

# Youth Violence

**Definition:** Serious violent crime includes murder, rape, robbery, and aggravated assault (assault with a weapon or with intent to cause severe injury). "Youth" includes anyone between the ages of 10 and 24.

## Summary

Youth violence is a serious public health problem. Youth are over-represented in violence both as perpetrators and victims. In 2005, there were 3,811 arrests of youth ages 10–24 for serious violent crime (age-specific arrest rate: 318 per 100,000). Washington youth arrest rates dropped by 40% from 1994 to 2005, but self-reported fighting did not decrease. Homicide is the third leading cause of death among 10–24 year-olds in Washington.

Reducing youth violence will require the development and implementation of effective evidence-based programs and policies. Effective programs to prevent youth violence include school-based programs to reduce fighting and bullying, parent training, and therapeutic foster care programs.

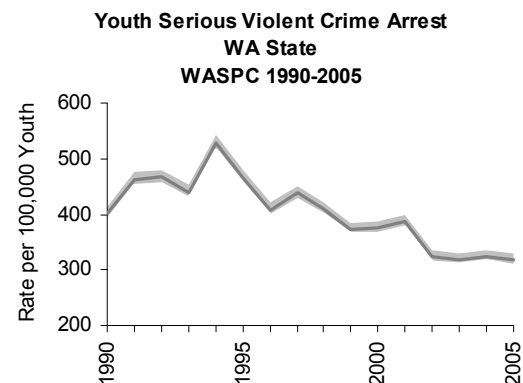
## Time Trends

Two aspects of arrest data make them different from other health indicators. First, arrest data report the location of the crime rather than where the perpetrator lives. Second, if multiple offenses occur in the same crime, the data include only the most serious offense. If, for example, a perpetrator both robs and assaults a victim, the arrest data count only the robbery. Serious violent crime arrests measure only a small proportion of violent acts perpetrated by youth, because many crimes do not result in an arrest.

From 1994 to 2005, data from the Washington Association of Sheriffs and Police Chiefs (WASPC) show a 40% decline in the arrest rate for youth ages 10–24, from 529 to 318 arrests per 100,000. National trends also show a decrease in arrest rates for youth ages 10–17 from 1994 to 2003.<sup>1</sup> Washington arrest rates for youth ages 10–17 in 2002 and 2003 were lower

than national rates.<sup>1</sup> Comparable U.S. figures are not available for young adults ages 18–24.

The U.S. Surgeon General characterized the large increase in youth violence in the late 1980s and early 1990s as a "violence epidemic."<sup>2</sup> An increase in the use of firearms by youth and young adults appears to have contributed to increased homicides during this period because firearms are more lethal than other weapons.<sup>2</sup>



