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ABSTRACT

This bulletin is intended to raise awareness of the magnitude and gravity of adolescent maltreatment and to provide information on public health program and policy interventions. A review of adolescent victimization, with a focus on vulnerable youth, provides background for the development of public health measures to promote prevention and ensure recognition and early intervention for treatment of adolescent abuse and neglect. Two sources for information about adolescent maltreatment are the National Child Abuse and Neglect Data System and National Incidence Studies of Child Abuse and Neglect. Information is provided about sexual victimization, links between abuse and adolescent sexual behaviors, the juvenile justice system, and adolescent responses to victimization. A pubic health framework for addressing adolescent maltreatment is outlined, with 10 specific steps to build programs and policy. (Contains 146 references.) (SLD)

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Adolescent Maltreatment: Youth as Victims of Abuse and Neglect

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Introduction

Although individual, family, and societal costs of adolescent maltreatment are not well recognized by our society, they are associated with multiple adverse consequences. Physical and sexual abuse are considered major etiologic agents in the new morbidity facing our youth (Krugman, 1992). The health and psychosocial consequences faced by many abused adolescents support this assertion. For those sexually abused, consequences may include premature or increased sexual activity, increased risk of unintended pregnancy, depression, increased suicide attempts, chronic anxiety, confused sexual identity, alcohol and other drug abuse, and delinquency. For those physically abused, consequences may include generalized anxiety, depression, adjustment and behavioral ("acting out") problems, academic difficulties, sleeping problems, increased drug use, self-destructive/reckless behaviors, suicidal ideation/behavior, violence against siblings and parents, eating disorders, and aggressive behavior (American Medical Association [AMA] Council on Scientific Affairs, 1993).

Abuse and neglect of young children currently receives significant attention; however, there is less concern about the maltreatment of adolescents. Adolescent abuse and neglect differs from that of children. Because of physical, cognitive, and emotional developmental differences as well as situational differences, adolescent abuse is less likely to be recognized than child abuse. The patterns of abuse also differ; for example, there is less mortality and head trauma and more sexual abuse among adolescents than among infants and young children. The responses of adolescents also differ from those of children: Adolescents can escape from the abuser more easily or can fight back. Although adolescents may avoid abusive situations more readily, their independence may place them at even greater risk of danger such as running away and living on the streets (AMA Council on Scientific Affairs, 1992).

This bulletin seeks to raise awareness of the magnitude and gravity of adolescent maltreatment and to provide information on public health program and policy interventions. A review of adolescent victimization, with a focus on vulnerable youth, will provide background for the development of public health measures to promote prevention and ensure recognition and early intervention for treatment of adolescent abuse and neglect.

Adolescent Populations at Risk

Although some adolescents survive abuse and do not seem to suffer extreme psychosocial and behavioral problems, many other abused adolescents are likely to be found in settings that reflect their response to abuse—particularly the health, social service, or juvenile justice systems. Many circumstances should heighten awareness of the possibility of current or prior maltreatment of adolescents: alleged physical violence against parent or caregiver; prostitution; pregnancy or sexually transmitted infections, especially in younger adolescents; truancy or poor performance in school; behaviors consistent with eating disorders; diagnosed conduct disorders or other mental health problems; aggression with peers and authorities; runaway behavior or "throwaway" behavior (in which the child is thrown out of the home); violations of the law; and alcohol or other drug abuse, or seeking treatment for such abuse (Krugman, 1992).

The Need for Thorough Screening

The knowledge that maltreatment is common among adolescents and that problems associated with abuse are prevalent in this population is persuasive evidence for clinically screening all adolescents at least annually for experience of abuse and/or neglect. Careful clinical screening is imperative for any youth who exhibits problem behaviors, especially those known to be consequences of abuse.

Because thorough assessments often are not performed, the underlying problem may not be addressed at all. In many cases, abused adolescents are treated for a secondary problem that may be a consequence of the primary problem of current or past abuse and/or neglect. Broadening the knowledge base and training all providers who work with adolescents (e.g., teachers, health and mental health care clinicians, law enforcement personnel, outreach workers, recreation workers, and lawyers) are essential to increasing the assessment and recognition of maltreatment as a significant contributor to certain adolescent health risk behaviors and their consequences.

Adolescents with a history of abuse that was never diagnosed or treated during childhood may exhibit health risk behaviors or put themselves or others in harmful situations as a result of their experience. For example, maltreated adolescents may exhibit abusive behaviors with more vulnerable children (as occurs with juvenile sex offenders). These vulnerable youth may also engage in behaviors (such as missing school or running away) that invite further abuse. In family environments that are chaotic and characterized by domestic violence, poverty, social isolation, and substance abuse, adolescents are also more likely to suffer abuse.

Behaviors of those abused as children and adolescents serve a purpose and therefore are not easily resolved. Simplistic analyses of adolescent behavior that consider only responsibility and choice (such as the "just say no" approach) are often irrelevant to the victim of abuse. For example, indiscriminate sexual activity that arises from a strong need for interpersonal attention may not respond to entreaties from clinicians or to fear of disease. Careful screening for the etiology of such behaviors and long-term comprehensive treatment to provide better coping strategies are needed to ultimately change the presenting behavior (Briere, 1992).

Ecology of Adolescent Maltreatment

Cultural and societal values undergird an atmosphere in which violence is accepted, as exemplified by the violence portrayed in television programs and movies; the belief in spanking as essential to disciplining children; the use of corporal punishment by schools; and the acceptance of sibling and spousal abuse as normal (Harrington and Dubowitz, 1995). As a society, we tend not to have a sympathetic view of adolescents. We prefer to cast them as perpetrators, not as victims of crime and violence; as pursuers of risk experimenting with drugs and sex, not as victims of abusive caregivers; as underachievers with no interest in the future, not as vulnerable youth suffering from low self-esteem and depression as a result of living with abuse.

Briere (1992) discusses the broad social forces at work that allow the victimization of those with the least "social power." He cites both the negative reactions by others to the apparently maladaptive and dysfunctional behaviors of survivors of abuse and the frequent challenges to the credibility of the survivors' accounts of their experiences. The individual often is blamed for behaviors that may be a consequence of the abuse. Such behaviors "may more accurately be seen as reflecting the injuriousness of his or her social environment than as evidence of any inherent personal defects or failings" (Briere). Although there is increasing recognition of the psychologically damaging effects of child and adolescent abuse, socially transmitted beliefs that minimize the impact of abuse persist. This problem, combined with the sexualization of children by our culture, impedes attempts to prevent child and adolescent abuse.

When the National School Boards Association surveyed school administrators about the primary causes of rising incidence of violence in schools, the administrators described an increasingly inhumane society of children and families living in poverty without hope, a

society of children without supervision and discipline who are reared in situations of violence, abuse, and addiction. The administrators spoke of the destructive lessons parents teach when they are physically and psychologically abusive to their children and allow them to treat others in the same manner. Many respondents cited the critical importance of the family in preventing violence and advocated parenting classes, family resource centers that link families to social services, and mandatory parental participation in school-based interventions for children with behavior problems. Also mentioned were the effects of television violence and violent lyrics in rap and rock music that socialize young people to accept violence as a natural or inevitable part of life (Amundson, 1993).

Abuse and Neglect Defined

It has been difficult to achieve consensus on a single definition of maltreatment or of specific types of abuse. Definitions may differ according to whether a case is being considered in a legal, social service, clinical, or research context. Maltreatment is traditionally categorized as physical abuse, sexual abuse, emotional/psychological abuse, and neglect (both physical and emotional).

Physical abuse refers to the use of excessive force that may (not necessarily will) result in bodily injury such as bruises, burns, cuts, or damage to internal organs.

Sexual abuse in the context of children and adolescents includes sexual contact with a child or adolescent that occurs within a relationship that is exploitive because of differences in age or power, or that is perpetrated by a caregiver or someone in a dominant relationship with a dependent person; physical force may or may not be present (Finkelhor, 1991; Sorenson and Bowie, 1994). This may include physical contact and such nonphysical contact as involvement in making pornographic videorecordings.

A much more specific definition of sexual abuse was provided in the Third National Incidence Study of Child Abuse and Neglect (NIS-3) (Sedlak and Broadhurst, 1996). The NIS-3 defined sexual abuse as action perpetrated or allowed by an adult or adolescent caregiver or parent/substitute in one or more of three categories: (1) intrusion—oral, anal, or genital penile penetration or anal or genital digital or other penetration; (2) molestation with genital contact—acts during which genital contact has occurred without intrusion; or (3) other/unknown abuse—unspecified acts not involving actual genital contact (e.g., visual exposure, use of children/adolescents in the production of pornographic materials) or inadequate or inappropriate supervision of a child's voluntary sexual activities.

Emotional abuse is defined as sustained, repetitive, inappropriate communications that produce emotional pain expressed as fear, humiliation, distress, and despair, and that damage the creative and developmental processes in such areas as intelligence, memory, moral development, attention, and imagination (O'Hagan, 1995). Emotional or psychological maltreatment is not just one harmful event, but a pattern of behavior that includes such acts as rejecting, isolating, terrorizing, ignoring, and corrupting (Garbarino, Guttmann, and Seeley, 1986, as cited in Tower, 1996).

Neglect involves the failure of the responsible person or entity (parent, system, or institution) to provide the basic care that a child needs to survive and develop normally. Such care includes food, shelter, clothing, education, medical care, discipline, and a safe and secure environment with adequate nurturance and affection.

Physical neglect by a parent or other adult caregiver is categorized in the NIS-3 according to seven specific types: refusal of health care; delay in health care; abandonment; expulsion from the home; other custody issues such as leaving the child with others for long periods of time because of unwilling-

ness to care for the child; inadequate supervision; and other physical neglect such as inadequate nutrition or hygiene.

Emotional neglect is also categorized in the NIS-3 according to specific types: inadequate nurturance/affection; chronic/extreme domestic violence in the child's presence; permitted drug/alcohol abuse; permitted other maladaptive behaviors (e.g., chronic delinquency); refusal or delay in seeking psychological care; and other emotional neglect (e.g., demanding behavior inappropriate to the child's age/developmental level).

