate the intervention, and then to change the system.

It is important to choose the right system for the intervention, since it requires such a great investment of staff time. In our experience, municipal court and human relations procedures were too complex a system for effective intervention after only 1 year. Also, high-risk adults were not motivated by arrest warrants or probation violation as consequences of nonparticipation. Their lives are often not orderly enough to allow participation. On the other hand, high-risk youth are more accessible, live more structured lives, and can be motivated more easily. Juvenile institutions and individual schools have been orderly enough systems to allow intervention.

In summary, when designing a violence intervention project, it is important to select the change agents and systems in which to intervene at least as carefully as selecting the interventions themselves.

Boston's Violence Prevention Project

Deborah Prothrow-Sith, MD, Associate Dean, Harvard University School of Public Health

THE VIOLENCE PREVENTION PROJECT is an effort to reduce the incidence of violent behavior and associated social and medical hazards for adolescents. The project is part of the Health Promotion Program for Urban Youth, Boston Department of Health and Hospitals. Through outreach and education, this community-based primary prevention effort is endeavoring to change individual behavior and community attitudes about violence. A supportive network of secondary therapeutic services and a hospital-based secondary prevention service project, directed toward patients with intentional injuries, supplement the primary prevention activities to provide a comprehensive program.

. . . 'the community is "saturated," a necessary tactic because the pressures encouraging violence are present in many aspects of adolescents' lives, and the violence prevention message must be reinforced.'

The project is modeled after other prevention initiatives that have focused on individual behavior modification using education and communication concerning risks. Such a community-based model has been successfully used in the prevention of heart disease and hypertension.

At the core of the intervention in the Boston project is a violence prevention curriculum used in high schools. This 10-session unit is designed to provide descriptive information on the risks of violence and homicide, provide alternative conflict resolution techniques, and create a classroom ethos that is nonviolent and values violence-prevention behavior.

The project takes the curriculum out of the schoolroom and presents it in less traditional educational settings in the community. These settings include alternative schools, recreational programs, public housing developments, Sunday schools, public schools, boys and girls clubs, Ys, and neighborhood health centers. Clergy and police have also been recruited to spread violence prevention education wherever and whenever they contact adolescents, their families, and other significant adults. Many community settings are used to communicate the messages of violence prevention. In this manner, the community is "saturated," a necessary tactic because the pressures encouraging violence are present in many aspects of adolescents' lives, and the violence prevention message must be reinforced.

Community agency providers are trained to deliver the curriculum in modified formats to the youth that they contact in their programs. The project's community educators work one-on-one with these providers to develop a presentation that is appropriate for the setting and the nature of their contacts with adolescents. Community agencies develop, with project assistance, their own projects relating to the issue of acquaintance violence. The community educators provide additional resources and use other, related curriculums and materials as needed.

The project is presently concentrating its efforts in Boston's two poorest neighborhoods. One neighborhood, Roxbury, is predominantly black and has the highest adolescent homicide rate in the city; the other neighborhood, South Boston, is predominantly white and has the most rapidly rising adolescent homicide rate. Data on assaults support this pattern of high and rising rates of violence in these neighborhoods. Approximately 7,000 youth, close to 40 percent of the teen population in those neighborhoods, will be reached through the community agencies.

New Project Goals

Because some youth need more than primary prevention efforts and the medical setting is sometimes the first and only place that troubled youth go for help, the project has started working with adolescents admitted to the Boston City Hospital with intentional injuries. Once released from the hospital, however, most adolescents do not return for followup services and are difficult, if not impossible, to contact. A new initiative uses pediatric nurses trained by the project to work with seriously injured adolescents, their friends, and family over the course of hospitalization and beyond. Support groups are currently conducted for young people as well as for their parents.

Another new effort within the project is to make the clinical setting more responsive to the needs of youth who are at risk for injury or death or who are engaged in violent behavior. A protocol for health care providers has been developed that provides guidance to clinicians on how to deal with adolescents who engage in violence.

Lessons Learned

The Boston project faced three specific problems that had to be addressed.

1. The prevailing notion among the general public that violence is inevitable and not preventable. To counteract this attitude, it was necessary to educate everyone in the community, not just the targeted adolescents. Media-based efforts and peer education strategies were essential in this process.

2. There was the usual emphasis by the media, politicians, and community members on criminal justice strategies as the appropriate way to rectify the problem. It was important to judge commitments to public health solutions on the basis of budget allocations and not merely on promises. We struggled not to get discouraged as we worked to increase the appreciation of prevention.

3. Program needs were often in conflict with community expectations. It was important to balance priorities for evaluation with the program's priorities and to attend to the other matters such as inadequate data sources and overzealous design of the evaluation.

Overcoming these initial barriers does not assure ultimate success. There are a number of other elements that characterize a successful violence prevention program. Foremost is empowering people through knowledge and resource sharing. Closely allied with empowerment is the need for the target population to design the program. In addition, the planners must solicit local political and community support and involve the media in all aspects of the program. A broad spectrum of the community—preachers, teachers, school administrators, politicians, elected officials, agency heads, hairdressers, and teens—needs to be recruited to lead and support the project. Above all, program planners need to be creative!

The Coalition for Alternatives to Violence and Abuse

Larry Cohen, MSW, Contra Costa County Health Services Department, Pleasant Hill, CA

MANY COMMUNITIES, including those in Contra Costa County, CA, experience violence as a growing problem. In 1982, community agencies concerned with violence prevention approached the Contra Costa Health Services Department's Prevention Program to coordinate a community-wide violence prevention campaign. These agencies, which handled a variety of issues including suicide, date rape, and fighting-assault, formed the Alternatives to Violence and Abuse Coalition (AVAC). They understood these issues to be components of the larger problem of violence and emphasized the importance of poverty, unemployment, racism, sexism, and alcohol and other drugs as significant contributing factors. Currently, the Prevention Program of the Contra Costa Health Services Department staffs the coalition with more than 20 agencies participating.

AVAC sponsored two major conferences and presented a community college course on alcohol and drug abuse and violence prevention. In addition, AVAC acted as an advocate for the passage of a California-wide ban on assault rifles. In 1987, the Maternal and Child Health Bureau of the Department of Health and Human Services funded the Youth Violence Prevention Project. The project implemented a violence prevention curriculum in several district high schools, teens were educated about cycles of abuse and interpersonal violence, and a peer counseling program was started. United Way of the Bay Area sponsored the component of this strategy directed at parents and established a workplace prevention program. Reaching parents at their worksites, the program offers them education and resources on a range of issues from drug and alcohol abuse to teen suicide. Currently, the program is utilizing these building blocks in broadening the community's response to violence.

'The project implemented a violence prevention curriculum in several district high schools, teens were educated about cycles of abuse and interpersonal violence, and a peer counseling program was started.'

This complex project has taught us vital lessons in what does and does not work in community-based violence prevention. Perhaps the most important obstacle to overcome is the notion that violence is "normal" and not preventable. Even among people who believe violence is potentially preventable, there is little agreement on the skills and approaches that will make a difference.

Because the prevention of violence requires a comprehensive approach, large coalitions are required for a systematic effort. The creation and management of these coalitions required a great deal of skill, attention, and resources. Educating professionals to look beyond their particular focus and "turf" to the larger picture is another vital task. Since the field of violence prevention is relatively new, we have also learned that success comes slowly and is mixed with substantial failures and disappointments.

We have drawn these fundamental conclusions from our years of experience with AVAC.

1. The public must be educated that violence is a health issue and is preventable.
2. We must recognize that males perpetrate most violence and that strategies to end violence must involve men in the solution.

3. Rape is a problem of assault and violence, although it is not included in statistics on injuries and violent deaths—statistics that most often indicate men as victims of violent crime. Acquaintance rape requires special attention.

4. Understanding the complex relationship between alcohol, other drugs, and violence is critical.

5. Youth and their families must be part of the solution.

6. Training youth and adults in the community in age and culturally appropriate skills to resolve conflicts is an important part of the solution.

7. An interdisciplinary approach to violence prevention is essential.

8. We must learn from other effective public health efforts and simultaneously use multiple strategies that range from individual, community, and professional education to organizational change and policy development.

9. Achieving tangible short-term successes is crucial to sustaining the vitality of the coalition and the commitment of agencies to the long-range goals.

10. Careful evaluation of violence prevention efforts contributes to their effectiveness and longevity.

On the basis of its long experience, the Alternatives to Violence and Abuse Coalition is currently funded as California's demonstration project on violence prevention, and it will be developing a "how to" guide for other California communities.

New Way of Fighting

Ronnie S. Jenkins, MS, Georgia Department of Human Resources, Atlanta

VIOLENCE CAN BE PREVENTED through nonviolent conflict resolution. An example of a school-based conflict resolution program is a "New Way of Fighting."

Two years ago, in 1988 the Fulton County (GA) Board of Education decided to consolidate six high schools that had been strong rivals into three high schools. About 3,500 students attended the three schools. The board spent a considerable amount of energy ameliorating the concerns of the teachers, staff, and parents, but it spent little time addressing the issues of the students. Consequently, during the first weeks of school, the environment was not conducive to learning; violence was pervasive among the students. The board of education's tribunal was overwhelmed with referrals, and young men were being suspended at an alarming rate. Gunshots were fired at several athletic events, fights broke out and, at one school, all dances were canceled for the year.

The student government association (SGA) of one school met with teachers and requested their help as they began a campaign to stop violence in their school. The students contacted the SGAs at two other schools and, over time, weekly meetings of the three SGAs were rotated among the schools, assisted by an outside facilitator and advisor. At these meetings, plans were formulated to stop the violence, many of them centering on providing training in conflict resolution skills to students in the high schools. The program was also extended to students in the middle schools that fed into the high schools.

Educators at one high school became increasingly concerned about the large number of Amerasian students who could not read at grade level, and the heightening conflict among the Amerasian males and the African American males which led to fights and suspensions. The Amerasian students who came to an unfamiliar environment had great difficulty communicating with faculty, staff, and other students, particularly the African American males. A youth partnership program has been particularly helpful in dealing with violence and the high dropout rate of the two groups. Each African American boy is paired with an Amerasian boy.

Through the intervention program, two outside consultants, an African American and a Cambodian immigrant, worked intensively with the two groups of students. Following a period of identifying problems, the boys brainstormed solutions, which were then presented and discussed among all students involved, administrators, and counselors of the school. This activity is continuing and is reinforced through weekly meetings during which Amerasian and African American students continue to work on their recommendations to resolve differences and to enhance their understanding and awareness of each other's culture.

Alternatives to Gang Membership: the Paramount Plan

Tony Ostos, Neighborhood Counseling Manager, Department of Human Services, Paramount, CA

IN MANY MINORITY communities gang activity and gang-related behaviors are a significant cause of interpersonal violence among youth, and violent acts committed by groups of young people are a daily occurrence in many minority communities across the nation.

The gang itself represents a deviant subculture within minority communities. However, not all gangs are made up exclusively of members of minority groups, and most minority youth are not involved in gangs. Nevertheless, to many minority youngsters, the gang represents the only organized, culturally identifiable peer group to which they can relate.

Violence directed at other minority youth is the overriding aspect of gang activity. Of the 159 gang-related homicides that have occurred so far in 1990 within the jurisdiction of the Los Angeles County Sheriff's Office, 102, or 64 percent of the victims, were Hispanic, 48 or 30 percent were black, and 9 or 5 percent were classified as "other."

Youths join or associate with gangs for a variety of reasons. Once a young person begins to associate with a gang, the violence is inevitable. He or she becomes either a victim or a perpetrator. Often the violence spills over to nongang members of the minority community. Clearly then, in order to address youth violence in minority communities, we must try to dissuade youths from joining gangs or becoming involved in gang activity.

The Department of Human Services in Paramount, CA, began in 1987 to work with preteen youth and their families to increase their awareness of constructive alternatives to joining gangs. A gang prevention curriculum, "Alternatives to Gang Membership," was developed. The curriculum, a major component of the Paramount Plan, is used with all fifth grade classes in the eight elementary schools that serve the city. The information is presented in a 55-minute session every week for 15 weeks. The units cover issues such as graffiti, peer pressure, tattoos, the impact of gang membership on family members, gangs and drugs, and opportunities and alternatives for youth.

The intermediate school followup program is another component of the Paramount Plan. Eight biweekly presentations are made in the seventh grade classes in the two intermediate schools within the city of Paramount. These presentations are designed to reintroduce, reinforce, and expand concepts presented previously in elementary school and to reach new students who did not participate in the fifth grade curriculum.

'Youths join or associate with gangs for a variety of reasons. Once a young person begins to associate with a gang, the violence is inevitable. He or she becomes either a victim or a perpetrator.'

A third component of the Paramount Plan consists of parent-community awareness meetings for parents of children in the targeted classes as well as for other interested parents. Also, the program's family counselor works individually with youth who are at high risk and with their parents to help them discourage their children from joining gangs.

Schools, police departments, and local human services offices have replicated the program in several school districts in the Los Angeles area, the State of California, and nationally. The Alternatives to Gang Membership Program can be used as a model for communities that are interested in preventing gang involvement. Further information on the program can be obtained by calling the City of Paramount Human Services Department, tel. 213-220-2121.

Panel Discussion 2: Funding of Community Interventions to Prevent Violence

Financial support is required to implement successful community violence prevention programs and to invest in the applied research needed to develop effective prevention strategies. Such financial resources, however, are scarce. A range of private and public organizations provide support for programmatic and research activities in the area of violence prevention. The purpose of this panel was to share information about how we can develop a public-private partnership to facilitate a planned, long-term funding effort for violence prevention in minority communities.

Focusing Public Attention on Violence Prevention

William H. Foege, MD, MPH, Executive Director, The Carter Center of Emory University, Atlanta, GA

THE UNDERLYING CONCEPTS that lay the foundation for successful prevention of violence must include focusing public attention on the problem. Even though the task of this forum is to concentrate on youth and violence, it is important to remember that violence is a problem of society and that society is the key to making prevention efforts work. In the late 1970s, we made remarkable strides in mobilizing society to immunize children; the lessons learned from that campaign have application for today's problems.

As we search for ways to describe violence in communities and convince people of its impact, we must learn to portray the faces of grieving parents and siblings, taking the language of statistics and putting it in the language of the heart. We must fight fatalism; violence is not inevitable, but will yield to intervention. We particularly need to keep teenagers from that fatalism, to encourage them to have faith in a society in which law applies to all and to remain curious and hopeful.

The public health approach to controlling infectious diseases has been to understand cause and effect; the same applies to violence. We need to expand the role of medicine to include issues of environment, poverty, and quality of life as causes of violence, and challenge people in medicine to seek out ways to use medicine to alleviate these problems. Furthermore, if we believe in the Golden Rule, then it follows that we cannot enjoy anything that is denied to others. Poverty is a disgrace, particularly when it is mocked by comparison with richness. Violence, although not an acceptable alternative to coping with poverty, is a predictable outcome.