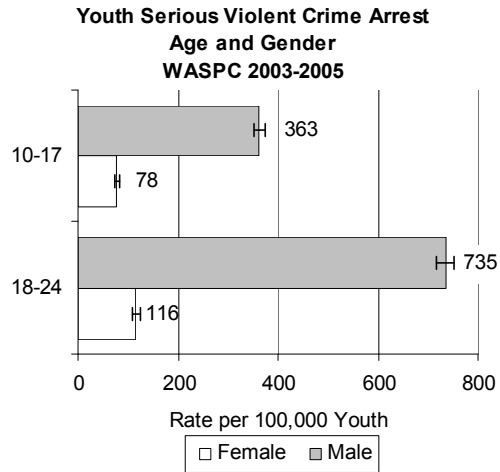
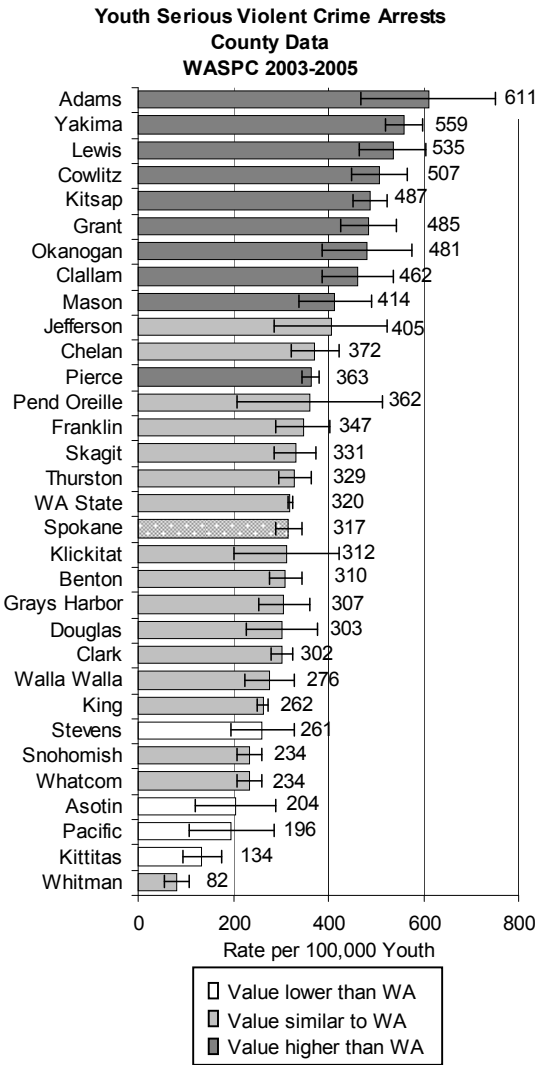
## Year 2010 Goals

The national *Healthy People 2010* does not set a goal for youth violent crime arrest. There is a goal to reduce physical fighting among adolescents in grades 9–12 in the previous 12 months to 32%. Washington appears to have met this goal. In the 2006 [Healthy Youth Survey](#), 34% ( $\pm 2\%$ ) of 8<sup>th</sup> graders, 29% ( $\pm 2\%$ ) of 10<sup>th</sup> graders, and 21% ( $\pm 2\%$ ) of 12<sup>th</sup> graders reported physical fighting in the previous 12 months.

## Geographic Variation

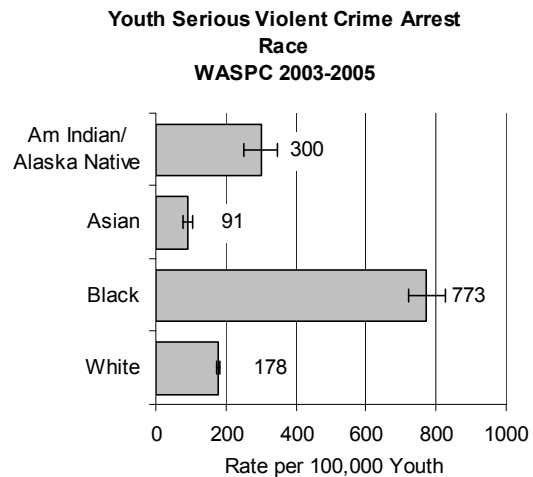
Seven Washington counties had [fewer than 20](#) arrests for violent crime among youth ages 10–24 during 2003–2005. Rates for these counties fluctuate even when combining three years, and the following chart does not include these counties. Counties vary widely in their rates of youth arrests

for violent crime, from fewer than 100 arrests per 100,000 youth ages 10–24 in Whitman County to more than 500 per 100,000 in Adams, Yakima, Lewis, and Cowlitz counties. Variations in law enforcement practices may explain some county-to-county differences.



**Race and Hispanic Origin**

In Washington for youth ages 10–24 and in the United States for youth ages 10–17, the highest arrest rates are among blacks and the lowest are among Asians. Nationally, violent crime arrest rates declined more for black youth than for other racial groups during 1994–2003.<sup>1</sup> The Uniform Crime Reports does not code Hispanic origin. The association between race and violent behavior appears to be due to differences in socioeconomic status and other risk factors associated with race.<sup>2</sup>



**Age and Gender**

During 2003–2005 combined, the arrest rate for violent crime among Washington youth ages 10–17 was 224 per 100,000. The arrest rate among young adults ages 18–24 was 435 per 100,000. These rates mirror national patterns in that violent crime rates are higher among young adults than among adolescents.