Educational neglect, which is identified separately by NIS-3, may involve permitting chronic truancy, failing to enroll the child in school, and failing to attend to the child's special educational needs.

Data Collection and Analysis

The National Child Abuse and Neglect Data System

At the federal level, the National Child Abuse and Neglect Data System (NCANDS) is administered by the National Center on Child Abuse and Neglect, Administration on Children, Youth and Families, U.S. Department of Health and Human Services. NCANDS is a voluntary national data collection and analysis program based on information reported by state child protective services agencies. Implemented in 1990 in response to the amended Child Abuse Prevention and Treatment Act (P.L. 93-247), this system includes two major components: the Summary Data Component, which compiles key aggregate indicators of state statistics on child abuse and neglect, and the Detailed Case Data Component, which includes case-level data from each state (U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, 1996).

Several national organizations also collect data on child maltreatment. Both the National Committee for the Prevention of Child Abuse (NCPCA) and the American Association for Protecting Children (AAPC) collect data from social service or child protection agencies in all 50 states.

Reports based on NCANDS and other data sources do not fully capture the extent of adolescent maltreatment. None of these sources can be considered complete (due to underreporting) and none consistently identifies cases in all age groups. By counting only cases reported to child protection agencies, the data sources fail to fully report the numbers and types of maltreatment cases for all ages and categories of abuse. For example, of all the adolescent maltreatment cases included in the first National Incidence Study (1980), only 39 percent had been reported to a child protection agency, compared with 76 percent of the cases involving younger children (American Association for Protecting Children, 1987).

National Incidence Studies of Child Abuse and Neglect

A more comprehensive body of information has been provided by the three National Incidence Studies: the NIS-1 (1980), NIS-2 (1988), and NIS-3 (1996). These studies are distinguished by their inclusion of case reports not only from social service agencies but also from other institutions and individuals such as hospitals, schools, and health care providers. Sponsored by the National Center on Child Abuse and Neglect, the studies are based on a nationally representative sample of professionals and agencies working with children and adolescents. The NIS data were collected with a national probability sample of 29 counties throughout the country. The NIS-2 and NIS-3 were based on 1986 and 1993 data, respectively.

The NIS-1, which limited the definition of maltreatment to cases of demonstrable harm, revealed that adolescents accounted for 47 percent of reported abuse cases while constituting only 38 percent of the population (U.S. Department of Health and Human Services,

1980). The NIS-2 and NIS-3 defined cases according to the "experience of demonstrable harm as well as the risk for harm but not necessarily harmed yet as a result of maltreatment."

Although the reported incidence of abuse and neglect increased substantially for all children between the 1988 and 1996 NIS reports, the cumulative rates for overall maltreatment increased most significantly for preadolescents ages 6–12. The NIS-2 reported highest incidence rates for overall maltreatment for adolescents ages 12–17, with an incidence rate of 25.7 cases per 1,000 youth (U.S. Department of Health and Human Services, 1988). The NIS-3 shows little change in the rates of abuse for adolescents ages 12–17. Reports vary regarding incidence and prevalence. NIS-3 data indicated that emotional abuse and/or neglect are the most common forms of maltreatment. NIS-2 data indicated that the risk for emotional neglect increased gradually with age, with the largest increase occurring between 12 and 17 years of age; however, NIS-3 showed the greatest incidence of all forms of neglect occurring in youth ages 6 to 14. The overall rates reported in the NCANDS data (1994) show that children ages 7–12 years represent approximately 32 percent of all reported maltreatment cases, while adolescents ages 13–18 represent 21 percent of reported cases.

NIS-3 data indicate that children living in families with an annual income below $15,000 were more than 25 times more likely to be maltreated than children from families with an annual income above $30,000 (Sedlak and Broadhurst, 1996). In every category, children from families with an income less than $15,000 experienced significantly more abuse than did children from higher-income families. No significant racial differences in the incidence of child or adolescent maltreatment were found in either the NIS-2 or the NIS-3 data.

Additional Data Sources

Many cases of abuse and neglect of adolescents are counted as juvenile justice statistics or mental health encounters—or may not be counted at all if served by the alternative youth service network. A police report concerning juvenile assault of a parent may be the only official statistic indicating a history of abuse of the adolescent (AMA, 1993).

To supplement child and adolescent maltreatment data, additional national sources can be used, such as the Office of Juvenile Justice and Delinquency Prevention (OJJDP); Federal Bureau of Investigation Uniform Crime Reports; the National Survey of Children; National Survey of Family Growth; National Incidence Study of Missing, Abducted, Runaway, and Thrownaway Children; and National Longitudinal Surveys of Labor Force Behavior of Youth.

OJJDP has launched a five-year plan to improve statistical information related to juvenile crime and victimization. This plan will specifically address gaps in information on children and youth in custody. OJJDP also will develop a research plan to organize and develop new knowledge on violence and delinquency. Because of the association between experiencing or witnessing violence and victimization and later engaging in violent and criminal behavior, OJJDP has an interest in understanding and monitoring broad trends in juvenile delinquency, violence, and victimization (U.S. Department of Justice, 1996).

In order to understand the extent of the problem, target services where most needed, and evaluate progress, it is essential to develop an annual reporting system for state and national statistics of all reported abuse, including crimes in which an adolescent was the victim. Because so many cases of maltreatment, especially adolescent maltreatment, are unreported, national studies are needed to help determine the level and nature of unreported victimization. Information is also

needed concerning individuals' and groups' subtle experiences of everyday types of victimization (such as assaults by peers or siblings) and how these experiences affect psychosocial development and functioning (Finkelhor, 1995).

Limited Recognition, Reporting, and Treatment of Adolescent Victimization

Adolescent disclosures of abuse are often ignored. Expressing disbelief or ignoring complaints and symptoms are common reactions among parents and other adults, including health care professionals, teachers, and social workers. The victimized adolescent has nowhere to turn for help, loses trust in adult protection, and feels vulnerable to further attacks. Without the immediate opportunity to repair self-worth or to mollify self-blame, further negative sequelae may follow.

Recognition of abuse as a problem depends on the willingness of the practitioner to consider the possibility that the condition exists. C. H. Kempe, who with his colleagues first wrote of the "battered child syndrome" in 1962, often said that no child ever died of a social work evaluation—but many died because they never received one (Krugman, 1992).

Difficulties in Recognizing Abuse

The limited recognition and reporting of adolescent maltreatment, although somewhat improved in the past 15 years, remains problematic. Sympathetic responses for victims tend to be inversely proportional to the victim's age. Young children are more likely to be perceived as weak and defenseless, while adolescents are often seen as behaviorally responsible for their misfortunes, and deserving of punishment for provoking their abuse. Over the years, the physical development of adolescents has accelerated as the onset of pubertal changes occurs at younger ages. Today, many youth are mistaken for older teens or adults and thus perceived as able to take care of themselves. Size and physical development may not indicate level of cognitive maturity, and adolescents face many issues they simply cannot negotiate for themselves.

Adolescents are frequently viewed as risk takers, responsible for their own problems. If adolescents are sexually active, they are not regarded as children, even if their sexual involvement is involuntary. Physical signs of abuse are less evident in adolescents, and physical injuries tend to be less severe than in younger children. Many view adolescents as inherently difficult, requiring more (perhaps even excessive) physical and verbal force in order to comply with rules and policies. Cultural acceptance of the use of physical force in discipline may prevent young people from distinguishing normal discipline from abusive treatment and thus from seeking help and advice (AMA, 1993).

Nonmedical agencies such as community youth development programs and detention centers are likely to interact with many adolescents, but staffs of these organizations may have little expertise and awareness in recognizing and screening for abuse and neglect. In addition, adolescents tend to use health care services less frequently than other age groups, so there may be less opportunity for professional assessment.

Fewer referral services are available for adolescents in comparison to the resources available for younger children. If services are unavailable (or perceived as unavailable), there may be less likelihood of reporting maltreatment. In addition, for adolescents as for all children, loyalty to and protection of family members affect the reporting of abuse. Adolescent victims may not want to file a report for many reasons, including concerns about confidentiality, feelings of embarrassment or self-blame, vulnerability, and the perception that adults will not respond. In some cases, reporting of abuse may be compromised if providers and consumers mistrust

child protection agencies (McCurdy and Daro, 1994).

Recognition of adolescent maltreatment is further complicated by varying and often subtle patterns of abuse. In some cases, the onset of abuse coincides with the onset of adolescence. In many other cases, abuse begins in childhood and persists into the teen years. Understanding these differences and other factors, such as the relationship between perpetrator and victim and the context in which the abuse occurs, is critical to effective recognition and intervention.

Because the treatment needs of abused adolescents tend to be more complex and extensive than those of younger children, adolescents may receive care only for the acute presenting problem (such as a sexually transmitted infection or a laceration). Abused adolescents often require multiple services, which may include crisis counseling, long-term mental health counseling, family therapy, transitional living arrangements, substance abuse treatment and education, pregnancy prevention and sexuality education, legal assistance, employment services, violence prevention and counseling, and interventions to deter gang membership. Without effective screening, referral, and case management, the problem of maltreatment and its consequences may not be recognized or treated.

Sexual Victimization

Many adults perceive adolescent sexual victimization as an improbable event; in fact, increased sexual abuse accounted for much of the increase in adolescent abuse documented in the National Incidence Studies between 1980 and 1988. Although much attention has been paid to the age of initiation of sexual intercourse, few research studies have investigated the circumstances surrounding an adolescent's first intercourse, especially the experience of involuntary sexual activity (Moore, Nord, and Peterson, 1989).

Prosecution and recognition of child sexual abuse varies from state to state. While all states have legal prohibitions regarding sexual activities between adults and minors, state laws vary concerning who can be classified as abused—or as an abuser. For example, under some state laws, to be considered a molesting child offender, a person must be at least 4 years older than the child; other states indicate that youth of a certain age (e.g., 15–17) can grant consent, and that sexual contact occurring during this age period must be considered consensual. However, in other states, statutory rape laws exist to protect a traumatized child or adolescent from such "decisions" (Donovan, 1997).