Lastly, we need successes. It is not necessary for success to be measured by attainment of all our goals. We need to start with smaller successes that we can build on. For example, one person in Tennessee working in the area of child restraints was the spark for a very successful national movement. We need to begin marking our small successes and making people aware of them, so that the momentum can grow into a national movement for the prevention of violence.

Establishing a Public-Private Partnership

Lawrence W. Green, PhD, Vice President, Henry J. Kaiser Family Foundation, Menlo Park, CA

FOUNDATIONS HAVE SUPPORTED the majority (52 percent) of the 51 violence prevention projects surveyed nationally by the Education Development Center. Only a third of the projects have been funded by either Federal (32 percent), State (34 percent), or local (30 percent) governments. Although foundations have been instrumental in helping get these pioneer projects off the ground, they should not be counted on for the ongoing maintenance funding of projects beyond their pilot or demonstration phases.

Foundations see their role as initiating and supporting innovative projects and demonstrating their efficacy and feasibility to government or other parties responsible for maintaining such programs if they fill a social need. Foundations have the advantages of flexibility, short turnaround, and ability to fund high-risk projects in areas where science has not yet established a track record for the innovations. However, they do not have the government's advantage of staying power. To remain innovative, they must move on to new

challenges and must not allow their limited funds to be tied down to the maintenance of programs that should become the responsibility of government or private sector interests.

The Kaiser Family Foundation (KFF) has funded violence prevention initiatives through support for policy analyses and position papers; demonstration and evaluation projects in Boston, Monterey, CA, and Philadelphia; and a variety of substance abuse projects with violence prevention components in Utah, California, and Oregon. KFF also funded the American Academy of Pediatrics' national conference on handgun control to prevent child injury from guns. Future prospects of KFF funding for a violence prevention center for populations living in poverty and related projects have immediate policy implications for government action, legislation, regulations, or funding priorities.

The Federal Role in a Public-Private Partnership

Martha F. Katz, MPA; Director, Office of Program Planning and Evaluation, Centers for Disease Control

TO BORROW A PHRASE from Bill Foege, "everything we do today rests on the shoulders—the accomplishments—of our ancestors." It is a statement that provokes me to think about older Americans and the messages they are giving us about violence. In almost every conversation with our parents, older friends, and neighbors, they report the latest mugging, rape, burglary, or murder. Because they are older, they feel particularly vulnerable and they are worried about their safety, their friends, and their families.

But they are also telling us that they remember a world in which violence was not so prevalent. They recall the safer times, in 1910 and 1960, when the homicide rate was half what it is today. As witnesses to the changes of the past 30 years, our older friends find the current state of violence truly unacceptable and they are telling us that we should too.

My task is to address the contributions that government can make to the prevention of violence in our society. To be slightly simplistic, the role that government can take has three dimensions. The government must listen to the people and their concerns, provide leadership in prevention efforts, and sustain the momentum over the long span of time needed to change what is happening in our communities.

The first step in creating change is to listen to people who speak for affected populations. In a democracy, politicians must listen to their constituents and carefully serve the will of the people. Just as the proponents of gun ownership have loud and clear voices, so must the advocates of violence prevention. I choose to begin my remarks with the concerns of the elderly because they too have loud, clear, and politically powerful voices. They represent one of the many allies that we can entice into advocating new, aggressive approaches to deterring violence. And as evidenced by congressional action on catastrophic health insurance, when older Americans speak, government does indeed listen.

Government is also responsible for providing leadership. By building a health-literate public, able to understand the health data we put before it, we will create a new atmosphere conducive to change. New partnerships will be established and creative strategies will emerge. Since our partners in foundations can be more daring in their innovations, their role may be to test some of the riskier ideas. Once tested, government agencies can share the new approaches nationwide.

Perhaps the most important role for government is to be there for the long haul, because the task will go well beyond the 2, 3, or even 5 years usually funded through private sources. To support this effort, the government can conduct surveillance of fatal and nonfatal injuries caused by violence, design demonstration projects to show feasibility and effectiveness, gain visibility for the importance of deterring violence, evaluate intervention efforts to show what works, and build the coalitions, the leadership, needed to shape a different future.

Leaders are willing to take risks, to float new ideas. So I will leave you today with one of the ideas of Jay Waller, of Wayne State University, who said, "Let's return the elderly to their status as elders. As elders, they will share the wisdom of the past, while being role models for the future."

Introduction: *The purpose of the working groups was to generate state-of-the-art information on the following topics: (a) prevention activities that minority communities can apply now to prevent youth violence, (b) identification of critical evaluation needs so that future research can be appropriately targeted, and (c) specific principles of community intervention relevant to the prevention of youth violence.*

Throughout the work group reports, the term "intervention" is used to describe activities that are designed to interrupt or intervene in the underlying causes of violent behavior or violent situations. These may not all conform to the formal public health interpretation of what constitutes a true intervention. However, the groups concentrated on what they considered the most effective or the most promising actions to prevent violence. Therefore, the reader will see a wide range of activities that target some aspect of the problem. Ultimately, the Centers for Disease Control will develop guidelines for the prevention of youth violence in minority communities that will define these activities more carefully with recommendations on how communities can combine interventions into a cohesive, effective program for violence prevention.

The charge to the work group considering application of the principles of community intervention was to develop guidelines for community efforts to organize and sustain successful violence prevention programs. The guidelines were to be based on the established principles of community intervention; however, they were to address the special barriers and challenges that African American, Hispanic, Native American, or other minority communities face in preventing violent behaviors and injuries.

The charge to the participants of the working groups considering general minority youth populations, high-risk youth, the issue of weapons, and early childhood interventions was to enumerate the various types of intervention strategies and to review what is known about the effectiveness of existing interventions in order to determine what minority communities should be doing now to prevent youth violence and to set priorities for evaluation research in this area. In their deliberations participants were to consider carefully the implications of cultural and social differences between minority communities and the changes that minority communities are undergoing.

Application of Principles of Community Intervention

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Introduction: adapted from the background paper prepared by Education Development Center, Inc. (*1*).

In his landmark 1978 work, "Criminal Violence, Criminal Justice," Charles Silberman noted that "Crime does more than expose the weakness in social relationships; it undermines the social order itself, by destroying the assumptions on which it is based." (*2*). If we substitute the word "violence" for "crime," we can begin to understand why violence is both a public health problem and a community problem. Examples of violence drawn from minority communities involve perpetrators and victims of violence as well as bystanders. In some aspect of violent behavior, every member of a community is cast potentially in one of these three roles.

The understanding that violence is a public health issue is a relatively recent but powerful development. The toll that violence takes in mortality, morbidity, quality of life, and use of health care resources indicates its effects on public health. The ability of public health researchers and practitioners to bring to bear the tools of epidemiology; surveillance; and the development, implementation, and evaluation of preventive interventions are examples of the contributions that public health can make to violence prevention.

On the other hand, the view that violence is a community problem is embedded in early American history. Before there was professional law enforcement, everyone in a community was involved in crime prevention (*3*). Therefore, in an important sense, public health's involvement in violence prevention is a return to ideas of community with deep roots in American history (*4*). And it is the sense of direct involvement that several current

community violence prevention programs seek to rebuild.

In addressing the problem of youth violence specifically in minority communities, it is common to think first of the inner cities of America's large metropolitan areas. It is important to remember that violence is not restricted to minority communities nor inner cities, but it is more concentrated there. In 1980, the homicide rate for young African American males living within Standard Metropolitan Statistical Areas (SMSAs) was more than twice that for young African American males residing outside SMSAs—95.8 per 100,000 as opposed to 40.8 per 100,000 (*5*).

Finally, violence is a community-based problem because its resolution is beyond the capabilities of those agencies to which it has been traditionally delegated. "Over the years we've tacitly and, I believe, mistakenly agreed that violence was the exclusive province of the police, the courts, and the penal system," wrote former Surgeon General C. Everett Koop (*6*). "To be sure, those agents of public safety and justice have served us well. But when we ask them to concentrate more on the prevention of violence and to provide additional services for victims, we may begin to burden the criminal justice system beyond reason."

Several objectives of "Healthy People 2000" address indirectly the prevention of youth violence in minority communities. Objective 7.1 calls for substantial reductions in homicide among African American men, Hispanic men, and African American women (ages 15–34 in each group), as well as among Native Americans (*7*). Other objectives address weapons-related deaths, weapons carried by adolescents, assault injuries, physical fighting among adolescents, physical abuse of women by male partners, and rape. Still other objectives relate to the need for comprehensive violence prevention programs and, especially important for this workshop, an increase in "culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations."

The development of community approaches to violence prevention, while harkening back to earlier forms of individual participation and community involvement, is a relatively recent phenomenon. In any given community, there are questions that need to be addressed: From where does the leadership for violence prevention come? What is the problem and what are its characteristics? Why is it happening? What resources are available and how can citizens be reached and involved in meaningful and effective ways? How can specific interventions be developed and implemented? And, importantly, how can their effects be measured?

'It is important to remember that violence is not restricted to minority communities nor inner cities, but it is more concentrated there.'

Violence among and against minority youth is a large and complex problem. Homicide and assault, child abuse, spousal battering, abuse of the elderly, rape, and sexual assault are all expressions of this problem. Our focus at this time on homicide and assault does not diminish the need to address other manifestations of violence. Whereas the toll of homicide and assault among young minority men has been well publicized, the toll of rape, sexual assault, and spousal abuse upon young minority women is generally underreported by victims and the media. Although violence is present in all communities, the disproportionate burden it places on the citizens of minority communities warrants special attention.

Underlying Assumptions

The working group identified several underlying assumptions about violence that need to be understood by both practitioners and community members in order to combat the problem of youth violence in minority communities.

- Violence is a learned behavior that can be changed and prevented. Although intertwined with larger social issues such as racism, poverty, and employment, violence is not the innate or inevitable expression of a person in relation to his or her environment. We are concerned with normal youth, raised in a difficult and frustrating environment, with limited options of response and frequent examples of violence in their experience and via the media. Under these conditions, violence is perceived as an accepted and appropriate response. If youth are provided with other options and other examples, the frequency and intensity of violent behavior can be modified and prevented.
- There is no single or simple solution. Violent behavior is the manifestation of complex economic, environmental, political, cultural, educational, and behavioral factors. This complex causation means

that multifaceted solutions are necessary. No single solution exists.

- A framework for action exists. Effective, community-based prevention programs must (*a*) reflect coordinated responses from many community organizations and groups, (*b*) include many activities and interventions targeted at specific risk groups, (*c*) provide societal support for individual behavioral change via advocacy and policy development, and (*d*) apply these multiple methods in multiple settings.
- Every effort must be made to insure the active participation of those for whom and to whom activities are being directed. Fundamental to the success of community intervention is a commitment to the principles of participation. Out of such a commitment, citizens are given their just entitlement to identify and choose their priorities, implement activities, and retain control over what happens in their community. This process is sometimes referred to as "empowerment." Because the sense of powerlessness and lack of control contributes to violence, conscious efforts to engender community participation, control, and responsibility are vital.
- The realization of meaningful change in such a complex problem will take time. The implications of this assumption are twofold: there must be a sustained commitment to acquire and maintain ample resources over time and political leaders and decision makers need to understand that the final measures of success—decreases in mortality, injury, and disability—will not be immediate, and a sustained commitment to provide resources is critical in achieving these objectives. Nevertheless, they should be alert for, and demand, intermediate indicators of change that forecast the ultimate goals of a program to prevent minority youth violence.

A Systematic Process for Programs

Different approaches to intervention are required depending on the circumstances, resources, and capacity of a given community. However, successful community-based approaches to prevention have several common characteristics.

Partnership formation. The magnitude and complexity of minority youth violence require the participation of multiple agencies, organizations, and individuals, including grassroots organizations and representatives. In effective community programs, diverse organizations and individuals recognize their common interest and develop coalitions or partnerships to work together for a common purpose. The carefully planned and coordinated efforts of multiple groups, each doing a little, accomplish more than the same efforts applied in an uncoordinated fashion. The need for coordination is underscored by the scarce resources available for community activities and the absolute need not to duplicate services.

Careful planning. Carefully planned community intervention programs enable prevention workers to (*a*) select and design intervention strategies relevant to the unique needs and characteristics of the target population, (*b*) establish measurable indicators of program progress, (*c*) make mid-course program adjustments as needed, and (*d*) evaluate program effects.

Resources. The talents, expertise, and work of community people are primary among the resources needed for designing and implementing interventions. Financial resources could come from a combination of sources: local businesses; private philanthropic organizations; local or State agencies interested in youth violence, such as the department of education, health department, and police groups, and national or Federal funding sources.

Whether the fiscal resources are direct agency budgets, research or program grants, or the collective contributions of multiple organizations, success depends on access to the fiscal resources necessary to plan, staff, implement, and manage the program. Although long-term funding is critical, the realities of available resources may necessitate that they be pieced together a few years at a time from a variety of sources.

Participant involvement. The principle of participation creates an environment of mutual ownership in a program. Participants have more invested in the program and are less likely to drop out, thus increasing the likelihood that the program will attain the desired outcome.

Goals and specific objectives. Effective community programs have both a general sense of direction (the goal) and a set of specific, measurable steps to move the community in that direction (the objectives). Specific objectives will vary according to the health problem of interest, the relative importance of the problem's contributing causes, and the specific interventions selected. An objective may be an increased awareness (the proportion of the population aware of the magnitude and preventability of the problem), improved knowledge (the proportion of youth who know that there are alternative means to resolving conflict other than violence), or a change in policy (revision of gun

purchasing requirements). Objectives also should be set for the number and type of activities conducted by the program.

Supportive data. Sound data that describe the nature and extent of the problem of violence in a given community are important. Such information enables communities to determine the areas of greatest need, select appropriate areas for action, set applicable and realistic objectives, and measure progress toward those objectives.

Sources of information about youth violence include the criminal justice system, family and youth services, schools, and businesses, to name just a few. One of the best sources of this information is the people themselves, both youth and adults in the community. Information gathered from personal interviews and focus groups is invaluable in identifying problems and tailoring interventions.

Multiple methods. It is important to reiterate that, because violence among minority youth has many factors and causes, the greatest effect will derive from the interaction and reinforcement provided by multiple interventions. Effective programs employ a combination of complementary intervention methods including legislative and policy development, large-scale media campaigns, educational programs for individuals and groups, and a wide range of other health communication strategies.

Qualified personnel. Effective programs are the product of careful planning, creative application, sound program management, and deliberate evaluation. The skills required to execute these tasks are acquired through special training and specific experience. They may be particularly scarce in the communities whose participation and ownership of the program is vital. Because the skills are so critical to program effectiveness, special efforts must be made to insure that the staff receive adequate training.