In Washington, as in the rest of the United States, most youth and young adults arrested for violent crime are male.

**Income and Education**

Washington data describing income and education of those arrested are not available. The Surgeon General concluded that low family socioeconomic status is a moderate risk factor for violence in childhood and a small risk factor in adolescence.

School achievement and success are associated with less delinquency and violence.<sup>2</sup>

## Other Measures of Impact and Burden

**Self-reported violence.** On the 2004 and 2006 Washington State Healthy Youth Survey, 28%–29% ( $\pm 3\%$ ) of 10<sup>th</sup> graders in public schools reported physical fighting in the 12 months before the survey. These rates are similar to those in 1995, the first year a Washington school-based survey asked this question. The rates are less than the national rate of 37% ( $\pm 2\%$ ) from the Youth Risk Behavior Survey conducted in 2005.

On the 2004 and 2006 Healthy Youth Surveys, 7%–9% ( $\pm 1\%$ ) of 10<sup>th</sup> graders in public schools reported carrying a weapon on school property in the past 30 days. These rates are similar to those in 1999, the first year a Washington school-based survey asked this question. The rates are similar to the national rate of 7% ( $\pm 3\%$ ) from the Youth Risk Behavior Survey conducted in 2005.

Nationally, the prevalence of self-reported violence among youth has been relatively stable for the past 20 years in contrast to the dramatic rise and fall in youth arrest rates for violent crime. Given that the underlying prevalence of violent confrontations among youth has not changed, the Surgeon General urges caution: “Should firearms once again become appealing and accessible to young people, the potential for a recurrence of the violence epidemic is quite real”(p. 34).<sup>2</sup>

**Hospitalization for victims of violence.** In 2002–2004 combined, Washington hospitals recorded an annual average of 434 assault-related discharges among youth ages 10–24, requiring about 1,900 hospital days per year. Eighty-four percent of the patients were male. From 1993 to 1999, assault-related hospitalizations for youth dropped from 49 per 1,000 youth ages 10–24 to 26 per 1,000 and then remained relatively stable, with 35 hospitalizations per 1,000 youth in 2004. While this decline is consistent with the decline in arrests for serious violent crime, some of this decline might also be due to changes in hospital admission practices.

**Victimization by violent crime.** National data suggest young people are at high risk for being victims of violent crime, as well as being

perpetrators. National Crime Victimization Survey data show that in 2005, 47 of 1,000 youth ages 12–15 and 45 of 1,000 people ages 16–24 reported being victims of violent crime. Comparable rates at older ages were 24, 18, 11, and 2 per 1,000 for adults ages 25–34, 35–49, 50–64, and 65 and older, respectively.<sup>3</sup> Violent crime victimization rates are higher for males, but females are more likely to be victims of sexual assault.<sup>3</sup> In 2002–2004 in Washington, 168 youth ages 10–24 were victims of homicide (4 per 100,000 youth). Homicide is the third leading cause of death in this age group.

**Quality of life.** Youth violent crime can seriously affect the quality of life for victims and their families. In addition, people living in communities with high crime rates often suffer from fear, anxiety, and a loss of freedom as people restrict their activities to avoid becoming victims of violence. Society also pays for violence through expenditures for police and criminal justice interventions, social services, and preventive educational activities. Exposure to community violence can be traumatic for children, and children exposed to community violence might be at risk for depression, interpersonal problems, or academic difficulty. Exposure to community violence is associated with other risk factors such as poverty, however, and so the causal relationships are not known.<sup>4</sup>

Youth who show high levels of aggression throughout childhood and adolescence are themselves at higher risk for a variety of outcomes that affect the quality of life including low educational attainment, persistent unemployment, poor physical health, alcohol and drug abuse, unintentional injury, depression, suicide attempts, relationship conflict, spouse abuse, and neglectful and abusive parenting as adults.<sup>5,6</sup> They also are at increased risk of being killed or permanently maimed.<sup>7</sup>