Risk Factors for Sexual Abuse

Young adolescents between the ages of 9 and 12 are at greatest risk for being sexually abused. Risk factors in addition to age include experiencing a lack of parental availability and supervision, having a poor relationship with parents or caregivers, or having a stepparent (Finkelhor, 1991).

Analysis of the National Survey of Children, the National Survey of Family Growth, and the National Longitudinal Surveys of Labor Force Behavior of Youth revealed the following risk factors associated with experiencing an unwanted sexual encounter during adolescence: living apart from parents; living in poverty; having a physical, emotional, or mental problem as a child; and having parents who drink heavily or use illegal drugs or who smoked cigarettes as a teenager (Moore et al., 1989).

A review of a national survey of adults concerning their experiences of childhood sexual abuse revealed similar risk factors—having an unhappy family life and living without one or both natural parents. Females were also found to be at higher risk for childhood sexual abuse if they had inadequate or no sexuality education (Finkelhor et al., 1990).

Perpetrators in Sexual Assault

The image of rape perpetrated by a stranger in a dark alley is firmly entrenched in this culture; frequently, however, the victim knows the assailant (e.g., teacher, employer, classmate). Studies suggest that the incidence of such acquaintance sexual assault ranges from 12 to 27 percent among high school students and from 17 to 52 percent among college students. In more than 80 percent of the rapes that occur on college campuses, the perpetrator is an acquaintance; an estimated 50 percent of these rapes occur on dates (Abbey, 1991, as cited in Peipert and Domagalski, 1994).

A chart review of young women presenting for care of sexual assault revealed that the assault occurred during a voluntary social encounter in 60 percent of the cases involving adolescent women, compared with 44 percent of the cases involving older women (Peipert and Domagalski, 1994). Since date rape occurs in a social context, the victim's credibility is often doubted. Male sexual aggression may also be regarded as normative behavior in many contexts, thus further diminishing supportive responses for victims.

In many communities, adolescents are victimizing each other both sexually and physically. Nearly 1 in 10 high school students will experience physical violence from a romantic partner (American Psychological Association, 1997). The troubled backgrounds and families of some of these adolescents have so impaired their development and ability to form relationships that they act out their feelings on others in their peer environment, on those who are developmentally most accessible.

Extent of Sexual Abuse

Because normal adolescent development brings an increasingly open expression of sexual feelings, attitudes, and behaviors, it may be mistakenly assumed that adolescent sexual behaviors are, in most cases, voluntary. Although adolescents may not recognize unwanted sexual contacts as abuse, when asked about experiences of forced or unwanted sex, they may be more likely to answer affirmatively. If feelings of ambivalence or self-blame were present during the sexual encounter, adolescents may resist the perception that the encounter was unwanted.

Adolescents frequently are not recognized as victims of sexual assault. However, a review of data on female rape victims revealed that 60 percent were age 18 or younger; 30 percent were younger than age 12 (National Victim Center and Crime Victims Research and Treatment Center, 1992).

Surveys of nonclinical student populations show a sexual abuse rate between 8 and 11 percent (Lodico, Gruber, and DiClemente, 1996; Riggs, Alario, and McHorney, 1990). In a southern state, a self-report survey administered to more than 3,000 urban and rural students in grades 8 and 10 also revealed a 10 percent rate of forced sexual experience. According to survey responses, 50 percent of the offenders were classified as a date, 12 percent as a stranger, 11 percent as a family member, and 27 percent as a combination of these. The likelihood of victimization increased if the student was female, African American, or living in a single-parent household (Nagy, Adcock, and Nagy, 1994).

In a rural midwestern state, 10 percent of a sample population of ninth graders reported having experienced sexual abuse (Hernandez, 1992). These adolescents were also more likely to report that both they and their families abused substances. Links between a history of sexual abuse and subsequent substance abuse have been well established (Hernandez, 1992; Nagy, DiClemente, and Adcock, 1995).

A 1994 study of seriously mentally ill youth revealed a high incidence of sexual abuse (McClellan and Adams, 1995). Most of these youth were female, with a high incidence of prior physical abuse and neglect, posttraumatic stress disorder (PTSD), and substance abuse.

A survey of adolescents using a family planning clinic revealed that 40 percent had experienced at least one unwanted sexual encounter prior to their 18th birthday. In a similar population in a family practice setting, 39 percent of the females and 16 percent of the males reported having at least one unwanted sexual experience prior to their 18th birthday. Most of the cases involved adult family members or adult acquaintances (Kellogg and Hoffman, 1995). Although the number of sexually molested adolescents is underreported among both genders, the underidentification of sexual abuse and assault is probably greater for males than females. Adolescent males, concerned about their developing sexuality and their image as young men, are less likely to report having been sexually molested, especially by a male perpetrator. The molested male adolescent, whether heterosexual or questioning his sexual identity, may fear that he will be perceived as homosexual (AMA, 1993; Finkelhor, 1995).

Links Between Abuse and Adolescent Sexual Behaviors

Sexual identity and sexual behavior patterns are established during adolescence; thus, it is crucial to understand the relationship between previous sexual abuse and the formation of sexual behaviors and to carefully assess abused youth for coercive and other inappropriate sexual behaviors. Conversely, it is important to assess those exhibiting aggressive or high-risk sexual behaviors for a previous history of abuse. Early and comprehensive interventions with these abused children and adolescents may help prevent more severe acting-out behaviors or further victimization (Lodico, Gruber, and DiClemente, 1996).

A survey of teens in Minnesota found that those who reported being sexually abused during childhood also reported engaging significantly more often in coercive sexual behaviors as adolescents than did nonabused youth (Lodico, Gruber, and DiClemente, 1996). Abused adolescents were also significantly more likely to be victims of sexually aggressive or coercive dates or acquaintances. Similarly, in a study of middle and high school students in metropolitan Los Angeles, students who reported having experienced an unwanted sexual encounter were more likely to be sexually active at the time of the survey than those who reported never having experienced such an encounter (Erickson and Rapkin, 1991).

In a study of eighth and tenth grade students in several southern communities, sexually abused girls were more likely to report the following: having intercourse at a younger age, becoming pregnant, using illegal drugs, having feelings of depression, expressing more frequent suicidal ideation, and having a history of being physically abused (Nagy, DiClemente, and Adcock, 1995).

Analysis of data from the 1987 National Survey on Children revealed that white female adolescents who reported a forced sexual intercourse also reported first voluntary intercourse at a younger age, had higher depression scores and lower internal locus of control scores, and sought and received more psychological services than a comparison group that had not experienced forced sexual intercourse (Miller, Monson, and Norton, 1995).

In families that are organized around the wishes and desires of the father or another male figure, females may have inadequate power to resist abusive behaviors. Rainey, Stevens-Simon, and Kaplan (1995) suggest that dysfunctional family dynamics that teach children to base their self-esteem on their sexuality may promote behaviors such as earlier voluntary sexual intercourse, choice of multiple sexual partners, and ineffective contraceptive use.

Pregnancy

Sexual abuse in childhood has been linked to early pregnancy in adolescence (AMA, 1989). Investigation of a sample of 535 pregnant and parenting adolescents conducted between 1988 and 1992 showed that 66.2 percent of these young women had experienced at least one unwanted sexual encounter prior to their first pregnancy. The average age at first molestation was 9.7 years; 24 percent of the sample were five years of age or younger at the time of first abuse. Repeated abuse, STDs, and substance abuse were more common in the abused group (Boyer and Fine, 1992).

The child or young adolescent who becomes pregnant between 10 and 14 years may be disparaged for becoming sexually active at an early age, when, in reality, she may have been sexually abused, often by a family member. Pregnancy in a young abused adolescent is a tragic symbol of her lack of safety, security, and protection. Unfortunately, a pregnancy does not always signal the end of abuse. A survey of 356 pregnant teens revealed that 20.6 percent had experienced some combination of physical and/or sexual abuse during the pregnancy (Parker, McFarlane, and Soeken, 1994). One team of investigators found that in a sample of pregnant girls who had been physically abused in the past, 40 percent had been struck during the pregnancy, with a family member or boyfriend being the likely offender (Berenson, San Miguel, and Wilkinson, 1992).

Prostitution

Sexual abuse of adolescents also occurs through the barter of their bodies for money, food, shelter, gifts, favors, attention, and drugs. Adolescents who engage in prostitution may be seen as promiscuous rather than as victims of past and current abuse. Teenage prostitution is de facto child sexual abuse, even if the young person has "voluntarily" agreed to participate. Although estimates have been made, there are no reliable national data to substantiate the actual number of adolescent prostitutes (Finkelhor and Dziuba-Leatherman, 1994b).

An estimated 75 percent of adolescent prostitutes are homeless or runaway youth (Farrow, 1993). One study of runaway youth reported that 38 percent of the males and 73 percent of the females were escaping from sexually abusive situations; 73 percent of this sample also reported being physically beaten (Hartman, Burgess, and McCormack, 1987). Sexual and physical abuse may decline after an adolescent leaves home but is often replaced by other abusive experiences such as sexual assault and introduction to drug use. Youth neither understand nor anticipate that running from one form of abuse at home will often place them in environments where they again are likely to be victimized.

Adolescent Abuse and the Justice System

An adolescent's response to maltreatment may lead to involvement with the juvenile justice system. Traumatic environments in childhood are a common denominator of poor developmental outcomes. Adaptations to various types of abusive environments (exposure to domestic violence, shootings and stabbings, and alcoholic or drug-abusing caregivers) may result in antisocial and delinquent behaviors (Durant, Cadenhead, Pendergrast, Slavens, and Linder, 1994; Widom, 1991; Garbarino and Garbarino, 1993).

A review of research on the family characteristics of adolescents accused of murdering a parent revealed histories notable for sexual abuse, parental violence, extreme violence by other family members, physical abuse of the accused adolescent, alcoholism of one or both parents, and parental psychiatric problems (Crespi and Rigazio-Digilio, 1996).