Evaluation. As with all responsible public health programs, program evaluation is essential. However, scientific evaluation of a complex, multifaceted community program, although technically possible, is not feasible without the infusion of extensive economic and technical resources. A few full-fledged outcome evaluations must be done, but that burden must be supported by larger academic or governmental efforts. Therefore, communities should be encouraged to employ practical evaluation strategies, including an accurate description of what has been done and how these activities relate to the program's goals and objectives. The evaluation data collected should be sufficient to identify and correct problems in the day-to-day progress of specific interventions; inform members of the community, decision makers, and possible funding sources of their progress; justify the costs of the interventions; and determine if their specific process and impact objectives are being achieved.

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Violence Prevention Strategies Targeted at the General Population of Minority Youth

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Introduction: adapted from the background paper prepared by the Education Development Center, Inc. (*1*).

CERTAIN TYPES OF PREVENTION efforts designed to reduce injuries resulting from youth violence are typically applied to the entire population of interest (or to the environment that affects this entire

'Recreational interventions provide an excellent outlet for pent-up tension, stress, and anger; therefore, they are a significant means to prevent violence. They also increase opportunities for youth to engage in healthy options and to spend leisure time in socially acceptable activities.'

population). Such an effort is the teaching of conflict resolution skills to urban high school students. In this example, the intervention tries to affect the manner in which all students resolve conflicts—not just those students who are thought to be likely to engage in violent behavior. Other types of general strategies to prevent youth violence may include public information campaigns, curfews, or youth development programs (for example, recreational and cultural programs).

Because most young people seldom or never engage in violence, there are those who question the soundness of implementing such untargeted or generally focused interventions, particularly considering the epidemic proportions of the youth violence problem. Some strongly suggest that resources should be directed toward those at high risk for violence or currently engaged in violent behavior. However, it may not be enough to focus prevention efforts on high-risk groups alone. For example, teaching peers of youth at high risk for violent behavior as well as nonviolent youth to resolve conflicts without violence may have the effect of altering the social environment in which violence occurs in ways that may lessen the likelihood of violent conflicts.

A number of violence prevention strategies have been developed to target the general population of young people. However, few are aimed specifically at minority youth and those that do are generally directed toward African Americans. The majority of programs and interventions are school-based. Some focus only on violence; they concentrate on education about risk, mediation, and conflict resolution. Others take a holistic approach and address a cycle of interacting problems (for example, low academic achievement, low self-esteem, drug use) through life skills training, mentoring, Afrocentric education, academic tutoring, and substance abuse prevention education.

Intervention strategies applied to the general population of minority youth can be divided into the following categories:

- Educational interventions are generally designed to change young people's knowledge, attitudes, and behavior patterns that could lead to violence. Educational approaches are based on the premise that violence is often precipitated by interpersonal conflict, which could be prevented if people are offered a range of nonviolent options and are motivated to choose a nonviolent response. Public information and education campaigns provide information on the impact of violence and publicize existing violence prevention services.
- Environmental technological interventions focus on changes within the environment that discourage the possibility of violence from occurring (such as the use of metal detectors to discover hidden weapons, landscape design that does not allow people to hide, reducing or making violence less glamorous in the media, and demonstrating positive conflict resolution in television shows and movies).
- Recreational interventions provide an excellent outlet for pent-up tension, stress, and anger; therefore, they are a significant means to prevent violence. They also increase opportunities for youth to engage in healthy options and to spend leisure time in socially acceptable activities.
- Legal interventions are strategies that employ laws and police enforcement to deter situations or an environment conducive to violence (for example, youth curfews, policing school campuses, and firearms regulations).

Underlying Assumptions

The working group on violence prevention strategies for minority youth in general identified the following underlying assumptions as important to successful community prevention campaigns.

First, basic to the success of any intervention in minority communities is instilling the concept of ownership. This ownership can best be accomplished by community people who identify their problems and develop their solutions; they choose the interventions and carry them out with appropriate help from a variety of service, business, and health personnel.

Second, youth and adolescents learn from a variety of people with whom they come in contact. Therefore, whenever possible, a broad range of people should be involved in violence prevention programs. For example, in school settings the

entire staff from the janitors to principals should take part in program plans. In addition, involved parents are integral to the success of both school-based and community intervention programs.

Third, violence prevention strategies should be disseminated to *all* communities, not just minority communities.

Recommended Interventions

The working group recommended the following intervention strategies:

1. School-based programs should meet the needs of specific schools and communities. These programs could include several elements.

- conflict resolution techniques that emphasize the development of empathy, impulse control, problem-solving skills, and skill in managing anger.
- plans for safe schools that include policies and environmental designs that are conducive to the prevention of violence. Some components of such plans include a comprehensive school health curriculum; school health services; landscaping designs that minimize the ability to hide in dark or covered areas, particularly near buildings; and a school policy that requires students to exhibit identification badges so that people who do not belong on the school grounds can be identified.
- mentoring and role model programs that provide minority youth alternatives to absent or negative role models. While serving as friends, teachers, confidants, and counselors, mentors demonstrate that minority adults function at high levels within society and show that they consider the young people worthy of their time and attention. People working in all settings, including business and government (and possibly college students), have a great deal to contribute to the self-esteem of youth.
- peer programs that use the powerful force of peer group influence to shape health norms and nonviolent behaviors and then support those norms and behaviors. Because adolescents are more likely to be influenced by peer group values (*2*), programs conducted by peers can be very influential. Although not yet evaluated in violence prevention programs, education by peers in other areas of health, such as alcohol, cigarette, and drug use, has been shown effective (*3, 4*).
- programs that incorporate self-esteem development, mentoring, role models, and culturally appropriate curriculums should be adopted on a school-wide, intensive basis rather than simply as part of classroom curriculum.
- programs that build self-esteem to foster better feelings about the way children evaluate themselves in terms of their personal attributes, abilities, and behaviors. Components of programs in self-esteem might examine teen suicide, families in crisis, child abuse, violence against women, growing up as a member of a minority group, respect for others' feelings, developing sound judgement and communication skills, and improving life skills and academic skills, including mathematics and reading.

2. Community programs that have the following components should be implemented:

- linkages among agencies that provide a wide range of services (for example, family service, health, mental health, and protective service agencies and police departments) to create a more comprehensive support system for violence prevention activities. Agencies must plan violence prevention activities together and share resources.
- media campaigns that promote public awareness of the need for violence prevention and publicize existing violence prevention services. Media campaigns should produce culturally appropriate materials, and campaign messages should be delivered by a representative of the community or the specific targeted group. It is helpful to use youth, sports figures, movie stars, and other entertainment or public personalities in media campaigns.
- a technical assistance and training system that gives professional and community people skills and training to promote and support violence reduction activities.
- mentor programs in the community that involve male and female role models and include exposure to family, career, and recreational situations that foster empowerment, life skills training, and conflict resolution.
- recreational, social, cultural, and training programs that increase opportunities for both boys and girls to explore socially acceptable and healthy options.
- job opportunities for youth that will contribute to productive futures to build knowledge and practical skills, self-esteem, and positive attitudes.

3. Strategies at the national level should be to establish a national plan to develop and coordinate violence prevention efforts and reduce the media's portrayal of violence as glamorous and heroic through the use of media campaigns that employ well-known public personalities.

Evaluation Issues

The working group made two recommendations concerning the evaluation of prevention strategies focused on minority youth in general: a longitudinal study of the impact of educational interventions from preschool through high school should be conducted and funded by multiple agencies. Better tools and study designs, including both qualitative and quantitative methods, must be developed to evaluate program impact. For example, the effectiveness of providers of youth services, the specific settings where they work, and the accessibility of intervention services should be evaluated.

Future research should be conducted to determine why some minority youth cope without resorting to violence. Also, longitudinal research, such as multi-city trials of community-based violence prevention programs modeled after the Hypertension Detection and Followup Program (*5*), should be conducted. In addition, the working group endorsed the findings of the Carnegie Foundation's meeting on evaluation of violence prevention programs (*6*).

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Violence Prevention Strategies Directed Toward High-Risk Minority Youths

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Introduction: Adapted from the background paper prepared by the Education Development Center, Inc. (*1*).

A HALLMARK OF PUBLIC HEALTH PRACTICE has been to focus scarce prevention resources, whenever possible, on those most likely to suffer illness or injury. In seeking to prevent injuries stemming from violence, these efforts might be focused on those most likely to be injured, those most likely to engage in violent behavior that injures others, or both. In many cases, this dichotomy is artificial. The person who engages in frequent violent behavior is also at increased risk of suffering violent injury or death.

As a group, minority youths are at high risk for violence, but within that broad group are youths at extreme risk, largely as a result of their environment, behaviors, and personal histories. Factors that have been associated with interpersonal violence include unemployment, poverty, low educational opportunity and achievement, drug or alcohol abuse, and weapon carrying. All are more prevalent in poor, urban, largely minority environments (*2,3*).

Targeting a narrowly defined population can be crucial to successful intervention (*4*). Interventions for minority youths at high risk for violence have tended to focus on a few target groups, such as gang members, drug users, and juvenile offenders. Other groups, such as families of gang members or weapon carriers, have received less attention.

High Risk Groups

The work group first identified five groups of high-risk youths that they considered to be of highest priority.

(a) Youths who live in geographically defined areas in which rates of violent death and injury are

extremely high. The high risk may be associated with a number of activities in the area, such as drug dealing or gang activity. Gang violence is typically associated with high rates of violent behavior and is almost always associated with a geographic territory, but an area may have very high rates of violence without gang activity. Further, children growing up in such areas are likely to model their self-defense and conflict-resolving behaviors on the violent actions that they see around them.

(b) Gang members and youths (ages 8–18 years), who are at risk for becoming gang members. The rate of violent offenses of gang members is three times that of delinquents who are not gang members (*5*). It is often difficult to distinguish between potential members and real members of gangs. Gang members sometimes include several generations within a family (*6*). Children and adolescents may seek the companionship, protection, monetary rewards, and a sense of belonging that they perceive results from gang membership.

(c) Youths who are members of families that have problems related to violence (such as unsupervised children, parental drug use, child abuse, and the absence of a role model). Abused or neglected children are at increased risk for delinquency, adult criminal behavior, and violent criminal behavior (*7*). Other studies have indicated that children from violent or troubled families (*8*), or from families in which parents display little affection (*9*), themselves develop violent behavior patterns.

(d) Violent youths, including those with histories of extreme violence, those who have entered the court system because of violent behavior, and imprisoned youths.

(e) Victims, relatives of victims of violence, and witnesses to violence. It is sometimes difficult to distinguish victims from perpetrators among high-risk populations. Being a victim of violence is associated with an increased chance of subsequently assaulting others (*10*). Very little is known about the impact on children and adolescents of witnessing violent incidents.

Underlying Assumptions

Knowing which subgroups of the population are at highest risk allows us to target intervention strategies; it does not, however, tell us what interventions are most appropriate and effective. The risk groups identified in this report are in two conceptual categories, (*a*) those with particular attributes (violent youths, victims and witnesses of violence, and youths from dysfunctional families), and (*b*) geographically defined high-risk groups (those living in a geographic area with high rates of violence or in a geographic area with gang activity).

The following underlying assumptions or principles are associated with interventions directed to high-risk persons, such as those with high-risk attributes.

(*a*) Each high-risk youth needs to be assessed individually to determine his or her underlying needs. For example, a high-risk person identified by having been arrested for a violent act may have particular skill deficits that need to be addressed, such as the inability to resolve conflict in ways other than resorting to violence. The person may be violent, however, primarily because he or she lives in an environment that reinforces violence. If the person has a dysfunctional family, the intervention must either address the family's problems or try to remove the person from that environment.

(*b*) Because of the powerful positive and negative influences of the family and social environments, interventions should address the environments, as well as the youth, whenever possible.

(*c*) Be realistic about outcomes. Only a small proportion of youths with histories of violent behavior change their behavior substantially in the long term in response to current strategies and conventional treatments. However, the costs of intervening should be balanced against the costs of not intervening.

(*d*) Evaluate individual failures that occur in intervention programs in order to provide information valuable for modifying the design of interventions.

(*e*) Programs should be designed to include and coordinate as many services as possible that reach high-risk youths.

(*f*) Interventions must be culturally competent. Information and materials must be appropriate and acceptable to the intended population. The people who deliver services should be members of that population, whenever possible.

(*g*) Some programs to prevent violence, by their nature, need to be coordinated on several levels of government.

(*h*) Services should be readily accessible by all youths, not only those involved with the social services or criminal justice systems, and the availability of the services should be well publicized.

For interventions directed at geographically defined high-risk groups, other principles relating to community issues should guide the design and implementation of preventive interventions.

'Information and materials must be appropriate and acceptable to the intended population. The people who deliver services should be members of that population, whenever possible.'

(*a*) The needs and problems of communities with high rates of injury and death from violence should be assessed to allow for identifying appropriate priorities for prevention activities.

(*b*) Interventions should be multifaceted. It may be better to do everything in a small area than to apply only one strategy in a large area.

(*c*) Interventions need to be more than 1- to 3-year efforts. New prevention interventions should be sustained efforts designed to change to accommodate emerging needs.

(*d*) Members of the community need to work to reclaim neighborhoods, parks, or other areas taken over by violent youths or gangs.

(*e*) Although the outcomes of violence include a tremendous burden of nonfatal injury, interventions must first work to reduce the incidence of homicide, and later expand to focus on nonfatal injuries when possible. Homicide is the most visible and tragic outcome of interpersonal violence; a reduction in homicides as a result of effective intervention will be highly visible and dramatic. It is likely that the incidence of homicides will need to be reduced before people will become enthusiastic about working to reduce the toll of nonfatal injuries.

(*f*) The community must own the intervention. Although activities may be started by governmental or other interested organizations, these groups should only sustain the effort until the community becomes actively involved and takes ownership of the program.

(*g*) Training and leadership are key ingredients in the success of community interventions. Leaders should be people who have hope for the community; this vision is at least as important as the usual qualifications or credentials. Training will translate vision, leadership, and the model for intervention into effective action. People who deliver services require support and need to have positive feelings about themselves. They need periodic interactive training to deal with job stress and burnout. They also need training in skills relating to specific content areas, such as conflict resolution.

(*h*) Because little is known about the effectiveness of community programs, evaluation plans should be designed and built into the structures of new and existing programs.

(*i*) Community resources that pertain to high-risk youths should be identified and coordinated.

Recommended Interventions

The work group recommended a separate set of programs and strategies for each of three groups of high-risk youths.

Strategies for youths from dysfunctional families.

(*a*) Programs to teach high-risk youths how to manage feelings, particularly those of anger.

(*b*) Programs, such as Outward Bound, that offer physically challenging activities that develop self-esteem, trust, and group support.

(*c*) Manhood and womanhood development programs that foster self-esteem, positive feelings about the opposite sex, and awareness of the responsibilities that accompany being an adult man or woman.

(*d*) Mentoring programs that provide positive psychosocial role models for youths who do not have this strong influence in their families.

(*e*) Academies for youths from dysfunctional families who also show promise in areas such as leadership characteristics, artistic or athletic ability, and intellectual ability.

(*f*) Programs such as National Youth Service that bring the adolescent out of a negative or destructive environment and into one that encourages performing public service.