## Risk and Protective Factors

Risk factors for violent behavior fall into five domains: individual, family, school, peer group, and community factors. There are complex relationships among the risk factors both within and across domains. As children develop, the relative importance of risk factors and domains changes. Risk factors tend to cluster within individuals, and young people with many risk factors are more likely than other youth to exhibit violent behavior. Evidence suggests that the total number of risk factors or the balance between risk and protective factors is most important in predicting whether violent behavior occurs. Many of the known risk

factors might not be causal but perhaps function as markers of groups at high risk for violent behavior.

Protective factors are aspects of the individual and his or her environment that moderate the effect of risk.<sup>2</sup> Relative to risk factors, little research has specifically addressed factors that protect against violent behavior. As a result, there is scientific evidence for only a few protective factors in reducing the risk of violent behavior. Research needs to identify protective factors and to determine when, in the course of a child's development, they most effectively buffer risks.

**Individual factors.** For boys, chronic physical aggression in childhood is the most consistent predictor of adolescent violence, and the boys who are most physically aggressive in childhood generally continue to be so in adolescence.<sup>7,8</sup> Other serious conduct problems such as stealing, lying, or destroying property in childhood also predict adolescent aggression. Boys who believe that physical aggression is a legitimate response or consistently misread social cues as hostile are also more likely to be aggressive. Language impairment such as poor vocabulary and scoring low on intelligence tests are generally associated with antisocial behavior, including violence, although research has not uncovered the reasons for this finding.<sup>9</sup> Juvenile delinquents use lower levels of moral judgment than other adolescents.<sup>10</sup>

Boys are more likely to be aggressive than girls, even after controlling for other known risk factors. But girls who are violent are at more risk than boys of suicide and a range of psychological disorders.<sup>11</sup>

A strong individual-level protective factor is an intolerant attitude toward deviance.<sup>2</sup> School achievement and success also protect against delinquency and violence.<sup>2</sup>

**Family factors.** In childhood, living in poverty and parental criminality are moderate risk factors for aggressive behavior. Other risk factors include poor parent-child relations, exemplified by harsh, lax, or inconsistent discipline. Children with divorced, separated, or never-married parents are at a slightly increased risk of violence, as are children who were separated from their parents before age 16. Child abuse and neglect consistently predict later violence, although most victims of child abuse do not become violent. In adolescence,

most family risk factors diminish in importance, as the influence of peers increases. Inadequate supervision and low parental involvement confer a small risk of violence among adolescents.<sup>2,11,12</sup>

An emotionally supportive parent who provides consistent rules and supervision or a caring adult who supports conventional behavior might protect against violence, but additional research is needed.<sup>2</sup>

**School factors.** In childhood, school factors such as a poor attitude toward school have small effects on later violent behavior.<sup>2</sup> This risk factor becomes more important in adolescence, particularly if it leads to academic failure.<sup>13</sup> Commitment to school buffers the effects of risk factors for violent behavior.<sup>2,14</sup>

**Peer factors.** Adolescents with antisocial or delinquent peers are at high risk of violent behavior. Although social isolation is not a risk factor for violence, adolescents who are unpopular and uninvolved in conventional school activities can turn to antisocial peer groups for acceptance. Gang involvement is a strong risk factor for violence. These three peer group factors—weak ties to conventional peers, strong ties to antisocial peers, and gang involvement—tend to cluster together, but they are each powerful predictors of violence in adolescence even when they do not occur together.<sup>2,11,12</sup>

Conventional friendships and peers who disapprove of violence might protect against violence, but research has not firmly established this relationship.<sup>2</sup>