Ford and Linney (1995) found that adolescents' exposure to violence, as victim or witness, may influence their use of violence.

Although studies do not support a definite cause-and-effect relationship, certain events and conditions have been shown to increase a child's risk of future violent behavior (Schwab-Stone et al., 1995). In a sample of African-American adolescents in Georgia, self-reported violent behavior was positively associated with past victimization or exposure to violent acts (Durant et al., 1994). Widom (1989, 1991) found demonstrable long-term consequences (such as delinquency, adult criminality, and violent criminal behavior) resulting from childhood victimization, especially from physical abuse in childhood; abuse or neglect during childhood increased the chances of juvenile arrest by 53 percent.

Abused children may be less able to form caring relationships and, consequently, more likely to engage in violent, negative acts. Homeless, runaway, truant, and abused youth may enter detention centers and jails when alternative placements are not identified or available. Youth who commit nonviolent offenses or "status" offenses are often detained rather than directed to community-based programs. Many youth who are incarcerated in detention centers have a history of being abused and neglected but their plight has never been brought to the attention of the child welfare system (National Research Council, Panel on High-Risk Youth, 1993).

Little is known about how effective the juvenile justice system is in rehabilitating adolescent offenders or preventing further delinquent behavior. Some states have reported recidivism rates of up to 70 percent, an indication of the critical need for more effective interventions (U.S. Congress, Office of Technology Assessment, 1991). In the juvenile justice system, social control rather than treatment is often the focus of intervention (Crespi and Rigazio-Digilio, 1996; Krisberg, Austin, and Steele, 1989, as cited in Mendel, 1995). Juveniles with a history of maltreatment who are placed in juvenile detention centers may be less likely to receive the treatment needed to address their experiences of abuse.

Given our understanding of the role of child and adolescent maltreatment in the lives of adolescents and adults who commit violent acts, it is clear that punishment alone in the form of incarceration will not resolve such behavior. More information is needed on psychotherapeutic treatment that addresses a juvenile's history of abuse and/or neglect, and the impact of such therapy on recidivism (Briere, 1992).

What might be a sympathetic response by society to the plight of abused adolescents is overshadowed by a perceived or real need for protection in the face of aggressive antisocial conduct (Garbarino and Garbarino, 1993). Public pressure to do something about aggressive adolescent behavior has influenced the courts to send increasing numbers of youth to already overcrowded detention centers where such services as medical and mental health assessments and treatment are limited.

Reaction to violent juvenile crime is now propelling youth into the adult criminal justice system. Even younger adolescents ages 13 and 14 are being judged by adult standards of prosecution. From 1987 to 1991, the number of juvenile cases transferred to adult criminal court increased by 29 percent. Although there is little evidence showing that youth receive harsher sentences in adult courts, youth held in adult facilities fare worse than those in juvenile detention, with even less opportunity for rehabilitative services and correspondingly higher rates of rearrest (Jones and Krisberg, as cited in Mendel, 1995).

Victims of Violence

In a society in which exposure to violence is becoming a routine part of growing up, children and adolescents are particularly vulnerable to being victims of or witnesses to acts of aggression. Healthy accomplishment of the developmental tasks of childhood and adolescence may be severely disrupted by such assaults to well-being and security.

While adolescents are often portrayed as purveyors of violence, they are rarely seen as its victims. Over the past 20 years, crime rates for violent victimization of youth have increased 36 percent for adolescents ages 12–15 and 27 percent for those ages 16–19 (U.S. Department of Justice, Bureau of Justice Statistics, 1994, as cited in Sells and Blum, 1996). Teens were more likely to become victims of violent crime than were older persons. In 1995, approximately one-third of all victims of violence were between the ages of 12 and 19 (U.S. Department of Justice, Bureau of Justice Statistics, 1997).

In 1989, the National Crime Survey Report estimated that 646,750 youth ages 12–19 were victims of multiple-offender crimes, including robbery, simple assault, aggravated assault, and rape. Over 1 million youth were victims of crimes perpetrated by a single offender. Among males ages 15–19, firearm-related homicides accounted for 88 percent of all homicides in 1991 and for 97 percent of the increase from 1985 to 1991 (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994).

African-American youth are more likely to be victims of violence than youth in any other racial or ethnic group. In 1991, the incidence of victimization among African-American juveniles was 20 percent greater than that among white youth (Snyder and Sickmund, 1995), a difference that persisted in 1995 (U.S. Department of Justice, Bureau of Justice Statistics, 1997). Homicide is the leading cause of death among African-American males ages 15–19. The violent victimization rate among young African-American females is reported to be almost twice as high as than that of their white counterparts (Zawitz et al., 1993).

Sexual Orientation

Among the most ignored, underserved, and mistreated of the adolescent population are gay, lesbian, and bisexual youth. Parent and peer pressure to be "normal" is strong, and derisive comments often go unchallenged by adults. Family and friends want to know about opposite sex interests and question adolescents about heterosexual dating. Many teens feel a necessity to lie or feign interest in a person of the opposite sex.

Adolescents who reveal same-sex interests publicly are subject to harassment, abandonment, and even assault (Taylor and Remafedi, 1993; Savin-Williams, 1994). A study by the National Gay and Lesbian Task Force found that 45 percent of gay males and 20 percent of lesbians experienced verbal or physical assault in high school (Brilliant, Tyiska, DiBara, and Fiset, 1996). These youth are also vulnerable to involvement in abusive romantic homosexual relationships as they seek affection and self-confirmation.

Adolescents who openly acknowledge a same-sex attraction or preference are likely to experience derision and rejection from homophobic peers and family. This profound sense of rejection often results in chronic psychological stress with such consequences as substance abuse, depression, and suicide (Remafedi, Farrow, and Deisher, 1991; D'Augelli and Hershberger, 1993). Responses from the Massachusetts Youth Risk Behavior Survey (1995) reveal that 36.5 percent of gay, lesbian, and bisexual youth attempted suicide in the previous year, compared with 8.9 percent of all other youth (Ryan and Futterman, 1997).

Responses to Victimization

Neglect

Neglect is the most frequent category of maltreatment reported for both children and youth. The prevalence of neglect and its outcomes for neglected youth are more difficult to track but are believed to be as injurious as physical and sexual abuse. For example, adolescents who reported minimal parental support and affection were more likely to be involved in violent behaviors (Saner and Ellickson, August 1996).

Sexual Abuse

As previously mentioned, sexual abuse during childhood and adolescence has a profound impact on the growing sense of self. Violation of the body and betrayal (especially by a family member) attack the core of one's being. Emotional, cognitive, and social development are often impaired. Serious psychological problems have been associated with sexual abuse, including depression, posttraumatic stress disorder (PTSD), eating disorders, and violent or aggressive behaviors (Felitti, 1991).

Experience of Violence

Studies have shown an association between adolescent exposure to violence (both as witnesses and as victims) and symptoms of trauma such as depression, anxiety, and anger, as well as PTSD. One comprehensive study (1992–93) of a diverse sample of more than 3,000 public high school students from large urban schools and smaller suburban schools found that adolescents were exposed to significant levels of violence and that this exposure was associated with symptoms of psychological trauma (Singer, Anglin, Song, and Lunghofer, 1995). Specifically, this study found that (1) recently witnessing or being victimized by violence in the home, (2) experiencing past threats, slaps/hits/punches, or beatings or muggings, and (3) experiencing sexual abuse were strongly associated with depression, anxiety, dissociation, and stress. The study also found that the following factors were predictors of angry behavior: (1) recently witnessing or being victimized by violence in the home, (2) experiencing past threats, slaps/hits/punches, or beatings or muggings, and (3) experiencing a knifing or shooting.

In communities in which violent acts occur regularly, adaptation to the social condition of witnessing multiple violent events may lead young people to feelings of pessimism, depersonalization, a decrease in ties to the future, the development of fatalistic attitudes about protecting one's life, and an increased willingness to resort to aggressive and antisocial behaviors. If these reactions are accepted as the norm and not as pathological, the incidence of violence is more likely to persist (Schwab-Stone et al., 1995). In studying 2,248 students from an urban high school, Schwab-Stone et al. found that 41.3 percent of the students reported witnessing at least one shooting or stabbing in the past year, and 73 percent stated that they did not feel safe in one or more locations. Most affected were minority youth and economically disadvantaged youth. This study supported the association between exposure to violence and diminished perception of risk, lower personal expectations for the future, dysphoric mood, antisocial activity, alcohol use, diminished academic achievement, and greater willingness to use physical aggression.

Psychological distress in the form of depression, hopelessness, and lack of purpose has been associated with self-reported repeated exposure to violence (as victim or witness), especially intrafamilial violence, among a group of adolescents living in or near public housing in a southern city (Durant, 1995).

Posttraumatic Stress Disorder

PTSD can develop after experiencing or witnessing an event that is life threatening or perceived as causing grave physical harm. The event must be serious enough to cause horror, intense fear, or overwhelming helplessness, and subsequent symptoms must be severe enough to cause significant distress or impaired functioning. Affected individuals continue to re-experience the event through intrusive thoughts, dreams, and flashbacks despite active and subconscious attempts to avoid stimuli associated with the trauma. Such individuals also have symptoms of heightened arousal, which may include sleep difficulties, hypervigilance, anger, and difficulty concentrating (American Psychiatric Association, 1994).

A study of urban adolescent females attending an adolescent medicine clinic found that these young women had prolonged and repeated exposure to multiple violent events, both in their communities and homes. These young women also reported a high percentage of PTSD-related symptoms (Horowitz, Weine, and Jekel, 1995).

Investigating the incidence of PTSD symptoms among adolescents in a major southern metropolitan area, Berton and Stabb (1996) found that 29 percent of high school students in the study demonstrated clinical levels of PTSD. The variable found to be most predictive of PTSD was self-reported exposure to domestic or community violence, rather than the actual amount of criminal activity documented in or near the school attended by the subjects. In this study, African-American males reported exposure to more violent crimes in their communities and schools than did white males. Consistent with other reports (Singer et al., 1995), Berton and Stabb noted that females reported greater symptoms of traumatic stress.