Strategies for victims of violence and witnesses of violence.

(*a*) Survival skills training, particularly training that includes how to remove oneself from a potentially violent situation.

(*b*) Programs that use police records or other methods to identify children who witness homicide. These children should be offered psychological counseling.

(*c*) Psychological counseling by culturally competent counselors who have been trained to counsel victims of violence.

(*d*) Mentoring programs that offer positive psychosocial role models, confidants, and allies for victims and witnesses.

(*e*) Support groups that provide mutual guidance and psychological support for those who have had the same experiences.

Strategies for violent youths.

(*a*) Training in conflict resolution and anger management that gives adolescents the skills to find solutions to conflict situations other than violence.

(*b*) Peer counseling and mediation that use peer group influence to shape norms of nonviolent behavior, encourage nonviolent responses to adversarial situations, and support those norms and behaviors.

(*c*) Referral to training programs such as the Job Corps or military-style camps that employ rigorous adherence to established, well-focused goals, delivered by strong authority figures.

(*d*) Programs similar to Outward Bound that provide physically challenging activities to develop self-esteem, trust, and group support.

(*e*) Mentoring that offers role model figures who represent alternative solutions to potentially violent situations, who counsel youths in positive life skills, and who represent and demonstrate alternative, positive lifestyles, including work options.

(*f*) Programs that divert youths from the juvenile justice system and encourage performing public service, mentoring by peers, or conflict-resolution training, to try to keep those who have had their first contact with the courts from coming back.

(*g*) Psychological counseling for recidivists.

Strategies for geographically defined groups. The work group developed a common set of interventions for youths living in geographic areas with high rates of violence and youths who live in communities with high levels of gang activity. These interventions were adapted from the Los Angeles intervention program, Community Youth Gang Services.

(*a*) Chose areas with high rates of violence, and homicide in particular. Identify within the geographic area those places, such as certain streets and parks, that have been taken over by violent persons or groups, such as gangs or drug dealers. Identify sites for intervention, such as schools, recreation areas, and potential worksites for youths.

(*b*) Establish street-level intervention efforts. Those who work on the front lines in street intervention programs should be ex-members of gangs, people who have worked in parks and recreation programs, and probation officers who understand the high-risk youth in the area. Street outreach workers must be skilled in crisis intervention, particularly in recognizing and identifying potentially violent situations, as well as in skills needed to lower levels of anger.

(*c*) Mobilize community members and conduct a community awareness and education campaign. One of the first steps in mobilizing the community is to make people aware of how close the problem is and of the fact that people are being killed in their own neighborhoods. Recruit local people for the education campaign. They can serve as catalysts to galvanize the community to take action.

(*d*) Establish school programs at the elementary and middle or junior high school levels that include the elements of building self-esteem, clarifying values, heightening cultural awareness, and reducing biases. Educational programs need to emphasize success and to employ special programs or role models to underscore the feasibility of the youth being successful. Examples are Star Kids/Star Parents programs and junior graffiti busters. The message of the educational component should not simply be don't join gangs, but should emphasize the message that personal options and careers are alternatives to violent lifestyles.

(*e*) Establish a job placement program. Work opportunities provide positive aspects, such as offering the opportunity to make money, building self-esteem, and providing opportunities to spend a number of hours each week in the company of people who are role models and perhaps advisors to and friends of working youth.

(*f*) Establish recreational programs that provide positive alternatives for social interaction and a release for youthful enthusiasm and energy. Recreational programs can offer alternatives to the social support promised by gang membership.

(*g*) Coordinate mental health services, drug abuse programs, and other social service programs that are available to high-risk youths.

Evaluation Issues

Because of time constraints and time spent debating and exploring intervention alternatives, the working group did not make recommendations for evaluation priorities. Their discussions noted the difficulties in evaluating community programs that were made up of a number of strategies. When many activities are going on, which may be essential to the success of community programs, it is difficult to determine the efficacy of individual strategies. Community-based organizations often do not want to put scarce resources into evaluation

efforts, choosing instead to place funds in community interventions. However, funding sources rely on evidence of success in evaluating the merits of particular programs.

Recognizing these constraints, the working group acknowledged the need to conduct evaluations of the recommended interventions to determine which techniques and approaches work, which of those at high-risk are reached effectively through the intervention, what the long-term impacts on behavior are, and what level of maintenance (resources and program components) is required.

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Weapons and Minority Youth Violence

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Introduction: Adapted in part from the background paper submitted by Education Development Center, Inc. (*1*).

WEAPONS SUCH AS guns and knives are used in more than 80 percent of the homicides involving youth in the United States (*2*). Weapons, particularly firearms, are an important cause of youth's disabling injuries as well as deaths. In Detroit, 40 percent of all traumatic spinal cord injury results from gunshot wounds (*3*). Most of the homicides among youth occur in the context of an argument and are committed by someone known to the victim (*4*). In these cases, the immediate accessibility of a firearm or other lethal weapon is considered by many to be the factor that turns a violent altercation into a lethal event.

The rates for fatal and nonfatal injury reflect the increasing impact of weapon-related deaths and disabilities among minority youth. Homicide rates for persons ages 15 to 24 have been 40 to 50 percent higher than the average for the general population, with a still wider gap (to more than 60 percent) emerging in 1986 and 1987 (*5*). Among the young, minorities suffer disproportionately. In fact, homicide by firearms is the number one cause of death for young African American men. About 1 in 32 urban African American males from 16 through 24 years of age is the victim of a handgun crime (that is, robbery, assault, homicide) (*6*). The prevalence and severity of firearm violence has been enhanced by the sophistication of the types of weapons used and by the use of alcohol and other drugs. Among firearms, handguns are disproportionately used in violence.

The principal consequence of firearms is to worsen the consequences of violence: injuries become deaths, and attempted rapes and robberies are successfully completed. Whole communities may be caught in the crossfire, and the people suffer both direct and indirect effects. For example, school absenteeism may increase; health care

resources expended to treat persons who have been shot are not available for other purposes.

Because injuries caused by firearms typically affect young males and are more severe than other types of injuries, they exact a great financial toll. In 1985, firearm injuries are estimated to have resulted in a productivity loss of $370,706 per person and cost society an estimated $14.4 billion in lifetime costs (*7*). These costs burden not only the injured but also families, employers, the community, and society. The psychological burden of firearm injuries is substantial, but it is difficult to calculate. The cost of fear is borne by the whole community.

These afflicted communities may also be the ones whose residents perceive the greatest need for self-protection. Firearms are frequently acquired for protection, although the data indicate that this may be counterproductive in relation to the safety of household members (*8*).

If weapons are perceived to provide protection against the unknown, their owners may not be assessing accurately the origin of the danger. Most homicides among youth occur during an argument and are committed by someone known to the victim (*4*). In firearms homicides, especially those committed by intimates, there is often a long history of abuse and violence (*9*). Weapons become the tools which amplify aggression and violence. Guns, more than other weapons, increase the likelihood that violence will produce a serious or fatal injury. Additional factors, such as exposure to violence through the media and playing with toy weapons as children, adversely shape our culture and attitudes about violence and weapons.

In recent years, illicit drug trafficking has provided the means and motivation to acquire firearms. Indeed, firearms play an important role in the drug trade (*10*). In some large cities, the levels of firearm violence have remained the same or even escalated after drug use epidemics have waned. This statistic suggests that once guns are in the community, they are available to settle minor disputes that are unrelated to the drug trade.

There is debate over many elements of firearm policy. Whatever the points that are debated, however, there is agreement that children and adolescents should never have unsupervised access to firearms. Yet such weapons are routinely confiscated by police and school officials across the nation. In California, from July 1, 1988, until June 30, 1989, schools confiscated 10,569 weapons, an increase of 21 percent over the past year (*11*). Although knives are the most common weapons found in schools, sophisticated firearms are also available to students, increasing the chances for serious injury or death (*12*).

Schools and communities across the United States have only begun to address the problem with a handful of programs and interventions that target weapons and youth violence. These essentially aim to educate people about the dangers inherent in possessing weapons, especially firearms; to restrict firearm availability and accessibility; and to reduce the potential lethality of weapons.

Although our knowledge of problems related to firearms has grown rapidly, important gaps in our information base persist. Some firearm-based interventions work. Local area restrictions and sentence enhancements have been associated with lower rates of firearm violence (*13*, *14*, and unpublished manuscript, G.I. Pierce, and W.J. Bowers: "The Impact of the Bartley-Fox Gun Law on Crime in Massachusetts," Northeastern University, Center for Applied Social Research, Boston, 1979). There is also a need to address gaps in current regulations, such as the exemption of the domestic gun manufacturing industry from the restrictions that apply to imports.

Underlying Assumptions

The following assumptions or guiding principles apply to all recommendations that follow this section:

- Because weapon ownership and use involve deeply rooted social, economic, and racial issues, interventions should address these issues, where they are appropriate. However, it is possible to reduce the incidence and severity of weapon-related injuries by strategies that do not directly address these issues.
- For an intervention targeting a specific community to be successful, key elements at the community level must be adequately represented in planning, implementation, and leadership roles.
- Intervention strategies must be characterized by features that reflect a clear understanding of the impact of racism and classism on weapon-related violence. Interventions must be designed in a way that recognizes that the underlying causes of weapon-related violence are primarily institutional in nature. That is to say, weapon-related violence is, in part, related to feelings of powerlessness, disenfranchisement, and differences in the way that institutions such as the criminal justice system treat poor people and people of color.

Although education alone will not prevent firearms injuries, public education can . . . raise the level of debate about the best ways to prevent firearms injuries in the community.

• A long-term investment in prevention programs should be a clearly stated priority of the program's funders. Changing attitudes and values as well as behaviors, particularly in such an emotionally charged area, requires time—more than 1–3 years. Time-limited interventions may make communities feel exploited and confused and may ultimately do more harm than good.

Priority Interventions

The work group on weapons and minority youth violence examined interventions recommended for communities and interventions to be implemented at all levels. Legal approaches are identified for community, State, and national levels. However, a wider range of interventions at the local level reflect the need to address people's understanding of the right to own weapons, the perceived need to own weapons, and the protection that they believe gun ownership affords them. These issues must be addressed locally, where cultural premises are better understood and workable solutions can be identified. Also, given the absence of effective regulations in many communities, education about firearms and the injuries that they produce is critical to the development of effective prevention strategies. Although education alone will not prevent firearm injuries, public education can have the benefit of raising the level of debate about the best ways to prevent firearm injuries at the community level.

At the community level, the following interventions have priority:

1. Develop community consensus regarding the possession and use of weapons. Two steps are needed to achieve this consensus:

• Develop a surveillance system for intentional injuries that collects information about the nature, circumstances, and weapons surrounding the injury so that community members become aware of the scope of the problem.

• Develop community awareness forums that address issues involving risk versus benefit of weapons ownership and use.

The level of community consciousness needs to be raised about the issues of weapons and their use. Communities must have sufficient information to educate people about the risks and benefits associated with access to firearms, such as whether or not guns should be in the home, the perceived need for security, and the perceived notion of safety when one owns a weapon.

The absence of adequate information on the impact of firearm violence in the community could be filled by the establishment of a surveillance system to provide community-specific information about who is involved in weapons-related violent behavior, the circumstances surrounding the violent act, and whether drugs and alcohol were involved. This information could be used to correct many of the myths and misconceptions that surround acts of violence. Surveillance data on firearm injuries could also be the basis for informing the community about the comparative risks and associated costs of easy access to firearms and for developing community consensus and, ultimately, for developing appropriate policies.

Programs to develop community consensus should be designed to ensure the clear participation and leadership of a broad community-based coalition. It is also critically important that any such programs include input from groups that bear the disproportionate burden of weapon-related violence.

2. Improve security and safety in high-risk environments along with the perception of safety. Modifying the environment to reduce the opportunity for weapon-related violent behavior should include the following:

• Neighborhood watches to increase the perception of safety at the community level and to improve community-police relationships.
• Technological devices that reduce the possibility of hiding weapons or of situations that could lead to violent behavior, such as metal detectors in schools and other high-risk areas to detect hidden weapons. Although there are few data on the effectiveness of technological or environmental strategies aimed at reducing injuries from violence, these types of strategies have successfully reduced other types of injury.
• Legal measures that limit the numbers of people

eligible to own firearms or the types of firearms that can be owned and carried. These interventions deal with some aspect of the sale, distribution, nature, possession, or use of firearms. Currently, regulations are most strict at the point of use and are weakest regarding manufacture and importation (*1*).

3. Require firearm safety courses as a prerequisite to obtaining a license to possess a gun. These courses teach people how to handle, use, maintain, and store firearms safely.

4. Ban the manufacture, sale, and importation of certain types of weapons and ammunitions that are designed to increase severity of injuries.

5. Educate the community regarding product liability litigation against gun manufacturers. This approach is based on the premise that manufacturers should be aware of the negative health effects of the use of firearms because of the growing body of scientific literature on the subject. Therefore, manufacturers should be able to foresee the danger of their products and be held accountable for them.

6. Increase efforts to restrict illegal trafficking in guns.

At the State or national level, these legal approaches are recommended by the working group:

- Transfer authority over guns to another department or agency, such as the U.S. Department of Justice or the Consumer Product Safety Commission (CPSC) and enhance its regulatory powers. The Federal agency that has jurisdiction over firearms is the Bureau of Alcohol, Tobacco, and Firearms within the Department of the Treasury.
- Efforts to restrict illegal trafficking in guns should be enhanced.
- Design and performance standards for firearms production should be established for domestic and foreign manufacturers.
- All gun owners should be licensed. Only licensed dealers should be legally permitted to sell guns (that is, private sales are prohibited), and all sales should be recorded. Just like drivers of motor vehicles, persons desiring to purchase and own a gun would have to take a test to prove ability, hold a picture license, register their firearms, and suffer punishment for a violation.
- A law should be enacted that establishes a national waiting period (for example, the Brady bill), that would allow for background checks of those wishing to purchase a handgun.
- State laws that preempt localities from legislatively addressing the gun issue should be fought and repealed. It must be recognized, however, that local gun regulations may have little more than symbolic value unless they are coordinated and supported by appropriate regulations at the State and Federal levels.

Evaluation Priorities

Principles of evaluation research. The working group recognized that requirements for rigorous scientific evaluations may reduce the sense of community ownership of an intervention and may prevent the undertaking of some worthwhile interventions. Therefore, while such evaluations should be promoted, excessively extensive evaluation requirements may be counterproductive.

However, subsequent discoveries of avoidable flaws in evaluations that have been advertised as rigorous and scientific may, over the long term, unfairly undermine the credibility of the interventions being evaluated. This danger is especially great in a field as politically charged as firearms regulation. Therefore, the design of funded evaluations should be of the highest scientific quality. The amount and duration of funding should be sufficient to ensure that evaluations are carried out as designed. This is most likely to occur if the funding of interventions and their evaluations are coordinated.

Effects of gun policy will vary because of special local conditions. Therefore, evaluations should be designed to specifically allow for and measure the differential impact on minority communities.