**Community factors.** Adolescents exposed to violence in their communities are at higher risk of violent behavior. Additionally, youth violence is somewhat higher in communities characterized by social disorganization—economic instability, high residential turnover, and a high proportion of single-parent families—and a possible reason is that these communities have fewer informal social controls, such as neighbors providing informal supervision.<sup>2</sup> Viewing large amounts of television violence in childhood appears to contribute to aggression in young adulthood.<sup>15</sup> Other risk factors include the presence of crime and drugs in the neighborhood and neighborhood adults who are involved in crime.<sup>2</sup>

## Intervention Strategies

Possible points of intervention begin with parents prior to the birth and continue throughout childhood, adolescence, and young adulthood. Public health generally focuses on preventing or reducing violent behavior by reducing risk and increasing protective factors. The criminal justice system focuses on

rehabilitating violent offenders, although they also work on prevention.

Programs can be ineffective or even exacerbate the problem. Programs that use “scare tactics” such as confronting youth with criminals in prison may make the problem worse.<sup>2</sup> Programs that group high-risk youth together, such as detention centers and “boot camps” might facilitate ties to antisocial peer groups.<sup>16</sup>

**Home visiting.** Home visiting programs for parents at risk of abuse (such as low-income, young single mothers) with very young children try to improve parenting skills and to provide social support. Some home visiting programs have reduced violent behaviors among youth,<sup>17</sup> but these findings are inconsistent. These programs have shown positive effects of reducing child abuse.<sup>18</sup>

**School-based programs.** School-based interventions to reduce bullying and improve relationship skills generally reduce fights and bullying for up to one year.<sup>19,20</sup>

**Parent training.** Programs for children with conduct disorders and their parents and teachers such as The Incredible Years are able to improve parenting and teaching and to reduce child conduct problems.<sup>21</sup>

**Family interventions.** Family interventions, including programs such as Functional Family Therapy and Multisystemic Therapy, show promise for children and adolescents who already show relatively severe aggressive tendencies or other problem behaviors. These interventions teach parenting skills and foster improvement in relationships among family members. In a recent review, seven out of eight well-conducted studies of Multisystemic Therapy found positive effects on at least one outcome measure, such as arrests, incarceration, or self-reported delinquency. But the largest and most rigorous study found no differences, and so more research is needed.<sup>22</sup> The evidence to date suggests that effective family therapy programs for juvenile offenders can yield net economic gains from \$1,900 to \$31,200 per youth.<sup>23</sup>

**Therapeutic foster care.** Therapeutic foster care programs serve youth who do not require secure institutionalization but cannot live at home because of behavioral or emotional problems. Foster parents receive special training to provide a structured environment for learning social and emotional skills. These programs

reduced subsequent violent crime by about 70% for up to a year.<sup>24</sup>

**Other programs.** Several other programs have shown promise in experimental studies but have been subjected to a limited amount of research. These include the Moving to Opportunity demonstration project that involves relocating families from high- to low- poverty neighborhoods; Childhaven’s Therapeutic Child-Care Program for maltreated children and their parents; and Turning Point: Rethinking Violence, a program to educate male first-time violent crime offenders and their parents about the consequences of violence.<sup>25</sup> Additional programs that have shown evidence of effectiveness in experimental studies but have not been replicated in large studies include Big Brothers Big Sisters and Promoting Alternative Thinking Strategies.<sup>16</sup> Some programs that reduce substance use have also been recommended for violence prevention,<sup>26</sup> but their effectiveness in preventing violence is not known at this time.

**See Related Chapters:** [Homicide](#), [Child Abuse and Neglect](#), and [Domestic Violence](#)

**Data Sources** (For additional detail, see [Appendix B](#).) State Arrest Data: Washington Association of Sheriffs and Police Chiefs (WASPC). Prepared by Washington State Department of Social and Health Services (DSHS) Research and Data Analysis. Age-specific population estimates excluding the population covered by agencies that do not report to WASPC prepared by DSHS Research and Data Analysis.

#### **For More Information**

U.S. Centers for Disease Control National Center for Injury Prevention and Control Website: <http://www.cdc.gov/ncipc/factsheets/yvfacts.htm> and Best Practices for Youth Violence Prevention: <http://www.cdc.gov/ncipc/dvp/bestpractices.htm>. National Youth Violence Prevention Resource Center Website: <http://www.safeyouth.org/scripts/index.asp>. The Prevention Institute, Violence Prevention Website: <http://www.preventioninstitute.org/violenceprev.html>.