Victimization at School

The past decade has seen a dramatic rise in gang presence in schools, attacks on teachers, and violent attacks on students (particularly shootings) that occur inside schools and on or near school grounds. Approximately 56 percent of incidents involving criminal acts against juveniles occurred in school or on school property; of these, 23 percent were crimes of violence (Snyder and Sickmund, 1995).

In a survey of school leaders nationwide conducted by the National School Boards Association, four out of five school districts indicated that the problem of school violence is worse now than five years ago; 78 percent had experienced assaults of students by other students in the past year, and 61 percent reported the presence of weapons in their schools. Sixty percent of urban districts reported incidents of student assaults against teachers and incidents of gang violence in their schools (Amundson, 1993). Being bullied or being beaten up in or near school were major concerns expressed by a national sample of children ages 10–16 (Finkelhor and Dziuba-Leatherman, 1994b; Finkelhor and Dziuba-Leatherman, 1995).

A national survey of high school students in 1995 found that 20 percent of students had carried a weapon during the one-month period preceding the survey (U.S. Department of Health and Human Services, 1996). An estimated 430,000 students reported taking some form of a weapon to school to protect themselves from attack or harm at least once during a six-month period (Bastian, 1991). Many adolescents express fear for their personal safety and identify the negative impact of violence (or threat of violence) on their ability to learn.

Media and Adolescent Victimization

Reviews of several research studies and commissioned reports confirm the relationship between exposure to violence in the media (especially television) and aggressive behavior. Exposure to violence in the media has also been associated with the development of victim characteristics of fear and apprehension (Donnerstein et al., 1994; Sege and Dietz, 1994).

Television viewing represents more than half of adolescent leisure time activity and consumes more time than any other activity except school attendance. By counting the number of hours children and youth spend in front of the television and calculating the number of violent episodes throughout the day, it is estimated that by the end of adolescence, a young person has seen more than 200,000 violent acts in the media (Huston et al., 1992, as cited in Donnerstein et al., 1994).

Nonviolent alternatives to angry, aggressive, and impulsive behaviors are rarely depicted in television or movies. Surveys show that youth view thousands of sexual references, innuendoes, and/or behaviors on television each year. Rarely do any of these scenes depict self-control, abstinence, or responsible sexual behavior. The Children's Television Act of 1990 was meant to improve the quality of and increase the amount of children's programming. Although networks have chosen to interpret the law's guidelines minimally, provisions in this legislation can be used to exert pressure for responsible programming concerning violence and related problems (Charren, Gelber, and Arnold, 1994). It is especially important that such legislation be applied to the needs and vulnerabilities of adolescents as well as those of younger children.

Public service announcements (PSAs) in radio, television, and newspapers can elevate public awareness of adolescent abuse and neglect. In addition to lobbying for more responsible entertainment programming, public health and youth advocates can collaborate with media outlets and use the media's powerful marketing ability to alert communities to adolescent health issues (Carnegie Council on Adolescent Development, 1995) and particularly to the problem of adolescent victimization, and to resources for prevention and treatment (Harrington and Dubowitz, 1995). These advocates can also work closely with public broadcasting stations, many of which are already involved in community outreach and education, to support parent and adolescent education in the roots and prevention of violence and abuse (Charren, Gelber, and Arnold, 1994).

Prevention of Adolescent Maltreatment

James Garbarino has proposed launching a public health campaign against the abuse and neglect of children and youth, similar to the smoking cessation campaign. He asserts that society must be prepared to change attitudes and beliefs over a period of time, not merely with a single, short-term message. Garbarino (1996) cited two major areas in which attitudes and beliefs need to be challenged: first, that raising children is the private domain of parents; second, that hitting children is an effective, harmless disciplinary tool. Garbarino (1993) has also identified the following five priority areas to protect children and youth from maltreatment: controlling family violence; establishing and maintaining high standards for the care of children and youth; developing community activities that demonstrate interest in children and their families; supporting social values and structures that strengthen families over time; and improving research-based knowledge about the "human ecology" of child and adolescent maltreatment.

Youth should have positive options and opportunities as a normal part of growth and development. The foundations for developing strong nurturing families ideally should be set before conception. Routinely teaching child development and parenting skills in school will serve youth well throughout life, both in understanding their present family dynamics and in approaching adulthood and the eventual formation of their own families (Tower, 1992).

Parents and other caregivers must be educated concerning the difference between discipline and punishment, from before a child's birth through the childhood years of growth and development. Ongoing assessment of family functioning and referral for services when needed should be incorporated into every pediatric/adolescent health care visit and should be considered as essential as immunizations for the health of the child and the community.

The impact of domestic violence and chaotic environments on the development of antisocial behaviors continues to be underestimated. Although not sufficiently evaluated, family support and family preservation programs have the potential to offer positive,

effective interventions. Family preservation programs that place parent aides and counselors in the household up to 24 hours per day should be expanded until all families in need can be offered services. Interventions that enhance parenting skills have been found effective in decreasing children's risks for aggression (Zigler, Taussig, and Black, 1992). Case studies have shown that comprehensive "wraparound" services can help to interrupt and eliminate abuse, improve school attendance and academic performance, increase self-esteem, and decrease delinquency and other antisocial behaviors (The Edna McConnell Clark Foundation, 1993).

School-based prevention efforts for adolescents should address such areas as life skills training, preparation for parenthood, and self-protection. Basic life skills in problem solving and coping as well as skills in daily living can help strengthen adolescents' sense of control of their lives and decrease their vulnerability (Tower, 1992).

Identification

Laws in all 50 states obligate those who work closely with children to report suspected or confirmed abuse. In some states, mandated reporters are specified by profession, such as physicians, psychologists, nurses, teachers, social workers, youth workers, probation officers, lawyers, and child protection workers; in others states, reporters are mandated by class of profession (such as medical professionals or school personnel). Both preservice and inservice training related to the maltreatment of adolescents and younger children should be required for all professionals and paraprofessionals working with children and youth. Requiring continuing education that addresses adolescent maltreatment (including clarifying reporting requirements and legal procedures) for those in youth-serving professions would increase awareness of the problem and improve skills in helping victimized youth (Reiniger, Robison, and McHugh, 1995).

Early identification of abuse is essential in order to intervene and treat it. As previously noted, youthful victims complain that even when they reveal episodes of abuse, adults respond with disbelief. A particular focus on training is needed to improve staff comfort and skill in interviewing techniques with adolescents. An atmosphere of openness and acceptance is critical for establishing rapport and facilitating a therapeutic relationship. Adolescents should feel that it is both acceptable and safe to disclose episodes of abuse. Every adolescent should be asked about possible experiences of abuse as part of routine and specialized physical and psychological assessments. In a childhood abuse study of adults in a general medical setting, 90 percent of those with a history of abuse had never before discussed the problem (Felitti, 1991). Taking a complete history and conducting thorough assessments are both necessary to uncover past or current abuse. The use of specialized assessments such as victimization scales and child abuse surveys can help the adolescent recall and identify behaviors and events that previously may not have been perceived as abusive.

Schools are well-established settings for the recognition and reporting of abuse, and these efforts need to be maintained and improved. Schools are also settings for prevention and treatment. School-based health centers (SBHCs) have an important role in early identification and intervention. Most youth spend much of their day in school, and in most SBHCs, students are able to access a broad range of services in one site, including physical examinations, care for acute problems, health and nutrition education, pregnancy and sexuality counseling, and mental health and substance abuse counseling. Such centers are increasingly visible and used by greater numbers of youth (Keyl, Hurtado, Barber, and Borton, 1996).

School-based mental health centers (SBMHCs) are not as prevalent as SBHCS but are just as essential. An estimated 12 to 22 percent of adolescents have a diagnosable

mental health problem. Students who may have adequate access to physical health care outside the school setting frequently have limited or no access to mental health and substance abuse services. Students have greater access to mental health services at school than at outpatient and private clinical offices (Weist, Paskewitz, Warner, and Flaherty, 1996). Clinic staff are known to students and have established a level of trust that allows students to express a variety of concerns. The clinics tend to be well utilized and are a popular resource for troubled students (Balassone, Bell, and Peterfreund, 1991). Since schools are a major part of most adolescents' lives, communities should seek to ensure mental health services in the schools. Until mental health centers or services are more available in school settings, it is essential to train such personnel as school nurses, school nurse practitioners/physician assistants, physicians, social workers, guidance counselors, and athletic coaches, to ensure that adolescents have access to needed assessment, treatment, and referral for mental health problems.

Treatment

Early detection and provision of needed treatment services are essential for secondary prevention or amelioration of the consequences of abuse. Treatment of adolescents who have been abused usually requires a compendium of therapies depending on the nature and circumstances of the abuse; services may include individual, family, and group therapies. Parents may receive parenting education, including help in understanding adolescent psychosocial development and in providing nurturance, structure, supervision, and appropriate discipline.

Awareness of factors that protect some abused youth and prevent them from experiencing the psychosocial sequelae of abuse may improve understanding and increase the effectiveness of prevention and treatment interventions. For example, resilience, or the ability to maintain adaptive functioning in spite of serious risk hazards, was assessed in a sample of sexually abused girls (Spaccarelli, 1995). The study found that resilience was exhibited by those who suffered less severity and duration of abuse, appraised abuse events less negatively, displayed more active coping strategies, and enjoyed a more supportive relationship with the nonoffending parent or guardian. Since parent support was the strongest predictor of resilience in sexually abused girls, treatment options should consider enhancing the relationship between the abused child and the nonoffending parent (Spaccarelli, 1995). Although more research is needed on treatment outcomes, therapeutic interventions such as family support, survivor groups, and individual therapy prevent the well-documented long-term negative effects of abuse and neglect (Eltz, Shirk, and Sarlin, 1995; Finkelhor and Berliner, 1995).