Specific criteria for evaluation may vary with the type of regulation. In general, culturally valid measures of the following are important concerning the regulation of guns: (*a*) the impact on morbidity and mortality, (*b*) monetary costs of weapon-related injuries and who pays, (*c*) the effect on community consensus, (*d*) the effect on perceived security, (*e*) the equity of enforcement, (*f*) the effect on violent and nonviolent crime rates, and (*g*) the effect on weapon ownership and weapon-carrying behavior.

Subjects for evaluation research. Each of the priority interventions recommended in the preceding section should be rigorously evaluated. Additionally, the following evaluative studies are suggested:

1. alternative data sources for surveillance of violence-related injuries,

'. . . requirements for rigorous scientific evaluations may reduce the sense of community ownership . . . and may prevent the undertaking of some worthwhile interventions.'

2. programs designed to reduce weapon-related violence in schools and high-risk environments,

3. impact of strategies to reduce weapon prevalence, including their effect on the flow of legal weapons to illegal markets,

4. impact of changing weapon regulations in communities including the impact among minority youths,

5. impact of weapon-specific interventions on violent behaviors,

6. impact of consensus-building interventions on policymakers and the community.

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Interventions in Early Childhood

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Introduction: Adapted from the background paper prepared by the Education Development Center, Inc. (*1*).

THE INCREASE IN REPORTED VIOLENCE during the last few decades has prompted a growing concern about its origins. The basic values, attitudes, and interpersonal skills acquired early in life are pivotal in the development of predispositions for violent behavior later in life. In addition, early childhood exposures to violent behavior, abuse, and neglect have been demonstrated to be risk factors for violent behavior and victimization during adolescence and adulthood (*2,3*). Violence prevention strategies that seek to (*a*) promote nonviolent values, attitudes, and interpersonal skills; (*b*) mitigate the consequences of exposures to violence; or (*c*) reduce risk factors for violence by targeting young children or their families, or both, are an important and underrecognized component of any long-term strategy to prevent violence.

Early childhood aggression is a critical consideration in the design of effective primary prevention efforts (personal communication, Carolyn Newberger, EdD, Children's Hospital in Boston, October 1990). Although children who demonstrate aggressive behavior at an early age will not necessarily behave violently as adults, they are at higher risk

for such an outcome. Longitudinal research indicates that early aggression is a strong predictor of aggressive behavior even 22 years later and that the stability of a person's level of aggression increases over time (*4*). These findings suggest that, unless directly addressed, a person's early aggressive tendencies are likely to be maintained and manifested in relationships with offspring, family, community members, and society in general (*5*).

Prevention efforts during early childhood must address the ways that children experience and learn violent behavior. Children may experience violence in a number of different roles: as the aggressor, as the victim, or as a witness. These roles provide opportunities for children to learn violence, either by direct experience or through observation. All three should be addressed in comprehensive efforts to promote the development of children into nonviolent adults.

Underlying Assumptions

The work group endorsed the following principles that promote positive development of children who live in communities that are plagued by violence.

1. Every child has a basic right to a healthy childhood with a standard of living that ensures the basic necessities of life (for example, food, clothing, shelter, health care) and the opportunity for optimal development. These principles are outlined in the "United Nations Convention on the Rights of the Child" (*6*).
2. Interventions must be sensitive to and appropriate for the cultural and social context of the community.
3. Society as a whole is responsible for the high tolerance of violent behavior. Every community must mobilize to change the cultural standards that condone and accept violence as a normative behavior. The idea that nothing can be done about violent behavior must be dispelled.
4. Stereotypes depicting communities of people of color as inherently violent are racist in nature.
5. Indigenous community institutions should be cultivated as partners in violence prevention activities because they are natural points of access and sources of support for those at risk.
6. Children from population subgroups, such as migrant workers, military families, recent immigrants, and undocumented aliens should also be included in early childhood violence prevention programs.
7. It is essential that interventions include consideration of the family unit. This approach should promote transgenerational modeling of behaviors incompatible with violent activity and the development of relationships in which child-raising is a shared responsibility. School-based interventions, while in themselves important, should include a family component.
8. Effective solutions require support from a partnership of Federal, State, and local governments.

Recommended Interventions

Recommended interventions focused on four points of service delivery: home, school, treatment setting, and community. To ensure effectiveness, key concepts promoting nonviolent behavior must be repeated across a number of social settings.

Most communities will have a number of ongoing activities that are compatible with violence prevention activities for the very young. Integration of interventions that prevent violence into these ongoing activities will minimize costs and avoid duplication of programs or services. It is also important to incorporate an evaluation component into interventions to measure their impact on the occurrence of violent behavior and its determinants. The results of evaluation will allow programs to be modified to achieve maximum effectiveness and their ineffective components to be dropped.

Home setting. Home visitation is a family support intervention that has been demonstrated to be cost-effective for a variety of health outcomes in children that are known determinants of youth violence (*7*). For example, home visitation has been shown to be effective in reducing the risk of child abuse and neglect (*8,9*); child abuse and neglect have been linked to increased risk of violent behavior in adolescence and young adulthood (*2*). Successful home visitation programs are based on "ecological models." In this model, influences on maternal and child health are viewed in terms of systems of material, social, behavioral, and psychological factors rather than as single influences. Nurse home visitors should establish a therapeutic alliance with the family during pregnancy and the early childbearing years and visit frequently enough and long enough to influence maternal and child outcomes. In addition, these programs should target families who are at high risk for maternal and child health problems by virtue of their poverty and lack of personal and social resources (*7*).

Home visits should precede the birth of the child, and continue until the child is approximately 2 years of age. Home visitation was initially conceived to provide advice, assistance, and support for parents in basic parenting skills (for example, nutrition, health care, and nurturing skills). Efforts are needed to incorporate activities that prevent violence into existing home visitation programs. These programs should include teaching parents about (*a*) conflict resolution, (*b*) appropriate disciplinary alternatives to corporal punishment, (*c*) ways to instill nonviolence as a social norm in children, (*d*) ways to teach and model nonviolent intervention strategies, (*e*) the dangers of weapons, and (*f*) monitoring the viewing of violent television programs.

Home visitation interventions carried out by nurses are expensive. Communities may need to explore the use of alternative types of home visitors to lower the cost of these services. For example, public health workers or lay visitors can be trained to provide some of the services. Pediatric nurses need not make every visit. Regardless of the type of home visitors chosen by communities, home visitors should be indigenous to the community. Visitors serve as mentors to parents and need to represent and understand the values and customs of the community. The expense and complexity of implementing home visitation programs in minority communities necessitate financial support and institutional backing from public and private sources.

Schools and day care settings. Educational interventions that emphasize nonviolent, cognitive interpersonal problem-solving skills, social skills training, and appropriate norms of nonviolent behavior have effectively reduced aggression among preschool and primary schoolchildren (*10*). Although the long-term effects of such education require further evaluation, current research suggests that such educational interventions should be implemented more broadly. Educational interventions focused on helping parents reduce the antisocial behavior of preadolescent children have also been found to be effective (*11*). These interventions can be delivered to children in schools, day care settings, after school programs, and youth groups.

Educational interventions should emphasize the development of nonaggressive norms of behavior (*12*). They should foster beliefs and attitudes that violence is not an acceptable way to solve interpersonal problems and that peaceful, constructive solutions are more effective and rewarding. These programs should encourage the development of cognitive skills, helping youngsters to overcome hostile bias in interpreting the behavior and intent of other persons and to devise alternative nonviolent strategies for dealing with interpersonal problems (*12*). These interventions are in addition to general training and practice in developing social skills, which are also recommended. The school curriculum should include training to counteract the effect of the violent content of television. Children must be convinced that television does not accurately represent the real world, and the violent behaviors that they witness on television are neither realistic nor appropriate (*13*).

The banning of corporal punishment in schools is a low-cost intervention that, while unevaluated, is consistent with other efforts to prevent violence in communities. In addition to the potential for physical injury, corporal punishment erroneously teaches children that violence is an acceptable means of resolving problems (*14*). As of December 1990, 29 States still permitted corporal punishment as a legitimate form of discipline in public schools; 21 States and the District of Columbia have banned the use of corporal punishment (according to personal communication of February 4, 1991, from Deborah Daro, PhD, Director, Center on Child Abuse Prevention Research, National Committee for Prevention of Child Abuse, Washington, DC).

Treatment settings. Therapeutic services exist for children who are victims of abuse and neglect, who are witnesses to violent acts, or who exhibit aggressive behavior. Victims of child abuse and neglect respond positively to therapeutic interventions on a variety of behavioral and cognitive dimensions (*15,16*). Although the long-term consequences of such intervention for preventing youth violence have not been widely examined, the present evidence strongly indicates that every effort should be made to get abused and neglected children into an appropriate therapeutic setting. Examples of therapeutic settings are individual psychotherapy, respite day care, therapeutic day care, and residential treatment programs.

Researchers are just beginning to recognize that witnessing violence has a negative effect on children. Research to date suggests that this impact can be profound (*17,18*). Further research and followup of such children are needed. In the interim, efforts to identify child witnesses and provide therapeutic services should be intensified and expanded, particularly for those children who witness violence in their family of origin. Therapeutic services for these children should explore grief and loss and

what the child is feeling after witnessing violence. Crisis intervention for schools and community groups and consultation with teachers, administrators, and parents about ways to respond to children who experience loss are also necessary.

Special day care centers are valuable settings for treating abused and neglected children. Respite day care provides a safe, nurturing, stimulating, and organizing environment for children who are abused or neglected. These programs include opportunities for children for socialization away from parents. Many of such children have not had the opportunity to socialize with peers other than siblings. Therapeutic day care programs provide a predictable, organized routine for eating, napping, and playing. This structure is very important for children with emotional and social disturbances whose homes are disorganized and chaotic. Play therapy can also be integrated into these experiences. Therapeutic day care goes beyond respite care in that it addresses the particular problems of each child. This type of program may be a positive alternative to foster care by keeping the child and parent together.

Community setting. Family support centers should be developed to offer programs and services to all community members, not just those at high risk. However, existing programs should be brought into an umbrella organization with new family services. Family support centers should include the following elements:

- Parenting education that addresses appropriate and effective discipline techniques, the danger of weapons in the home, and conflict resolution. Interventions that target discipline should associate parental use of corporal punishment and the message to children about the appropriateness of violent behavior (*19*). Other aspects of parenting education include techniques for managing anger and conflict resolution skills. An especially important aspect of parental education is providing information on the danger of having weapons in the home and information on the safe storage of firearms to keep them from children.
- Timely crisis intervention services for families or persons under stress and at risk for violence. This is particularly critical if violent incidents involve children. Interventions for parents who are abusive or experiencing loss of control include arrangements for alternative care of children, assessment of the factors involved in the abusive situation, counseling, and referral to followup services.

'Children must be convinced that television does not accurately represent the real world, and the violent behaviors that they witness on television are neither realistic nor appropriate.'

- Mentoring programs for children and parents that provide positive role models, confidants, and an avenue for exploring positive solutions to problems. For example, male mentors may have a strong, positive influence on the way that young boys relate to girls and women. Women mentors may positively influence girls' attitudes about themselves and subsequently with men in their adult lives. Mentors can supplement other services such as therapy for high-risk or abusive families.
- Ceremonies or traditions that strengthen a sense of family and community attachment. Children who participate in ceremonies that strengthen a sense of family and community develop a sense of connectedness with the community. For example, rites of passage that reflect cultural heritage and strong familial association within a society bond a community together. In addition, these rites instill intergenerational pride and self-esteem.

Public education campaigns promote public awareness of the need to prevent violence and the existence of violence prevention services. These campaigns need not be expensive or have the characteristics of glossy media campaigns that have been used to address other health problems. Public education campaigns for minority communities must be redundant and communicate appropriate information for the target population. The people who convey the messages must represent the groups they are trying to reach. These campaigns should make use of forms of communication and media that are indigenous to the community.

Evaluation Issues

Available evidence strongly indicates that interventions in early childhood are critical in any long-term strategy to prevent violent behavior. Currently, little is understood about the childhood exposures and behaviors that are most predictive of future violent behavior. There is also much to be learned about the most effective and developmen-

tally appropriate interventions for reducing the effects of harmful exposures and modifying violent behaviors (*20*). Research which addresses these questions is, in part, dependent on prospective, longitudinal studies that are expensive and require many years to complete. Despite this anticipated expense, support for longitudinal evaluation research of the effectiveness of early childhood interventions must be expanded.

There are many types of evaluation research designs, however, that are relatively inexpensive. Typically, these research designs use existing data in longitudinal analyses or evaluate an intervention in terms of its impact on key determinants of violent behavior in adolescence or young adulthood (for example, child abuse or neglect, aggression) that can be assessed over a relatively short period. Progress in determining the most effective childhood interventions is not wholly dependent on evaluation research that requires following children for long periods.

The evaluation of early childhood interventions can be facilitated by progress in several important areas:

1. The development of appropriate surveillance systems for the routine monitoring of child abuse and neglect and of children who witness violence. These systems would be very useful in evaluating many early childhood interventions.
2. More complete and accurate estimates of the economic costs of childhood exposure to violence. At this point in time the costs associated with the long-term consequences of early childhood exposures are poorly understood. This type of information will be critical to undertaking cost-benefit analyses of interventions in this area.
3. A stronger foundation than presently exists to support early childhood interventions can be developed through applied research in the following areas:

- The impact of violent events witnessed by children must be better documented and fully understood. Witnessing parental violence as a child has been demonstrated to be one of the most consistent risk factors for a man's use of violence toward his mate (*3*). We are only beginning to understand, however, the full magnitude and consequences for children of witnessing violence outside the home.
- We must better understand and identify the factors that protect some abused and neglected children from behaving violently later in life. Identification of these protective factors will assist the design of early childhood interventions for abused and neglected children.

4. Training materials and curriculums for gatekeepers and intervention deliverers (teachers, home visitors, physicians, caregivers, and so forth) should be developed and broadly disseminated. The success of many interventions in early childhood depend heavily on the knowledge and skills of such key gatekeepers as physicians and those who deliver the interventions (for example, nurse home visitors, teachers).

Priority topics for research on the evaluation of early childhood interventions include the following:

1. Evaluation of the consequences of placement experiences of abused and neglected children in relation to violent behavior in their adolescence and young adulthood. There are a broad range of placement and treatment options for abused and neglected children, their families, and their parents (for example, foster care, residential treatment programs, therapeutic day care, individual therapy) (*21*). Currently, we know very little about the relative effectiveness of these experiences in mitigating or perpetuating child abuse and neglect.
2. Assessment of the long-term effectiveness of early childhood training in cognitive interpersonal problem-solving skills, social skills, conflict resolution, and norms of nonviolent behavior for reducing violent behavior.
3. Assessment of the effectiveness of therapeutic interventions for abused and neglected children and those who witness violence in reducing the long-term deleterious consequences of these exposures.
4. Evaluation of the effectiveness of training material and curriculums in transferring appropriate knowledge, attitudes, beliefs, and skills to key gatekeepers and intervention deliverers (for example, teachers, home visitors, physicians, caregivers, and so forth).
5. Assessment of the effectiveness of early childhood mentoring programs for diminishing childhood aggression, violent behavior later in life, and child abuse and neglect. Early childhood mentoring programs include at least two types: (*a*) those in which children are mentored by adults and (*b*) those in which parents are mentored by other parents.