#### **Technical Notes**

Arrest reporting is voluntary, and a small number of law enforcement agencies do not report their crime and arrest statistics to state authorities. To adjust for non-reporting, the population estimates provided by DSHS Research and Data Analysis exclude the population covered by agencies that do not report to WASPC. Population estimates adjusting for non-reporting agencies are not available for racial or Hispanic origin comparisons. From 2003–2005, police jurisdictions covering about 99% of youth ages 17–24 reported to WASPC. Rates for Island County are not included because before 2005, more than half the

population lived in jurisdictions where agencies did not report arrests.

Comparable U.S. figures are not available for 2003-2005 or for ages 18-24 because U.S. population estimates do not exclude the population covered by non-reporting agencies, except for special reports.<sup>1</sup>

Homicide data were from the U.S. Centers for Disease Control and Prevention Web-based Injury Statistics Query and Reporting System (WISQARS) program, available online at [www.cdc.gov/ncipc/wisqars/default.htm](http://www.cdc.gov/ncipc/wisqars/default.htm).

## Endnotes

<sup>1</sup> Snyder, H. N., & Sickmund, M. (2006). *Juvenile Offenders and Victims: 2006 National Report*. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

<sup>2</sup> Office of the Surgeon General, U.S. Department of Health and Human Services. (2001). *Youth Violence: A Report of the Surgeon General*. Retrieved December 4, 2006 from <http://www.surgeongeneral.gov/library/youthviolence/youthviolereport.htm>.

<sup>3</sup> Catalano, S. M. (2006). *Criminal victimization, 2005*. Bureau of Justice Statistics Bulletin NCJ 214644. Retrieved November 20, 2006 from <http://www.ojp.usdoj.gov/bjs/pub/pdf/cv05.pdf>.

<sup>4</sup> Lynch, M. (2003). Consequences of children's exposure to community violence. *Clinical Child and Family Psychology Review*, 6, 265-274.

<sup>5</sup> Tremblay, R. E., Nagin, D. S., Seguin, J. R., Zoccolillo, M., Zelazo, P. D., Boivin, M., et al. (2004). Physical aggression during early childhood: trajectories and predictors. *Pediatrics*, 114, 43-50.

<sup>6</sup> Jaffee, S. R., Belsky, J., Harrington, H., Caspi, A., & Moffitt T. E. (2006). When parents have a history of conduct disorder: how is the caregiving environment affected? *Journal of Abnormal Psychology*, 115, 309-319.

<sup>7</sup> Loeber, R., & Farrington, D. P. (2000). Young children who commit crime: Epidemiology, developmental origins, risk factors, early interventions, and policy implications. *Development and Psychopathology*, 12, 737-762.

<sup>8</sup> Broidy, L. M., Nagin, D. S., Tremblay, R. E., Bates, J. E., Brame, B., Dodge, K. A., et al. (2003). Developmental trajectories of childhood disruptive behaviors and adolescent delinquency: A six-site, cross-national study. *Developmental Psychology*, 39, 222-245.

<sup>9</sup> Rutter, M. (2003). Commentary: causal processes leading to antisocial behavior. *Developmental Psychology*, 39, 372-378.

<sup>10</sup> Stams, G. J., Brugman, D., Dekovic, M., van Rosmalen, L., van del Laan, P., & Gibbs, J. C. (2006). The moral judgment of juvenile delinquents: a meta-analysis. *Journal of Abnormal Child Psychology*, 34, 692-708.

<sup>11</sup> Rappaport, N., & Thomas, C. (2004). Recent research findings on aggressive and violent behavior in youth: Implications for clinical assessment and intervention. *Journal of Adolescent Health*, 35, 260-277.