Placement

Placement outside the home remains controversial as part of a treatment plan for abused children and youth. At this time, there is not sufficient information to know whether removing preadolescents and young adolescents from an abusive home or providing intensive family preservation and counseling better supports the adolescent's recovery from abuse, allows the youth to successfully complete the developmental tasks of adolescence, and prevents some of the negative sequelae of victimization. Considering delinquent behavior as a potential negative outcome of child abuse and/or neglect, Widom (1991) found that children whose first foster care placement was at an older age had higher rates of arrests for delinquency and adult criminal behaviors than those who were never placed in foster care or were placed in care at a younger age, remained in foster care for more than 10 years, and moved infrequently.

Therapeutic foster care is an important community-based alternative to incarceration and hospitalization. Host families are trained by mental health professionals to manage dif-

ficult behaviors. Consultation and support for host parents and for the child continue throughout the foster care experience.

When adolescents are at serious risk for harm in the family or have been thrown out of their homes, placement is necessary. Independent living projects help adolescents ages 16 and older to make the transition from an abusive home environment, an institution, or foster care to independent living. Such projects focus on helping adolescents pursue education and career development and learn basic skills to function independently.

Recreational and educational activities provided by such programs as sports leagues, Boys and Girls Clubs, and departments of recreation and parks can serve as positive and constructive diversions and alternatives to negative and destructive behaviors that may result from individual experience of abuse or exposure to domestic or community violence. These are other places (in addition to schools) that could be used to provide victimization assessment and counseling services and other preventive and treatment interventions such as workshops in conflict resolution or parenting education.

All adolescents need at least one functional adult who plays an active role in their daily lives. Mentoring programs sponsored by social service agencies, fraternities and sororities, churches, community and religious organizations, and others are emerging as a hopeful intervention to provide needed adult guidance and relationship. However, mentoring programs have not been sufficiently evaluated to know how effective they are in preventing negative psychosocial outcomes for abused children and adolescents.

Violence at home is often at the root of a child's behavior problems and often extends from one generation to the next. As discussed earlier, exposure to intrafamilial violence may be even more traumatic for adolescents than witnessing community violence and may result in depression and hopelessness (Durant et al., 1995). Many adolescents have no concept of loving, supportive relationships free of physical and verbal aggression. Domestic-violence prevention programs for adolescents at risk for repeating such patterns could help interrupt this cycle and provide a supportive environment in which to seek help for problems resulting from violence at home. For adolescents and families at risk, parenting classes and individual and group treatments should be made available through schools and community agencies such as family support centers.

Although additional research and evaluation of treatment programs and other interventions are necessary, we do have information about how to treat adolescent victims. The impediments lie more in the assessment and understanding of maltreatment; the organization of services and commitment of resources (which can restrict access to care for adolescents); the scarcity of mental health services for youth and their families, especially those without health insurance; and the approaches to youth and families that emphasize control and supervision instead of therapeutic interventions for both victims and perpetrators (Marneffe, 1996).

Education and Training for Providers

Although awareness of the maltreatment of children and adolescents has increased, training has not kept pace with providers' need for knowledge and expertise in assessing and treating child and adolescent abuse (Marneffe, 1996). A survey of social workers, lawyers, judges, police, nurses, physicians, psychologists, and other professionals attending a seminar on child sexual abuse revealed striking deficits in both preservice and inservice training (Hibbard and Zollinger, 1990). More than half of the respondents and more than 25 percent of those who saw five or more child sexual abuse cases per month reported no previous formal training in the assessment and treatment of alleged sexual abuse victims.

Social workers and police were more likely to have had training than other professionals. Those professionals with some formal training and those who saw five or more cases per month scored better on the content questions than those without training or with less experience with abuse victims.

Fewer physicians and lawyers participated in these trainings, compared with those in other professional groups. In a review of other research documenting the reasons why physicians and lawyers may not want to be involved in such cases, Hibbard and Zollinger (1990) found a range of responses, including unwillingness to devote large blocks of time to a poorly reimbursed activity, concerns about damaging family-physician relationships, and frustrations with the court and child protection systems.

Within health, education, and social service professions, knowledge and training for many who work with adolescents has been limited or absent; consequently, responses to adolescent needs are often inadequate and inappropriate. Abused adolescents are less likely to be identified and less likely to obtain needed services than younger children.

Training should raise professionals' awareness of abuse, provide history-taking methodologies, teach techniques for interviewing adolescents about maltreatment, present models for prevention and treatment of abuse, and address issues of confidential care with adolescents. Because cultural and ethnic differences affect adolescents' susceptibility and response to violence and victimization, cultural competency training should be included. Training should begin during basic professional education and continue on a regular basis for practicing professionals.

Providers' Experience of Abuse

Although not well addressed in the literature, the ability of individuals working with abused children and adolescents may be affected by their own experience of abuse (Weaver, 1994; Rew and Christian, 1993; Tower, 1992). The professional's own abuse issues and unaddressed feelings may impede recognition and treatment in several ways, including (1) how the abuse incident is (or is not) reported; (2) what treatment modalities and other interventions are selected; and (3) how therapy is conducted with the adolescent and family.

In a study of professionals working with sex offenders, 32.7 percent of respondents (31 women and 18 men) reported having experienced childhood sexual abuse. Many of the respondents with a history of childhood sexual abuse felt that this experience had a positive influence on their ability and motivation to work with sex offenders; others reported a negative effect on their work (Hilton, Jennings, Drugge, and Stephens, 1995).

In a survey of undergraduate nursing students attending a major university, 47 percent of the women and 38 percent of the men reported having one or more unwanted sexual experiences in childhood. This study examined coping strategies and well-being among students reporting childhood abuse and found reason for concern about levels of well-being in this sample population and their ability to master the skills needed to work with "similarly vulnerable populations" (Rew and Christian, 1993). The investigators emphasize that more research is needed to increase awareness of this issue and to provide insights into the training and supervision of professionals who work with children and youth.

Policy and Program Implementation

Societal neglect of adolescents is reflected in the limited insurance reimbursement for diagnosis and treatment of abuse; in federal, state, and local budgets that ignore or reduce funding for services to youth; in the shortage of treatment centers for adolescents involved in drug use and drug trafficking; in limited

health resources; in nonstimulating school environments that fail to establish or enforce expectations for success; in inadequate provision of school books and supplies; and in the lack of family economic and social supports.

Judicial System

State and federal laws such as the Adoption Assistance and Child Welfare Act of 1980, which increased the scope of judicial involvement and oversight in cases of child and adolescent abuse and neglect, require that the court maintain open cases until the child or adolescent is returned home safely or placed in a new permanent or independent living situation. This has strained systems by asking them to take on much greater responsibility and supervision without additional resources (U.S. Department of Justice, Coordinating Council on Juvenile Justice and Delinquency Prevention, 1996).

Communities must commit financial resources to upgrade the court system that deals with family violence, juvenile status offenders, and custody cases. In some states (Hawaii, Nevada, New Jersey, New York, and Rhode Island), unified family courts have been established in which specially trained judges and other professionals hear all family-related cases and provide leadership to develop integrated service plans, establish nonadversarial dispute resolution, and avoid conflicting court orders (U.S. Department of Justice, Coordinating Council on Juvenile Justice and Delinquency Prevention, 1996; Myers, 1994).

Court appointed special advocate (CASA) programs use trained volunteers to advocate for individual children and youth during court proceedings. Because such advocates have only one or two cases, they are more effectively able to coordinate resources, monitor services, and help to ensure the timely placement of at-risk youth in safe, supportive environments.

Children's advocacy centers facilitate investigations of child and adolescent abuse and neglect, provide a community-based approach to improve case management of children and families affected by abuse, increase the rate of successful and swift prosecutions where indicated, and coordinate treatment and follow-up of victims and their families (U.S. Department of Justice, Coordinating Council on Juvenile Justice and Delinquency Prevention, 1996).

Corporal Punishment

Policies that imply acceptance of the use of physical force to solve disputes or to control behavior help young people learn in a negative way about inappropriate and ineffective behavior. For example, the existence of corporal punishment in public institutions provides a negative learning model for behavior toward the children in the care of such institutions (Tower, 1992). In spite of evidence that physical punishment does not achieve desired long-term behavioral outcomes and that other, more effective disciplinary tools can be taught to parents, a 1991 study of family physicians and pediatricians in Ohio (McCormick, 1992) revealed that 70 percent of family physicians and 59 percent of pediatricians responding to a self-report survey supported the use of corporal punishment. The American Academy of Pediatrics (AAP) Committee on School Health has asked pediatricians to take a leadership role in abolishing corporal punishment in all schools (Poole et al., 1991). AAP has developed a policy statement urging the prohibition of corporal punishment in schools and the use of alternative methods of dealing with student behavior problems (American Academy of Pediatrics Committee on School Health, 1991).

Family Support and Preservation

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) includes new legislation for Family Preservation and Support Services to develop, strengthen, and expand family preservation and community-based family

support programs. Under this legislation (which is administered by the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau), all states, eligible Indian tribes, and political jurisdictions may receive funding. (ARCH Fact Sheet No. 37 provides a full description of this legislation.) Family support and family preservation programs shift the emphasis from removing children and youth from an abusive environment to changing family behavior and providing a broad range of support to the family unit in order to improve family functioning. Although these programs have not been thoroughly evaluated, anecdotal evidence indicates that family behaviors can be modified and that children and adolescents can safely stay within their families (The Edna McConnell Clark Foundation, 1993; Skibinski, 1995). Recent federal funding provides support to states to enhance collaboration between maternal and child health and human service agencies to ensure that such family services are both comprehensive and accessible to a broad range of populations.

Juvenile Detention

In contrast to present conditions in many facilities, all juvenile detention centers should be disciplined, organized, therapeutic centers with well-trained personnel at all levels who regard every interaction with a detained youth as an opportunity to help the youth improve self-esteem and life skills. Mental health assessment and treatment must be become a routine part of each detainee's comprehensive health care. Mental health professionals in juvenile detention centers should be trained to identify the range of mental health problems encountered in detainees (many of whom have histories of abuse and neglect), from developmental delays and depression to suicidal and homicidal ideation.

Child Fatality Review

All states and/or communities should have child fatality review teams that review all cases involving youth ages 18 and younger. These teams are a valuable tool in designing and advocating for prevention programs and in identifying common elements and precursors of child and adolescent victimization that can be recognized and treated prior to an incident of fatal abuse (Durfee, Gellert, and Tilton-Durfee, 1992).