Evaluations of early childhood interventions should incorporate cost-benefit and cost-effectiveness analyses whenever feasible. Such anal-

yses are very useful in assessing the short- and long-term consequences of action or nonaction in implementing early childhood interventions (*16*).

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Transcript of a closing keynote address

Needed: A New Pathway to the Prevention of Violence

Deborah Prothrow-Stith, MD, Associate Dean, School of Public Health, Harvard University

I have a special greeting for all here today, including the Centers for Disease Control staff and my colleagues who have traveled the paths of this working group meeting over the last 2 days. The paths have not always been straight. They have had crooks and turns and circles. They have sometimes been quite rocky with steep slopes and we have had some inclement weather.

At the start of this journey, we were welcomed by the distinguished leadership of Morehouse Medical School and the CDC. We were called to collective action by the Deputy Chief of Police of Atlanta. We were inspired and the sun shone brightly with the words of the Surgeon General, as she told us to care for our children and asked us for intensity, broad thinking, and creativity. We received our maps (not road maps, either) and directions from Mark Rosenberg when he compared violence to AIDS and cancer and the 40 deaths from measles. (Actually when Mark spoke, I thought of the words of Dr. Darnell Hawkins when he said, "We just ain't serious about homicide among blacks." He added that this was not great grammar, but that it was the truth.) We received our equipment and survival instructions from Tim Thornton and his staff and we were off traveling as five groups along five unchartered paths.

We experienced difficult terrain: ideas clashed like underbrush that must be cut away before a path can be created. Critical places to explore for some were unimportant to others. We certainly disagreed over what directions to take, but we continued the journey. The first time our paths

converged, we were given concrete examples of "how to" by the first panel. During the break, we learned from each other that all the groups had similar struggles—no map was a road map—because in some places there were no roads! And it became clearer and clearer that we were to chart the way and draw the maps. Frustration built, but we continued our trail-blazing expedition. What was strikingly absent were the deep canyons of self-centeredness, the boulders of pettiness, or the circular detours of my turf, your turf.

On the second day we converged again to learn that there was no new money and no real plan to reallocate monies. Bill Foege, Larry Green, and Martha Katz took the hot seats and delivered the news. Dr. Foege reminded us to tell "the real people" stories and to show the faces behind the numbers. Dr. Green shared the strategies of working with foundation boards and of leveraging opportunities. Martha Katz told us the story of an elderly man who was a victim and prescribed coalition building with the elderly. Dr. Foege closed their panel by reminding us that progress has been made: "violence was a nonissue for mainstream public health 10 years ago, and that has changed. Private sector and government monies have both been added to the pot." But frustrations rose: 50,000 deaths each year from homicide and suicide and there is no beef. Where's the beef?

Nevertheless we got back to the hard work of charting new paths and, predictably, the underbrush got thicker. Can oppressed people afford to give up their guns in a society where the oppressor is armed? How do you address the issues facing people living in high-risk settings without stigmatization? How do we handle poverty? Poverty and classism, race and racism: should we make intervention recommendations concerning these issues, or should we write a preamble to explain our position about the overwhelming influence of these social factors on youth violence? Is the focus on the issues of black males a way of ignoring female victims and domestic violence? And then there was the ever present and critically important question from Dr. Omowale Amulera Marshall: how do you empower and fund African American men to help solve the problem with the African American male adolescents?

The underbrush was thick, frustrations rose further. Yet we continued over the hills, through the valley, cutting out a path, and now we're here. Dr. Mason, we are convening again to share our recommendations with you and to hear from you.

Expectations are high, but your leadership is needed. We have our draft recommendations. We have delivered through inclement weather, pain, cold, rocky terrain, steep slopes, hard climbs, and large pitfalls.

Who are we? Why did we come? Why did we stay? We are a diverse group from many places within this country. Several professions are represented here. We have diverse interests and perspectives that relate to interpersonal violence. We came because of a sincere desire to help, to try at yet one more meeting to further the cause, to walk together one more time, and to welcome the new folks. We came to chart the way and deliver a map and we have done that. It is not perfect but it is good, and now we have expectations of you.

Your history of elevating the CDC Office of Minority Health in the face of opposition and hiring as the Assistant Director for Minority Health our colleague, Rueben Warren, let us know that your heart is good and you have courage. Your successful push to give AIDS funds directly to community-based organizations in the face of major bureaucratic opposition lets us know that you have vision and you can get the job done. Your presence here demonstrates your interest and commitment to this issue.

We could leave here having attended another in a long series of conferences on violence, better networked, more aware of some new people in the field and their work, and with thicker skin with which to face our personal battles. Or we could leave here with the promise of your leadership and your help. We could leave here as part of a large movement

- to eliminate the stepchild status of intentional injury within the injury prevention movement,
- to get funds allocated or reallocated to reflect proportionately the problem of violence,
- to get those funds to people of color in community-based organizations.

This movement has at its core your good heart, your vision, your courage, and your ability to get it done.

The AIDS prevention effort has flourished and is well funded. What does AIDS have that we do not? Certainly it is not a bigger problem. Certainly it is not any more concentrated in minority communities. Certainly it is not any more devastating to young people. We do not have a magic bullet for violence or for AIDS. Both have complicated other overwhelming issues like racism, poverty, and

substance abuse. What does AIDS have that violence does not?

In the AIDS movement, there are people who lie in the streets and spray paint an outline of their bodies in protest, people who interrupt meetings and heckle government officials. And they get the beef. Do we need to act in such a fashion? In the area of violence prevention it is important for us to model prosocial approaches to our frustrations, but that does not make our frustrations any less real. We need the beef! We need your leadership. Thank you for this opportunity to continue our movement. Thank you for this opportunity and for coming, and now tell us how will you help us.

Closing Remarks

Prevention of Violence: a Public Health Commitment

James O. Mason, MD, DrPH, Assistant Secretary for Health, Department of Health and Human Services and Head, Public Health Service

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THERE'S AN ENGLISH PROVERB that says, "If you keep good men company," and I would add women, "you shall be of their number." Now, if "the difference between a good man and a bad man," as William James said, "is the choice of a cause," then I couldn't be in better company than with those who have committed themselves to the well-being and preservation of our nation's youth.

My association with Dr. Prothrow-Stith dates back to August 1989 when she, Dr. Woody Meyers, and Dr. Reed Tuckson came en masse to my office in Washington. They didn't need to convince me that the prevention of youth violence was a public health responsibility and, as such, should be one of our priorities. On that, we were already allies. They brought with them an impressive program proposal in hopes of convincing me that it would work to address the avalanche of preventable disability and death resulting from violence. That they're persuasive persons is evidenced by this conference and the growing commitment of the Department of Health and Human Services to preventing the waste of young lives through the tragedies that you have been talking about for the past 3 days.

And they are tragedies—not just for the victims and their families, but for the perpetuators. Like the "quality of mercy . . . that blesseth both him that gives and him that takes," a violent act against someone violates not only that one who is injured but the one who commits the offense as well. Not one, but at least two lives are maimed or destroyed.

Portraits of Violence

Let me tell you a true story. It may not be the most dramatic one that you've heard or the most unusual. But to me it is powerful because it's personal, it's a portrait in the statistics. It happened on a Sunday a month ago in one of our major cities. As the police reconstructed events, a brother of a friend of mine stopped to give a lift to several young men whom he undoubtedly knew from his years of teaching school in the area. The youths robbed him, and then, apparently because they knew he could identify them, they beat him, dumped him from his car, and repeatedly ran over him.

Ironically, the victim's sister, and my friend, could not be reached on the day the tragedy occurred. She was working overtime, involved in a program to prevent the kind of violent behavior that took her brother's life.

I grieved with my friend and her family for their tragic loss. But I also grieve with the nation for the tragic "loss" to society represented by the three young men who perpetuated the deed.

Mark Twain, in answering a toast "To the babies" at a banquet in honor of General Ulysses S. Grant, November 14, 1879, said:

> "Among the three or four million cradles now rocking in the land are some which this nation would preserve for ages as sacred things, if we could know which ones they are."

Actually, we would preserve as sacred each of those being rocked.

The sad truth is, there are some cradles whose value we will never be able to judge not even with the passage of time. The cradles are empty, and the young men and women who outgrew them are gone. For some, time, as we reckon it, has stopped—the potential of these young people cut short by violent acts. For others, time marches on. But they, like their victims, in all probability will never fulfill their true potential.

Who is to know if we have lost a Martin Luther King, Jr.? a Dr. Benjamin Mays? a Mary McLeod

Bethune? or a Michael Jordan? Just this past week the front pages of America's newspapers mourned the tragic death of Jay Bias. According to news reports, it's been more than 4 1/2 years since Jay tearfully followed the casket of his older brother, Len. And now the tears are for Jay, gunned down in a parking lot of Prince Georges Plaza.

It is said that Jay aspired to becoming a basketball star like his brother. Maybe he would have. Who knows, he may have even have been better than his brother. But their cradles are empty, and the young men are gone. It's too late for Len and Jay Bias, and it's too late for the brother of my friend and for the more than 21,000 Americans who die from acts of violence each year. It's too late for the 120 young Americans who died while this forum was held.

Our job is to make sure that 10 years from now, when we look back to assess our progress for the 1990s, that it's not already too late for the occupants of the cradles rocking today.

Violence Prevention—a Public Health Goal

Back in 1980, with the publication of the 1990 health objectives for the nation (*1*), the prevention of violence became an official part of the national strategy to reduce health disparities between minority and nonminority populations. Not that homicide and other forms of violence do not occur in the white community. They do. But even 11 years ago we knew that it takes its severest toll from young minority males, particularly blacks and Hispanics between ages 15 and 24.

Once the 1990 objectives were in place, our first challenge was to enlist the support of our colleagues at the State and local levels and get them to put violence prevention on their agendas. Traditionally, interpersonal violence has been considered the sole domain of the criminal justice system. Public health involvement was a new and different concept. As recently as 1987, only 2 of 325 State health department injury-prevention programs focused on homicide. Frankly, it's been an uphill battle convincing the public health community, first, that the prevention of violence was an appropriate public health function, and second, that it was amenable to the public health principles and practices of

1. epidemiologic investigation including risk factor identification,
2. surveillance,
3. goal setting, and
4. community-based action that includes surveillance, risk group identification, risk factor exploration, and program implementation.

Thank God, we have now reached the stage where action by public health practitioners, in close cooperation with community leaders, is not only possible but actively called for.

Communities all across the country are responding. Schools are teaching young people that violence is not their first and only recourse when they are angry or frustrated. Local public health agencies are targeting at-risk populations. Professionals, volunteers, and concerned citizens are talking about and beginning to implement constructive solutions.

We heard the Reverend Jesse Jackson, who was with Jay and Len Bias' parents, calling for all Americans to unite around the tragedy of the deaths of Jay and Len. Dr. Jackson spoke of conflict resolution, getting rid of anger and frustration without pulling a trigger or hefting a knife.

For many young people, our change of heart came too late. The 1990 objective for reducing homicide among black males was not met. In fact, between 1980 and 1990, the numbers dramatically worsened. Homicide was one of the most important factors contributing to a decline in life expectancy for black males.

Dr. Robert Froehlke, of the Centers for Disease Control (CDC), says that today it's more likely for a young black male to die on the streets of our major cities than it was for a U. S. soldier to be killed during a tour of duty in Vietnam.

Despite our failures, during the decade of the 1980s we learned important lessons. We learned that our focus on young black males, while entirely appropriate, was too narrow. We need to expand our circle of concern to include young black women and Hispanic and American Indian males.

We learned that we need better data, particularly at the community level where prevention programs are implemented. We need more comprehensive surveillance systems to help identify at-risk populations, to devise programs, and to evaluate the effectiveness of those programs.

And finally, we learned that combating violent behavior must be a joint effort. Communities, churches, researchers, educators, volunteers, social workers, and families need to be in there right from the start.

Tactics of Prevention

The truth is, young people are not saved by

bureaucrats sitting behind desks in Washington, DC, or, for that matter, Atlanta, GA. They're saved one-at-a-time by people like you, by volunteers in churches and boys clubs, and by teachers and coaches in schools. And most importantly, they're saved at home. Abraham Lincoln said it simply, "The hand that rocks the cradle rules the world."

Many of the problems afflicting today's youth are the result of problems in their homes. Violence begets violence. If a boy is beaten or kicked by his father, then he learns that when he is angry or frustrated, that is the way to respond.

We have a multitude of studies that support the relationship between child abuse and subsequent violent behavior. According to a review of related research, Gelles said (*2*):

> "One of the consistent conclusions of domestic violence research is that individuals who have experienced violent and abusive childhoods are more likely to grow up and become child and spouse abusers than individuals who have experienced little or no violence in their childhood."

Similarly, a study of adult male prisoners convicted of first-degree murder found that two-thirds had experienced "continuous, remorseless brutality during childhood."

Now, I don't want to be accused of misusing statistics. Admittedly, there are studies that find no significant relationship between violent childhoods and violent behaviors. There are young people from violent homes who turn out to be stalwart citizens. The pathway isn't always straight and certain.

What is certain is that, all too often, troubled families have troubled children. It's the rule, rather than the exception. A recent National Center for Health Statistics-supported indepth survey of American children found that one in five children under age 18 has a learning, emotional, behavior, or developmental problem that researchers say can be traced to the continuing dissolution of the two-parent family (*3*). And according to Francis Iannl, most gang members come from, "single parent families where the mother had been unable or unwilling to establish adequate behavior controls over her male children."

America's homes do not have to be troubled and her young people do not have to be violent if you and I do everything in our power to make sure they are not, and if Government policies support families in their responsibilities and do not hinder them in any way.

William Raspberry, the noted columnist, takes it one step further (*4*):

> "There's a simple reason why so many youngsters haven't learned the values espoused by their elders. They haven't been taught.
> "They haven't been taught by the institutions (home, school, and church) traditionally responsible for direct ethical instructions, and they haven't been taught by the example of their elders. . . .
> "Teach," he admonishes us, "by precept and example."

Young people need to be accepted, to feel like they belong and are doing something that warrants attention, if not praise. If they don't fit in with positive friends and behaviors, then they will seek the company and activities where they do. We will never be successful by simply telling a young person, "No, don't do that."

We have to replace don'ts with do's. If we don't want young people to react to anger with violence, then we have to teach them other forms of conflict resolution. If we don't want them hanging out on street corners in gangs, then we need to give them alternatives—some place better to be, like the ball park or the drama club. If their friends are losers and dragging them down, then we need to sponsor the kinds of programs that help them make better friends. We cannot leave young people in a void and expect them to thrive.