<sup>12</sup> Loeber, R., Pardini, D., Homish, D. L., Wei, E. H., Crawford, A. M., Farrington, D. P., et al. (2005). The prediction of violence and

homicide in young men. *Journal of Consulting and Clinical Psychology*, 73, 1074-1088.

<sup>13</sup> Borowsky, I. W., Ireland, M., & Resnick, M. D. (2002). Violence risk and protective factors among youth held back in school. *Ambulatory Pediatrics*, 2, 475-484.

<sup>14</sup> Brookmeyer, K. A., Fanti, K. A., & Henrich, C. C. (2006). Schools, parents, and youth violence: a multilevel, ecological analysis. *Journal of Clinical Child and Adolescent Psychology*, 35, 504-514.

<sup>15</sup> Huesmann, L. R., Moise-Titus, J., Podolski, C-L., & Eron, L. D. (2003). Longitudinal relations between children's exposure to TV violence and their aggressive and violent behavior in young adulthood: 1977-1992. *Developmental Psychology*, 39, 201-221.

<sup>16</sup> National Institutes on Health. (2004). *Preventing Violence and Related Health-Risking Social Behaviors in Adolescents: an NIH State-of-the-Science Conference*. Washington, DC: National Institutes on Health. Retrieved November 21, 2006 from: <http://consensus.nih.gov/2004/2004YouthViolencePreventionSOS023htm.htm>.

<sup>17</sup> Connor, D. F., Carlson, G. A., Chang, K. D., Daniolos, P. T., Ferziger, R., Findling, R. L., et al. for the Stanford/Howard AACAP Workgroup on Juvenile Impulsivity and Aggression. (2006). Juvenile maladaptive aggression: a review of prevention, treatment, and service configuration and a proposed research agenda. *Journal of Clinical Psychiatry*, 67, 808-820.

<sup>18</sup> Task Force on Community Preventive Services. (2005). Recommendations to reduce violence through early childhood home visitation, therapeutic foster care, and firearms laws. *American Journal of Preventive Medicine*, 28, 6-10.

<sup>19</sup> Mytton, J., DiGuiseppi, C., Gough, D., Taylor, R., & Logan, S. (2006). School-based secondary prevention programmes for preventing violence. *Cochrane Database of Systematic Reviews*, Issue 3.

<sup>20</sup> Wilson, S. J., Lipsey, M. W., & Derzon, J. H. (2003). The effects of school-based intervention programs on aggressive behavior: a meta-analysis. *Journal of Consulting and Clinical Psychology*, 71, 136-149.

<sup>21</sup> Webster-Stratton, C., Mihalic, S., Fagan, A., Arnold, D., Taylor, T., & Tingley, C. (2001). *The Incredible Years: Parent, Teacher And Child Training Series: Blueprints for Violence Prevention, Book Eleven*. Blueprints for Violence Prevention Series (D.S. Elliott, Series Editor). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

<sup>22</sup> Littell, J. H., Popa, M., & Forsythe, B. (2006). Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17. *Cochrane Database of Systematic Reviews*, Issue 4.

<sup>23</sup> Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). *Benefits and costs of prevention and early intervention programs for youth*. Olympia, WA: Washington State Institute for Public Policy.

<sup>24</sup> Hahn, R. A., Bilukha, O., Lowy, J., Crosby, A., Fullilove, M. T., Liberman, A., et al. (2005). The effectiveness of therapeutic foster care for the prevention of violence: a systematic review. *American Journal of Preventive Medicine*, 28, 72-90.

<sup>25</sup> Limbos, M. L., Chan, L. S., Curren, W., Schneir, A., Iverson, E., Sekelle, P., et al (2007). Effectiveness of interventions to prevent youth violence: A systematic review. *American Journal of Preventive Medicine*, 33, 65-74.

<sup>26</sup> Blueprints for Violence Prevention. (2007). *Blueprints model programs overview*. Retrieved July 19, 2007 from [www.colorado.edu/cpsv/blueprints/model/overview.html](http://www.colorado.edu/cpsv/blueprints/model/overview.html).