Child Protective Services

Funding to increase the number of child protection workers and ongoing intensive training to ensure the quality of their work should be a priority. Increased reporting has placed additional burdens on child protective service agencies and has forced the use of more stringent screening. Cases may be closed prematurely without adequate follow-up or family work; because of insufficient resources, some agencies have decided not to consider cases of adolescents (typically those older than age 15).

Because child protective services and other social services do not have the resources to manage all referrals for evaluation and treatment of abuse, care is often episodic or unavailable. The health care system is one place with the potential to provide continuity and coordination of care (Krugman, 1992). However, barriers to care persist for many young people, such as the approximately one out of seven adolescents who are uninsured. Because the health care system may be the only place that conducts skillful ongoing screening, treatment, referral, and follow-up for young victims of abuse or those at risk, it is even more important to have systems of primary, preventive, and continuous care in place for adolescents.

As a society, we are at risk for viewing violence as unpredictable and unpreventable or (more disturbing) as a normal response, an acceptable expression of human nature. However, research and longitudinal studies offer considerable information on interventions and socioeconomic policies that contribute to positive child and adolescent development

and to the prevention of youth and interpersonal violence, delinquency, and abuse later in adolescence and adulthood (Rosenberg and Fenley, 1991). Considering some of the risk factors for youth violence—low socioeconomic status, neighborhoods that suffer from disorganization and high crime rates, unemployment, lack of family affection and cohesion, education deficiencies, substance abuse, and a history of being abused or witnessing violence—several areas are amenable to change and responsive to prevention and treatment.

Prevailing negative attitudes about youth affect the quality and quantity of services and support systems available to adolescents. The settings in which adolescents develop and make critical life decisions must be personally affirming and supportive rather than indifferent, suspicious, and abusive. Adolescents' environments must be changed to better meet their needs and to address the changed economic and social conditions that confront them. The serious problems faced by young people today can be prevented or ameliorated only if the responsibility for these problems is seen not as solely that of the individual adolescent, but as a shared responsibility with adults and community institutions such as schools, media, community and youth organizations, and religious groups (Takanishi, 1993). ■

A Public Health Framework for Addressing Adolescent Maltreatment

The nature of adolescent health problems and the ecological origins of abuse and neglect of youth require close collaboration between public health and other agencies in order to develop effective data collection and monitoring, prevention and treatment interventions, and evaluation and quality assurance activities.

The role of public health in addressing adolescent maltreatment includes: monitoring and documenting the circumstances and extent of adolescent maltreatment through the collection of data and other information; informing policymakers and the public about the scope, nature, and risk factors of maltreatment; and developing, implementing, and assessing prevention and treatment programs to decrease the incidence and prevalence of maltreatment.

In 1995, the Child and Adolescent Health Policy Center at The Johns Hopkins University developed the document *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America* (Grason and Guyer). Based on the consensus of several public and private organizations as well as federal, state, and local agencies, the publication outlines 10 essential public health services to promote the health of mothers and their children (p. 5). Replicating the framework of the 10 essential public health services, this technical information bulletin presents maternal and child health (MCH) program functions as they relate to the prevention and treatment of adolescent abuse and neglect, and lists suggested activities for each function. The approaches presented on the following pages assume that most activities will involve consultation and collaboration between public health and other agencies, including social services/child protective services, mental health, education, and justice/law enforcement.

1. Assess and monitor maternal and child health status to identify and address problems.

The availability of data, research information, and intervention/treatment evaluation on adolescent maltreatment is limited. Recent research on child and adolescent sexual abuse is providing clearer and more definitive information on incidence and prevalence data, ages of occurrence, and short-term and long-term sequelae.

Reported data on child abuse and neglect, which usually cover ages 0–18, most often are derived from substantiated cases that have been reported to and investigated by state and local child protective services agencies. This method excludes indicated cases or those that lacked sufficient evidence to be substantiated.

The National Incidence Studies of 1988 and 1996 added information from sentinel reporters based on both a "harm standard" and an "endangerment standard," which allow for reporting of potential or unsubstantiated abuse.

Meta-analyses of research data on the incidence and prevalence of types of abuse contribute to an understanding of the extent of the problem, but this research has been neither systematic nor readily available.

In order to estimate the extent of adolescent maltreatment and to monitor the effectiveness of policy development and program implementation, it is essential to have both accurate definitions of what constitutes adolescent maltreatment and data on its occurrence.

Specific public health activities may include the following:

- Establish definitions of abuse and neglect specific to adolescents. Most definitions apply to both children and adolescents but some categories (such as dating violence or prostitution) would be added.
- Establish sources and set up systems to determine current data on abuse and neglect of adolescents, and establish mechanisms for including disaggregated, adolescent-specific maltreatment data in an MCH data repository.
- Ensure that needs assessments include issues specific to adolescents and to adolescent maltreatment.
- Ensure that assessment and data collection are representative of all sectors of the community, including racial, ethnic, and linguistic minorities, homeless and incarcerated youth, and out-of-school youth.
- Set up systems for tracking/monitoring adolescents known to child welfare systems in order to ensure ongoing services and to evaluate the effectiveness of interventions.

2. Diagnose and investigate health problems and health hazards affecting women, children, and youth.

Because incidents of adolescent abuse and neglect are consistently underreported within present reporting systems, diagnostic activities are especially important to better define the circumstances and occurrence of adolescent maltreatment.

Specific public health activities may include the following:

- Incorporate adolescent maltreatment issues in surveys of youth, families, health care and other service providers, and other key community informants.
- Include questions about experiences of abuse and neglect in health risk surveys of adolescents (Nelson, Higginson, and Grant-Worley, 1995).
- Support the development of child fatality review teams at appropriate levels—state, county, and/or local (U.S. Department of Health and Human Services, 1993). Ensure that child fatality review teams perform reviews of all deaths of youth up to age 19, and that team members have expertise in adolescent health and development.
- Suggest that child fatality review teams also examine adolescent deaths from suicide, homicide, and motor vehicle and other injuries for underlying incidence of abuse. (Adolescent deaths typically may not be considered in relation to abuse and neglect, since the incidence of fatal injuries from physical abuse decreases with the age of the child.)
- Train clinicians to screen adolescents for past and current abuse and/or neglect as well as exposure to violence (including dating violence) either as a victim or a witness; encourage clinicians to help document the incidence and prevalence of adolescent maltreatment and related circumstances.
- Target information-gathering efforts primarily (but not exclusively) toward settings in which abuse and neglect are known to be significant factors in the backgrounds of the involved adolescents: homeless and runaway programs; school dropout prevention projects; juvenile justice prevention, diversion, and detention programs; substance abuse and mental health treatment programs; and adolescent pregnancy and family planning programs.
- Gather, analyze, and report on quantitative and qualitative data and recommend systems improvement based on the findings.

3. Inform and educate the public and families about maternal and child health issues.

Information about abuse and neglect of children often reaches the public through a media exposé, in which stories involving extreme cases are sensationalized. Families, adolescents, and other community members need to be well informed about issues of adolescent maltreatment.

Specific public health activities may include the following:

- Inform and educate the community about family and individual factors that place an adolescent at risk for abuse and/or neglect, behavioral signs that may indicate a history of abuse, and prevention and treatment resources available for both families and individual adolescents.
- Encourage primary prevention by supporting the development and broad dissemination of parenting training/education and of culturally sensitive and linguistically appropriate materials that help to inform, guide, and direct parents and caregivers in the effective parenting of adolescents, especially young adolescents. In many areas, special approaches may be required to address issues of acculturation and intergenerational conflict for immigrant populations.
- Sponsor programs for parents of adolescents, such as parenting classes and/or support groups in the workplace.
- Develop fact sheets on the incidence and prevalence of adolescent maltreatment, signs and symptoms of abuse/neglect in adolescents, screening and counseling techniques, and referral resources for youth and families. Distribute fact sheets and provide education and training programs for school personnel, law enforcement personnel, departments of human services, managed care providers, community health centers, juvenile justice personnel, religious institutions, recreation departments, and youth service organizations.

4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

Specific public health activities may include the following:

- Establish coalitions or use existing coalitions to address adolescent health issues and ensure that the complex issues of adolescent abuse and neglect are considered in all coalition activities, including attention to both general adolescent health issues and specific health problems such as adolescent pregnancy, substance abuse, and violence.
- Work with child fatality review teams to publicize findings among lay and professional communities to mobilize efforts to improve services for abused youth and those at risk for abuse.
- Prepare fact sheets on statewide and/or community adolescent maltreatment issues and distribute them to policymakers and advocacy and consumer groups.
- Work with health and human service membership organizations to ensure that adolescent maltreatment issues are incorporated in training, advocacy, and outreach.
- Ensure that representatives of ethnic, racial, and linguistic minority groups are included in committees, work groups, and other decision-making bodies.

5. Provide leadership for priority-setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.

Healthy People 2000 objectives provide a framework for setting priorities and assessing progress toward meeting goals. In some states and localities, these objectives have been modified to reflect local conditions more accurately.

Selected *Healthy People 2000* objectives related to the abuse and neglect of adolescents and to the interpersonal conflict and violence among adolescents include the following:

6.14 Increase to at least 75 percent the proportion of providers of primary care for children who include assessment of cognitive, emotional, and parent-child functioning, with appropriate counseling, referral, and follow-up, in their clinical practices.

7.4 Reverse to less than 22.6/1,000 children the rising incidence of maltreatment of children younger than age 18.

7.12 Extend protocols for routinely identifying, treating, and properly referring suicide attempters, victims of sexual assault, and victims of spouse, elder, and child abuse to at least 90 percent of hospital emergency departments.

7.14 Increase to at least 30 the number of states in which at least 50 percent of children identified as neglected or physically or sexually abused receive physical and mental evaluation with appropriate follow-up as a means of breaking the intergenerational cycle of abuse.

7.16 Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as part of comprehensive school health education.