What we need are more programs like the D.C. Service Corps Program, announced by the District of Columbia. By putting kids to work renovating shelters for the homeless, restoring playgrounds and parks, organizing after-school programs, and assisting elderly people with chores and home repairs, the Corps, according to news accounts, can substitute activities that some urban kids participate in—such as dealing in drugs, dropping out of school—with community service and thereby gain the self-esteem that constructive activities produce.

The Next Steps

Eighteen of the 298 objectives in "Healthy People 2000" (*5*) relate specifically to violence and abusive behavior. These objectives reinforce this message that the public health community has a vital role in stopping the epidemic of violence.

"Healthy People 2000" emphasizes the need for the immediate implementation of comprehensive violence prevention programs. In short, it maps our course.

By "our" I don't mean the Federal course. "Healthy People 2000" is the people's plan. Many of you contributed to its design. And now we need you to make it a reality. We no longer need to look for every answer. We know what to do.

We are starting on the right track. As Secretary Sullivan will tell you, we intend to become even more deeply involved. He will explain the Department's new initiative to help communities improve outreach and services to minority males at risk of a wide range of healthy and human service problems, including violence.

But communities, churches, schools, health departments, and volunteer organizations, and last but not least, families must also get on track. This forum has taken concrete steps toward providing communities with the tools to translate the violence prevention objectives in "Healthy People 2000" into real action. But we must not let it stop there. These most important first steps are only the first of many steps we must take together if we intend to reach our goal by the end of this decade. We will use your recommendations at this forum as guidelines for future action.

Conclusion

I began by quoting Mark Twain's wisdom pertaining to the younger generation, so I'll conclude on the same note. In the toast to General Ulysses S. Grant, Twain said:

> "We haven't all had the good fortune to be ladies; we haven't all been generals, or poets, or statesmen; but when the toast works down to the babies, we stand on common ground."

By virtue of our shared commitment to the nation's children—to youth in minority communities—we stand on common ground. We are engaged in a good work, one that does more than build programs; it builds people. These young people are humans becoming. "For every man in an honored place, is a child that used to be" (anonymous).

Every young person—whether black, Hispanic, Asian, or American Indian—has great worth and value. Not all can become Martin Luther King, Jr.'s, Louis Sullivans, or Antonia Novellos. Their honor is in being good, upright citizens, mothers and fathers, teachers of their children, good neighbors who contribute to society by living out their lives in a decent, honest way.

That we be dedicated in our united efforts to help these young people avoid the tragedy of violent behavior and achieve their rightful potential is my challenge at the conclusion of this conference. May we work unitedly and diligently toward that end.

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The Prevention of Violence — A Top HHS Priority

Louis W. Sullivan, MD, Secretary of Health and Human Services

(Dr. Sullivan addressed the forum via closed circuit television)

HOMICIDE and violent behavior are nationally recognized, preventable public health problems that traditionally have been left to the criminal justice system. The public health sector has a legitimate and important role in working together with the criminal justice, social service, and educational sectors to reduce the dramatic toll in injuries and deaths that violence and abusive behavior inflict on our society.

Unfortunately, minorities and youth in this country continue to suffer a disproportionate share of violent death and injury. We must strive to identify effective strategies for preventing injuries in those at greatest risk.

I am personally committed to improving health and human services to minorities. In May of this year, I announced the availability of $1.5 million for grants to improve health and human services to minority men. Those at high risk of homicide, suicide, and unintentional injuries are at the heart of this initiative—which is only a small beginning. Progress in this area must continue, and I deeply appreciate the work you have done this week to move this concept forward. In this time of limited resources, it is critical that we develop public-private partnerships to provide long-term funding for violence prevention in minority communities. You have created the momentum, and I will monitor your progress with great interest.

The Department of Health and Human Services views the prevention of violence as one of its top priorities. The Year 2000 Objectives for improvements in the health of Americans places emphasis on reductions in violent and abusive behavior and calls special attention to the impact of this problem on minorities and youth.

The Forum on Youth Violence in Minority Communities is one of the first concrete steps to be taken in the direction of identifying effective homicide and nonfatal assault prevention strategies. Each of you is to be commended for the time and effort that you have expended in contributing to this important event.

One out of every five persons in the United States is a member of an ethnic minority. However, Time magazine recently reported that, "the voice of minorities remains barely a whisper." This voice grows stronger with every conference, every workshop, and every individual commitment to help abolish the health disparity that divides this nation. Thank you for your commitment to ensuring longer and healthier lives for all Americans.

Executive Summaries of the Background Papers

Background papers for the conference were prepared by Education Development Center, Inc., to provide the participants with as much information on the current status of interventions in the field as possible. From this information and from their own experience, the members of each working group were to prioritize what they would recommend that communities do to prevent youth violence, the key evaluation needs, and the specific principles of community intervention that apply to the prevention of youth violence.

The background papers were prepared with the support of the Centers for Disease Control, Minority Health Professions Foundation, and the Carnegie Corporation of New York. The papers do not reflect the review or input from Carnegie staff. Key contributors providing guidance and suggestions were James A. Mercy, PhD; Patrick W. O'Carroll, MD, MPH; Kenneth Powell, MD, MPH; Mark L. Rosenberg, MD, MPP; and Timothy Thornton.

The executive summaries of these background papers follow.

Application of the Principles of Community-Based Programs

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VIOLENCE IS A COMMUNITY problem and a public health problem. The first half of that statement represents a rediscovery of beliefs embedded in the early history of American communities. Before professional law enforcement officials came on the scene, everyone in a community was involved in crime prevention (*1*). It is this sense of direct involvement that current community violence prevention programs seek to rebuild. The recognition of violence as a public health problem is more recent and is based on the toll that violence takes in mortality, morbidity, and health resource expenditures. Public health researchers and practitioners can make important contributions to prevention through their abilities to apply principles of epidemiology, conduct surveillance, and develop and evaluate interventions that address youth violence in minority communities (*2*). The public health effort grew in part from the realization that the prevention of violence is beyond the capabilities of the criminal justice system acting alone.

If violence is a community problem and, indeed, one that affects every community in some measure, it is also true that minority communities bear a disproportionate share of death, disability, and violence-related social disintegration. The cycle is particularly vicious—disempowerment breeds violence, and violence breeds even greater powerlessness.

The history of community organization encompasses models that range from the paternalistic, in which the recipients of services resulting from the community organization had no or very little voice in determining the problems to be addressed, to a model in which an indigenous leader or group organizes and carries out a program with or without outside assistance. Real-world efforts in community organization generally combine elements from both extremes.

Several general principles that apply to community organization can be identified:

- Community competence is the ability of various parts of the community to collaborate effectively in identifying needs, achieve consensus on goals and priorities, and effectively implement actions to achieve the goals (*3*).
- Participation is an essential element in community organization because it allows individual persons to take effective ownership of interventions and to build on each experience.
- Relevance contributes to the success of community programs because success is much more likely if programs are built on the community's felt needs and concerns rather than on the agenda of an outside agency.
- Planning interventions is a critical step that must be taken to convert an agreed-on goal into a practical plan of action.
- Empowerment and creating critical consciousness are extremely important functions of programs that address violence. Empowerment is the process of enabling individual persons and communities to increase their control and their ability to define and achieve the goals that they define as meaningful.

Specific, essential tasks that should comprise a process for developing community programs to prevent violence include developing leadership, identifying the problem, devising a strategic plan to address it, translating the plan into action through an intervention or a program of interventions, implementing that program, and evaluating the effects.

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Violence Prevention Strategies Targeted at the General Population of Minority Youth

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VIOLENCE IN AMERICA continues to impair and jeopardize the lives of young people and the quality of life in the communities where they live. Statistics on assaults and homicides highlight the dramatic impact violence has on minority youth in particular. The pressure to respond to the problem of youth violence has led to the development of new strategies and the replication of existing ones in a variety of settings. This background paper examines the range of interventions designed to reduce injuries and death that are targeted to the general population of minority youth or to the environment that affects them.

Most young people seldom or never engage in violence. And based on the almost-epidemic proportions of the problem of youth violence, many people question the soundness of implementing such untargeted or generally focused interventions. They strongly suggest that resources should be directed toward those at high risk for violence or currently engaged in violent behavior. However, it may not be enough to focus prevention efforts solely on high-risk groups. For example, teaching peers of youth at high risk for violent behavior—as well as nonviolent youth—to resolve conflicts without violence may have the effect of altering the social environment in which violence occurs in ways that lessen the likelihood of violent conflicts.

In a review of programs and interventions for the general population of minority youth, we found that, almost without exception, the programs identified were for African American youth. The majority are school based, perhaps because schools promise the largest "captive" audience. Some programs have been developed with a specific focus on violence and concentrate on education around risk, conflict resolution, and mediation. Others take a holistic approach and address a cycle of interacting problems (for example, low academic achievement, low self-esteem) through life skills training, mentoring, Afrocentric education, academic tutoring, and

career development courses.

For the purposes of this paper, intervention strategies have been placed in four categories: educational, recreational, environmental-technological, and legal.

Educational Interventions

The enormous toll violence takes in terms of morbidity, mortality, and economic costs has led to the acknowledgement of violence as a public health problem. This position is supported by epidemiologic data, which show that when violence takes place, it is acquaintances or family members who are most likely to be involved—not the stranger who comes "out of nowhere" to attack and kill—and the violence is often precipitated by an argument, rather than a crime such as robbery or burglary. Because violence is often precipitated by interpersonal conflict, it follows that it can be prevented through educational interventions that provide people with a range of other nonviolent options—and instill in them the desire to choose a nonviolent response. If violence is almost always the result of behavioral choices, then it can be prevented through the use of educational interventions designed to change young people's knowledge, attitudes, and behavior patterns that could lead to violence.

Educational interventions are being employed, some of them quite successfully, to prevent youth violence. These interventions can be placed in three categories.

1. interventions to build male self-esteem—manhood development curricula, mentors and role models, and immersion schools (an intensive program combining academics, culturally appropriate curricula, counseling, and mentoring by African American males);
2. education in conflict resolution and mediation curricula, training, and technical assistance; crime prevention and law-related education; and life skills training;
3. public education interventions—public service announcements, educational videos, video conferences, and media education.

Recreational Interventions

Physical activity provides an excellent outlet for pent-up tension, stress, and anger. According to the National School Safety Center, the contention that sports can serve as an effective antidote to delinquency has been made throughout the 19th and 20th centuries by educators, sociologists, psychologists, and penologists (*1*). Although recreational activities have not been viewed as a major intervention that can prevent violence, a well-designed, multi-component program that includes a recreational intervention can be effective. Hundreds of such interventions are being employed in communities across the country. They are operated by organizations such as the Police Athletic League, Boys and Girls Clubs, Girl Scouts, Boy Scouts, YMCAs, and YWCAs.

Environmental-Technological Interventions

Because environmental and technological interventions do not depend on human behavior, they have been most successful in addressing other public health problems. In many cases, such interventions have contributed to reductions in unintentional injury and death because they have the potential for reaching large numbers of people and offer automatic protections without requiring behavioral change. Examples include child-proof safety caps for medications, automobile airbags, and automatic safety belts.

The traditional public health model—which attributes occurrences of disease to a multitude of complex interactions among the host, the pathogen, and the environment—is now being applied to violence. However, more emphasis has been placed on the host (victim) and the pathogen (perpetrator), because of the challenges of applying environmental interventions. In addition, environmental interventions have sometimes met with public opposition because they have been viewed as infringements of personal freedoms. Environmental-technological interventions include metal detectors, concrete barriers, and other strategies that are mostly school-based.

Legal Interventions

Legal interventions include curfews and policing school campuses. Youth curfews are very much in the news, with the implementation of a program in Atlanta, GA, and discussions of their feasiblity in other cities.

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Violence Prevention Strategies Targeted towards High-Risk Minority Youth

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MINORITY YOUTH, IN GENERAL, are at high risk for violence. But within that broad group are youth at extreme risk, largely as a result of their environment, behaviors, and personal histories. The factors associated with interpersonal violence include unemployment, poverty, few educational opportunities and low levels of achievement, drug or alcohol abuse, and weapon carrying. All are more prevalent in poor, urban, largely minority environments (*1*).

Targeting a narrowly defined population can be crucial to successful intervention. Interventions for minority youth at high risk for violence have tended to focus on a few target groups: gang members, drug users, and juvenile offenders. Other groups, such as families of gang members or weapon carriers, have received less attention. Many youth are informally labeled as "high risk" by teachers, health care providers, and law enforcement agencies and are the focus of multiple interventions. (This loosely defined, varied population requires further definition in order that targeted interventions may be developed.) Violence prevention interventions for other high-risk groups such as youth abused or neglected as children, are virtually nonexistent.

Researched for this background paper were strategies that targeted nine high-risk groups. Seven categories of interventions were employed with these youths.

The high-risk groups were gang members, potential gang members, abusers of drugs or alcohol, drug dealers, juvenile offenders, youth with histories of fighting or victimization, carriers of weapons, youth abused or neglected as children; and loosely defined high-risk youth that included school dropouts and unemployed males.

The seven categories of interventions follow: education (efforts in schools, communities, and within the criminal justice system); outreach through community-based counseling, street work, and health care institutions; legal (law enforcement, police-community collaborations); recreation; work or academic; media (public information campaigns for example); and physical environment.

A recent review of evaluations of violence prevention programs conducted for the Carnegie Corporation revealed that few programs have been evaluated sufficiently to prove their effectiveness (*2*).

The reasons for inadequate evaluations are many—lack of funding, staff inexperience with evaluations, and fears that results might threaten future funding. Many programs employ a variety of interventions, and it is difficult to separate and evaluate the individual components of the program. In fact, these various components may be successful because of their comprehensiveness and synergy. Another limitation is that the information frequently documents changes in knowledge and attitudes rather than behavior. The extent to which knowledge and attitude changes correlates with or predicts behavior change, either at the time of testing or over a longer period, is uncertain.

With these limitations in mind, interventions can be categorized as "proven effective," "promising," "ineffective or counterproductive," or "efficacy unknown or insufficiently studied." The following findings are listed for the types of intervention strategies.

Education

Educational interventions have been used with each of the high-risk groups, but the results vary widely. Educational interventions take place in many settings (schools, institutions, community organizations) and use many formats including curricula, brochures, and workshops. Educational interventions are usually designed to convince youth that they have alternatives to violence and teach effective and constructive ways to deal with anger and confrontation. Only among juvenile offenders has an educational intervention been proven effective in terms of decreased aggressive behavior and suggestions of decreased recidivism (*3*).

Among other high-risk groups, educational interventions were, in most cases, promising—judging from program reports, numbers of persons exposed to programs, and qualitative data about what youth learned. For example, preliminary data from Project RAISE, which involved the loosely defined high-risk group, indicate that school attendance rates for students were higher and that their retention rates (nonpromotion to the next grade) were lower. (Laura Chambers, Director of Mentoring Resource Center, Baltimore Mentoring Institute, supplied information on the project in a telephone interview in October 1990.)

For youths who carry weapons, there is insufficient information about the effectiveness of educa-

tional interventions and there are some indications that education alone may not lead to behavioral change.

Outreach

Outreach interventions include one-on-one counseling in less formal settings, such as streets or parks, and communication between health care providers and patients who are the victims of violence or at risk of violence. Other types of group and individual outreach programs are such activities as teaching juvenile offenders about the impact of violence on the victims' lives, crisis management or mediation with gang members, and individualized long-range planning.

Outreach interventions have been used with gang members, potential gang members, drug and alcohol abusers, juvenile offenders, youth with histories of fighting or being victims, and the loosely defined group of high-risk young people. Outreach interventions may serve a useful purpose in diffusing crises (for example, potential gang confrontations); however, the evidence was not sufficient to show the effectiveness of outreach as a promising intervention.

Legal

Legal interventions refer to standard law enforcement procedures and to police-community collaborations to reduce violence, including the use of crisis intervention teams made up of police, probation officers, and community workers. Collaboration of local agencies and local residents with law enforcers enables both law enforcement and community personnel to benefit from each other's resources, information, and experience. Police referrals to community-based programs enable public health professionals to come in contact with greater numbers of high-risk youth. Collaboration can result in low-profile efforts such as neighborhood watches and volunteer patrols linked to the police and in higher profile efforts such as street-based crisis management teams that act in impending gang conflicts and violence.

Legal interventions have been used with gang members and the loosely defined high-risk youth group. Such interventions (often in combination with outreach) can be useful as a form of crisis management but they cannot serve as a primary means of prevention. Alternative sentencing programs are promising.

Recreation

Recreational interventions are based on the premise that when given alternatives, high-risk youth will be less likely to hang out, do drugs, drink, fight, engage in criminal activity, and recruit others to engage in these activities with them. These interventions consist of activities such as midnight basketball leagues.

Recreational interventions have been used with gang members, potential gang members, juvenile offenders, youths with histories of fighting or victimization, and loosely defined high-risk youth. The experience with these interventions as well as the findings of the National Committee for Injury Prevention and Control (*4*) indicate that these are promising interventions.

Work and Academic Opportunities

Work and academic opportunities are designed to compensate for the lack of work and education, or opportunities to obtain them, that puts youth at risk for violence-related activities. These interventions consist of job and career counseling, preparatory classes for the graduate equivalency diploma, job skills training, instruction in reading and mathematics, and opportunities to work or volunteer. Designed to offer youth positive, constructive alternatives and to gain experience, build self-esteem, or earn money, the interventions also have the practical effect of getting youth off the streets and into school or jobs.

Work and academic interventions have been used with gang members, drug and alcohol abusers, juvenile offenders, youth with histories of fighting or victimization, and the loosely defined high-risk group. For other risk groups there is insufficient evidence of the efficacy of these interventions.

Media

Media interventions aim to give broad exposure to the nature of the violence problem and possible solutions, and they can help to change attitudes and norms regarding violence and related behaviors. These interventions include ad campaigns, talk shows, and news features. Media efforts often complement other interventions by raising public awareness and creating support for positive activities.

Media interventions have been used with potential gang members, drug and alcohol abusers, and the loosely defined high-risk group. There is insuf-

ficient evidence that these interventions are effective. However, the effects of media educational campaigns may not be seen for a year or more. Further research is needed to clarify how these campaigns can bring about behavioral change and how they can be accurately targeted to risk groups. There is some evidence that media interventions, such as scare tactics, can have a negative impact.

Physical Environment

Environmental interventions, such as installing metal detectors in places where youth congregate, concrete barriers that restrict traffic, or open lighted areas that deter activities that could result in violence, have been tried in limited circumstances as a means of reducing gang activity and appear to have promise for the prevention of crime and drug-related activities. However, the intentional nature of violent injuries limits the success of environmental interventions.

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Weapons and Minority Youth Violence

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VIOLENCE ASSOCIATED WITH WEAPONS is a major public health problem. Each year, growing numbers of young people are killed or severely disabled in violent altercations that involve weapons. And among the young, minorities suffer disproportionately. In fact, homicide by firearms is the number one cause of death for young African American men (*1*). Although firearms and other weapons are only part of the problem, they are the tools by which aggression and violence turn fatal. If the weapon happens to be a gun, then the chances of the anger becoming fatal increase. Recognizing this problem, schools and communities across the United States have begun to address the problem with a handful of programs and interventions that target weapons and youth violence. Interventions designed to reduce youths' use of weapons can be divided into three broad categories: educational-behavioral change, legal, and technological-environmental.

Currently, there exist only a few educational programs designed to prevent weapons misuse by youth, especially minority youth. These programs usually combine a number of educational strategies such as firearm safety courses, public information campaigns, counseling, classroom education, peer education and mentoring, and crisis intervention. Given the difficulty of controlling handgun availability through legal and technological countermeasures, education about injuries attributable to firearms may be a critical first step toward a comprehensive approach to preventing them.

Legal countermeasures, which limit the number and types of people eligible to own firearms or the types of firearms that can be owned and carried, are usually designed to affect everyone, not just minority youth. There are thousands of Federal, State, and local laws dealing with the sale, distribution, nature, possession, and use of firearms to control the availability of firearms at the State and local level. Baker and coworkers (*2*) suggest intervening at four different points in time: (*a*) when the gun is used, (*b*) the period of possession, (*c*) at the sale or transfer, and (*d*) at the manufacture or importation. Currently, regulations are most strict at the point of use and are weakest regarding manufacture and importation. In the future, laws may have more impact if firearms are most stringently regulated at the point of manufacture.

However, in the absence of uniform national laws, many local or State gun control laws may not be particularly effective. Criminals may simply go out of State to buy weapons, which they may in turn sell. The role of the Federal Government in gun control is viewed by some as crucial because it can provide the coordinating framework for the myriad of State and local laws. The current Federal legislation is limited, and recent efforts to change it have been unsuccessful. Despite the proliferation of gun control laws in the United States, there still remains some uncertainty about the effectiveness of previous legislative attempts to restrict availability and use of firearms.

Existing technological and environmental measures are based on the premise that automatic protections are generally more effective than those

that require repetitive actions. These interventions include modifications to weapons (especially firearms), ammunition, and the environments where weapons are used. To date, there are very few evaluation data on the effectiveness of technological and environmental interventions aimed at reducing weapons violence. However, given the success of past technological and environmental strategies aimed at reducing other types of injury (*3*), additional strategies should be explored.

Potential educational and behavioral change interventions include educating students and their communities, legislators, policy makers, the media, and health professionals and adolescent patients in clinical settings about the dangers inherent in carrying or possessing firearms. Potential legal interventions include assessment of firearms legislation, changing pre-emption laws, monitoring legislators' voting records and lobbying them, product liability suits, taxation, stricter licensing and registration policies, and bans on selected types of firearms. Potential technological-environmental interventions include designing safer weapons, eliminating some types of ammunition, modifying the environment in which weapons are used or carried (including building peaceful, cooperative school environments and reducing poverty).

There is much evidence from the field of public health, especially injury prevention, to show that these strategies have the potential to prevent weapons misuse among minority youth. It is not enough to focus solely on the technological or environmental measures or on getting rid of firearms; a combination of preventive strategies must be used. Before interventions can be discussed, however, professionals must address issues including the inadequacy of information on which to base firearms policy and practice, how local communities can play a role in the prevention of firearms injuries and deaths of minority youth, and the ethical and philosophical issues associated with the use of particular interventions such as metal detectors.

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Interventions in Early Childhood

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THE PREVENTION OF VIOLENCE among minority youth has been approached from many different perspectives, but intervention efforts that begin in adolescence may be too late in the process of child development to effect comprehensive, long-term changes in aggressive behavior. Early childhood, then, represents an optimal time for violence prevention intervention. Aggression is learned from a very early age; and as children move through the normal course of development, family and peer relationships, living environment, and media violence all affect the development of aggressive behavior. For minority children, however, an increased likelihood of low socioeconomic status may increase exposure to violence and present greater obstacles to the development of social competence than those confronting children from higher socioeconomic backgrounds. Interventions designed to reduce the development of aggression in early childhood fall into two broad categories: educational-behavioral and therapeutic.

Although not abundant, educational interventions for new parents do exist and are often incorporated into prenatal and well-child health care. These programs focus primarily on increasing care giving and discipline skills, anger management, and social support, and they employ parent aides-mentors and home visitation. Relatively few effective educational intervention strategies targeting very young children exist, but many programs designed for early elementary school children are adaptable to culture-specific day care or preschool environments, or both. These interventions commonly use strategies designed to teach or enhance interpersonal problem-solving skills, self-esteem, anger management, communication, conflict-resolution skills, and empathy.

For parents and children already displaying violent or aggressive behaviors, therapeutic interventions are also available but often less readily so for low-income families. Aside from individual or family counseling, only a few therapeutic alternatives are available for parents. However, some residential and therapeutic or respite day care programs involve both parents and children. In addition, foster care, grief counseling, and conduct-disorder therapy are available for children.

Aggressive behavior is produced by a constellation of factors, and effective intervention programs must be based on a multidimensional, culture-specific approach. Additionally, interventions in early childhood must often include two target populations—both parents and children—because of the enormous familial influence during early childhood. However, early childhood intervention strategies are often hampered by the problem of access. Many families are isolated from social services and quality health care, and many children under age 5 are not enrolled in center-based day care or preschool. Reduced access means that numerous young families, especially families of low socioeconomic status, find that center- or school-based interventions are not readily available. Community-based interventions, then, may offer the most effective means for reaching inner-city families with very young children who are at high risk for violence.

There is clearly a need for further research and evaluation, especially in the development of reliable measures of behavioral outcomes. In addition, a number of critical issues, including cultural norms, socioeconomic status, media violence, children's resiliency, and social policy, must be considered in designing effective interventions. Until racial disparities are removed from society, minority children will continue to be at higher risk than their nonminority counterparts for exposure to violence and possible subsequent aggressive behavior. Interventions in early childhood that support positive parent-child relationships and encourage the development of social competence may be one of the most effective strategies to prevent violence among minority youth.

Evaluation of Community-Based Violence Prevention Programs

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THE NEED FOR PROGRAMS to prevent youth violence is undeniable. In neighborhoods beset by the problems of youth violence, the enthusiasm for starting community-based programs is typically great. Too often, however, programs are disseminated widely without any proof of their effectiveness. There is no evidence that these programs accomplish their goal(s), because little attention and few resources have been dedicated to evaluating their evaluations.

In 1989, after reviewing the state of the art in injury prevention interventions, the National Committee for Injury Prevention and Control concluded that "there are few models and much uncertainty about the effectiveness of many available [interpersonal violence and suicide] countermeasures. Therefore the greatest need is for interventions that are designed with specific, measurable objectives" (*1*). More recently, a review of violence prevention programs carried out for the Carnegie Corporation of New York concluded that few, if any, programs have been the subject of evaluations sufficiently rigorous to prove their effectiveness (*2*).

There are two powerful barriers to advancing the field of violence prevention in minority communities and communities in general. First, there is no evaluation at all of what's done; second, there is an evaluation that is virtually doomed because the participants—evaluators and program staff—cannot understand or respond to each other's strengths and needs.

Evaluation is a powerful tool that often is not employed or not employed correctly. Evaluations can answer the questions shared by virtually all those dedicated to the complex and at times overwhelming work of violence prevention. They ask: is our program reaching the right people at the right time in their lives—children and adolescents in school and out, their parents, teachers, counselors, other important service providers, and community members? Are our classrom materials, media presentations, parent outreach, community meetings, and other activities being used the way we had intended? Are they accomplishing what we expected? In what ways? Which specific interventions or components of our program work best? Where should we place more of our efforts in the future? The answers to these questions, obtained through careful evaluation, can empower community efforts to prevent youth violence.

Few community-based programs aimed at preventing youth violence will ever be involved in what has been termed "efficacy evaluation," that is, assessment of the impact of a well-defined intervention conducted under closely monitored, controlled, and close-to-ideal circumstances. Indeed, experience with substance abuse programs suggests that an emphasis on "research-oriented" evaluation has the negative effect of reducing a sense of community ownership and involvement. Most youth violence prevention evaluations—like the programs them-

selves—must be carried out under less than ideal circumstances, often on limited budgets. Thus, they must take into account and be responsive to the imprecision, complexity, and other difficulties of making and measuring results in ever-changing, politicized, and often demanding communities. These factors require a specialized kind of evaluation, and an evaluator experienced and comfortable with the tasks (and inherent research limitations) of such an approach.

Strengthening evaluation efforts can strengthen community violence prevention programs in at least four vital ways:

- providing individual programs with information on which interventions work best, which do not, and how to advance the staff's efforts in the future;
- providing solid evidence of program effectiveness, undeniably the most compelling argument for continuing and expanding violence prevention efforts, particularly in a time of budget constraints and cost cutting;
- ensuring that there are ways to collect and share information across programs, thus cross-fertilizing and enriching the field of youth violence prevention; and
- identifying the research needed to support program and evaluation efforts, such as expanded investigations into the determinants of violent behavior, better ways to measure intermediate outcomes of violence, and improved surveillance of the range of violent behaviors and their negative outcomes on youth, families, communities, and the nation.

Three types of evaluation are useful in determining the effectiveness of programs: formative, process, and outcome. Formative evaluation assesses the development of a program and its specific interventions (for example, determining which media campaign slogans are most compelling for different audiences). Formative evaluation techniques are typically used before an intervention is fully implemented and the information that it yields is used to plan strategies.

Process evaluation determines what services were actually delivered; it is an important management tool. In addition to keeping records of the number of people served and their characteristics, process evaluation helps program staff determine how well they are meeting their objectives; it can provide the information needed to determine what interventions can be tested through outcome evaluations; and it documents the planning, development, and implementation stages, which will help others replicate the program.

Outcome evaluations compare the situation before and after an intervention is implemented. They show (*a*) what changes have occurred and (*b*) that these changes are the result of the intervention itself, not of some other factors.

There is an important distinction between *being* evaluated and *doing* evaluation. Program staff—and the community as well—should become active participants in their own evaluations, not subjects who submit to being studied and reported upon. To accomplish the mental transition from being evaluated to doing evaluation, program staff may need additional training that empowers them to become "doers." At a minimum, with the assistance of a trained evaluator, program staff should come to recognize the importance of participating in their evaluation, the requirements and benefits of different levels of evaluation, and what they can expect to gain from their efforts. This background enables program staff to make the evaluation work for, not against, their program.

Finally, the need for evaluation does not mean that all programs must be evaluated to the same extent. Indeed, different levels of evaluation are necessary for different programs. Nevertheless, some basic requirements for any evaluation should be understood as minimum standards for the field. Although evaluations need not conform to rigorous experimental designs drawn from research methodologies to be valid or useful, they have to be developed and implemented with sufficient care so that their findings are convincing.

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