At the time the U.S. Department of Health and Human Services published *Healthy People 2000: Midcourse Review and 1995 Revisions,* tracking data had not yet been established to determine whether these objectives had been achieved nationally. The role of the public health system is to publicize and implement programs to achieve the national objectives and/or to develop objectives and establish an agenda specific to local community needs.

5 (continued)

Specific public health activities may include the following:

- Review *Healthy People 2000* objectives and assess state and community progress toward reaching objectives; if appropriate, establish state and/or local objectives that reflect local conditions.
- Set agendas and activities for achieving desired goals, using *Healthy People 2000* objectives and/or other benchmarks.
- Develop expertise in adolescent maltreatment issues or work with experts in the field and testify at public hearings and legislative hearings.
- Organize educational events/briefings for legislators and/or staff.
- Work with local agencies that provide services to adolescents in high-risk situations to encourage such agencies to also provide abuse awareness and education services to youth, families, schools, social service and mental health agencies, law enforcement agencies, managed care organizations, and other providers of care.
- Ensure that maltreatment issues are included in needs assessment tools and that communities collect data or organize existing data in a way that clearly documents the needs of abused youth and their families.
- In collaboration with relevant public agencies and private organizations, develop state objectives for adolescent maltreatment and plan for expanding the use of screening, treatment, and follow-up protocols by hospitals, managed care organizations, school-based health centers, community health centers, family planning programs, and other providers.
- Work with other agencies such as child protective services, law enforcement, juvenile justice, education, and mental health to develop coordinated plans for state and community interventions to reduce the incidence and sequelae of adolescent maltreatment; and produce and disseminate reports that document state and local progress in meeting objectives.
- Work with private sector health groups such as state medical and nursing associations, hospital and managed care associations, and child and family services to promote professional and community education and program development to meet the needs of maltreated adolescents and their families.

6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.

Specific public health activities may include the following:

- Interpret and publish guidelines regarding federal and state legislation affecting abused and/or neglected adolescents and their families, including mandatory reporting laws, data collection and reporting requirements, and statutes concerning emancipated minors and guardianship.
- Educate local, state, and federal policymakers regarding the needs of maltreated youth, using expert testimony and research findings. (For example, when adolescent abuse is part of a continuum established in childhood, there is less likelihood that family counseling and intervention will be successful. Therefore, such youth may need assistance in preparing for independent living and in obtaining a waiver of restrictions based on minor status so they can live independently.)
- Organize expert testimony on issues of adolescent maltreatment for national, state, and local entities who are developing health and social service legislation, standards of care, and program and funding guidelines.
- Participate in the legislative review process to ensure that health and social service legislation adequately protects and provides services to maltreated adolescents.
- Draft or contribute to the writing of legislation that would ensure adequate prevention services; assessment, treatment, and follow-up care; and program alternatives for such groups as adjudicated, pregnant and parenting, and homeless youth.
- Work with the Medicaid Administration to ensure that waiver applications and contracts for managed care include sufficient primary care and mental health services for adolescents (including school-based health and mental health care), and adequate screening, referral, and treatment of all adolescents.

7. Link women, children, and youth to health and other community and family services and assure access to comprehensive, quality systems of care.

Adolescents traditionally are underserved by the health care system (U.S. Congress, Office of Technology Assessment, 1991) and thus do not have the benefit of comprehensive health care that includes screening and treatment or referral for psychosocial problems, and specifically for abuse and neglect.

Mental health services, an essential component of treatment for abused adolescents, are limited and difficult to access. Access issues include the costs of mental health services and limited coverage for such services by many health insurers; inconvenient location and hours of services for many adolescents/families; and the stigma that persists for those seeking psychological care, especially adolescents.

Racial, cultural, and socioeconomic factors affect access to care and the effectiveness of treatment and prevention. Cultural variations help define differences in forms and styles of abuse as well as treatment. Cultural beliefs and attitudes can influence one's vulnerability to maltreatment and the experience of victimization as well as the victim's expression of need and response to interventions (Brilliant et al., 1996).

Specific public health activities may include the following:

- Assess the need and provide resources for nontraditional methods of care delivery for adolescents, such as mobile vans, mall health centers, school-based or school-linked health centers that include mental health services, and school-based mental health centers.
- Work with organizations representing distinct racial and ethnic groups to develop culturally and linguistically appropriate outreach and health promotion materials and messages concerning family violence and adolescent maltreatment.
- Provide/coordinate training in the cultural aspects of adolescent maltreatment and in developing culturally and linguistically sensitive interventions with youth and families in cases of suspected or confirmed abuse and/or neglect.
- Provide leadership to ensure appropriate diversity in state and local program staff providing consultations and services related to adolescents.
- Develop toll-free information and referral lines for youth and establish mechanisms to publicize their availability. Ensure that appropriate information and referrals are available for a broad range of problems, including abuse and neglect.

7 (continued)

- Provide technical assistance and training for providers and health plans in the screening, treatment, and referral of maltreated adolescents. Assist with the development of standards, protocols, and assessment tools so that issues of abuse and neglect can be included routinely in health care visits.

- Disseminate information about effective treatment for adolescents who have been abused and/or neglected.

- Monitor adolescent health visits to health plans and community providers to assess the frequency and adequacy of screening, identification, treatment, and/or referral for abuse and/or neglect.

- Collaborate with the juvenile justice system to assess health care needs and health resources for youth in detention. Develop links with community-based care to ensure continuity for youth as they are released from facilities.

- Develop and implement training and technical assistance for corrections health personnel concerning issues of adolescent maltreatment and effective interventions with youth who may be victims as well as perpetrators.

- Seek funds and provide support for projects that provide and coordinate comprehensive services for adolescents in such high-risk situations as living on the streets, being incarcerated, living in single-parent homes with incomes below the federal poverty level, being truant from school, and being involved in gang activity. Work collaboratively with other departments that also have responsibility for these youth in order to develop collaborative programs and funding.

8. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.

There is a critical need to improve provider capacity in understanding, recognizing, and intervening to prevent adolescent maltreatment and to treat adolescents who are victims of abuse and/or neglect.

With an increased understanding of the relationship between adolescent risk behaviors and past or ongoing maltreatment, it is essential that providers become knowledgeable about the behavioral sequelae of abuse and neglect. For example, understanding the association between sexual abuse and adolescent sexual behaviors and early pregnancy, or between physical abuse and alcohol use by adolescents, adds an important dimension to the assessment and treatment or referral of adolescent clients.

Specific public health activities may include the following:

- Develop and disseminate fact sheets on the incidence and prevalence of adolescent maltreatment, the effects of maltreatment on behavior, and recommendations for individual, family, and community prevention and intervention.
- Work with state professional membership groups to sponsor training and to develop programs in the area of adolescent maltreatment.
- Work with other agencies such as child protective services and human services to develop and sponsor training related to adolescent maltreatment, including assessment tools and techniques, treatment, and program development and evaluation.
- Expand interdisciplinary training opportunities, especially for adolescent health and social service providers, school staff, and law enforcement and juvenile justice personnel, in the area of adolescent victimization and adolescent aggression and violence.
- Identify institutions and individuals with expertise in adolescent maltreatment and enlist their consultation and collaboration in training, program development and evaluation, and research.

9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

In response to a documented or perceived need, programs are often developed without the benefit of a sound theoretical base or evaluation plan. Although these programs may be successful, there is little basis for determining success, examining components that contribute to success, improving services, or ensuring sustainability.

Despite increasing awareness of the extent and seriousness of adolescent maltreatment, little is known about the effectiveness of individual assessment, family and community risk assessment, prevention, or treatment related to abuse and neglect of youth.

Specific public health activities may include the following:

- As part of baseline data, develop resource inventories describing statewide and/or community-based health and mental health care services for adolescents. Include information on the following: screening, treatment, and referral for maltreatment and associated problems; accessibility of transportation; financial eligibility requirements; availability of language translation services; use of culturally appropriate information and services; and staff representation from the ethnic and language groups of client populations.

- Through surveys, interviews, and other information-gathering techniques, develop profiles of the knowledge, attitudes, and practices of public and private providers concerning maltreatment and interpersonal violence.

- Determine whether care providers for adolescents are familiar with and use such tools as *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (Green, 1994) and Guidelines for Adolescent Preventive Services (GAPS) (1994).

- Work with groups that are establishing quality-of-care indicators, such as the National Committee for Quality Assurance (NCQA), Medicaid, school-based health services, and professional organizations to ensure that screening and treatment or referral for adolescent maltreatment and its sequelae are included.

- Assist local communities in designing and conducting surveys and data analyses to determine needs in the area of adolescent maltreatment. Gather local community data and information in state-level planning and program development efforts.

- Perform or support evaluations of program interventions to prevent and treat adolescent abuse and neglect and interpersonal violence, and use the results of these evaluations in program and policy development.

10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

Research on child and adolescent abuse and neglect, and program development aimed at prevention, early detection and treatment of victims, and intervention with perpetrators, have not kept pace with the increased incidence and prevalence of maltreatment. Given the strong associations between a history of being abused and such adolescent problems as substance abuse, early pregnancy, depression, suicidal behavior, aggression, and delinquent behavior, more information and more effective strategies are necessary to prevent abuse and neglect and to treat children, adolescents, and families who are involved in abusive relationships.

Providers, policymakers, and the public need more information about etiology, prevention, and treatment in order to increase their commitment to action. Public health has a unique role in efforts to further improve awareness and define the epidemic of abuse, to educate professionals and the public, and to promote research and program development for improving family functioning and maintaining community and institutional integrity.

Specific public health activities may include the following:

- Provide expertise and resources to develop models for prevention, screening, and treatment of adolescent maltreatment and interpersonal violence.
- Support adaptation and replication of promising program models for prevention, screening, and treatment of abuse and neglect of adolescents. Ensure that adequately funded evaluation components are included.
- Support research related to child and adolescent abuse and neglect.
- Maintain awareness of and participate in national program demonstrations to prevent and/or treat adolescent victimization.
- Organize and disseminate results of research and demonstration projects related to adolescent maltreatment.

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