Epilogue

Training Healthcare Professionals in Youth Violence Prevention

Closing the Gap

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The invited manuscripts[1–21] authored for this special issue of the *American Journal of Preventive Medicine* represent the broad array of definitive activity and expertise in this country currently focused on the development of effective educational tools for health professionals around the issue of youth violence. The discussions range from general strategic approaches to specific programmatic descriptions. They cover a variety of educational or practice settings, address multiple topics and content areas, and focus on different points of practical application along the learning continuum. The granular detail employed in the conveyance of these initiatives is impressive, informative, and instructive. Indeed, in this collection of articles, there is relevant experience available for any health or public health professional directly, or indirectly, engaged in intentional injury science and, specifically, in the prevention of youth violence.

Not surprisingly, several general themes and unifying concepts emerge throughout the supplement that are fundamental to the public health approach to youth violence prevention. Among them are: (1) an acknowledgment of the etiologic complexity of violence and the need to incorporate comprehensive strategies into intervention thinking, (2) an integral infusion of a culturally appropriate community context early and consistently as a central component of prevention efforts, and (3) an expectation of a discrete set of core competencies that any health or public health professional should possess regardless of discipline. However, the most resonant theme identifies the gap, if not the chasm, between intellectual and theoretical "buy-in" support for the education of professionals in youth violence prevention and the actual application and incorporation of such knowledge into practice. In other words, there is a descending cascade of penetrance flowing from robust provider priority, through weak provider preparation, to spotty provider practice when it comes to youth violence prevention. As epilogue to this important supplement, it is worth briefly examining each of these areas of challenge from the pragmatic perspective of those healthcare professionals most likely to regularly encounter children and their families—the frontline clinician.

Priority

There is little doubt that healthcare professionals in this country are increasingly accepting youth violence prevention as a critical health and public health issue. Major organized medicine bodies have publicly adopted and embraced the development of approaches to violence prevention as key strategic pillars for their organizations and constituents. In their overview article, Sidelinger and colleagues cite evidence that a growing majority of physicians, particularly, those delivering community-based and primary care services, acknowledge an important role in the prevention of intentional injuries.[6] In a periodic survey of 1632 members of the American Academy of Pediatrics, more than one third reported having recently treated a child with an injury resulting from domestic or community violence. Most pediatricians feel that they have a role to play in the prevention of such injuries, and there is evidence to suggest that parents and community leaders also perceive a central role for pediatricians in the prevention of youth violence.[22,23] The problem that Sidelinger et al.[6] and other reviews elaborate throughout the supplement, is the disconnect between perceived responsibility and actual practice. The same surveys that indicate physician willingness and desire to serve an interventionist role also note a disappointing rate of actual participation in routine prevention behaviors and practices such as screening, counseling, and referral.[24–26] In other words, the heart is willing but the head is unprepared.

Preparation

The supplement is conveniently organized in sections that group the manuscripts by targeted discipline, i.e. physicians, nurses, allied health and public health professionals, with an additional section on issue-specific training. Within the sections, the individual arti-

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cles comprehensively address a variety of approaches to educating healthcare professionals that include examples of case-based learning models, clinical scenarios, and teaching guides. Implementation of the educational resources span the longitudinal continuum of provider training from undergraduate, through graduate/post-doctoral, including residency and subspeciality fellowship, on into continuing education and life-long learning. Indeed, the provided information offers an encyclopedic menu of evidence-based options from which a training program director or coordinator might choose. However, pragmatically speaking, this is where the preparation gap truly begins. In their report on the development of core competencies for healthcare professionals, Knox and Spivak[5] point out that the governing body for medical school accreditation, the Liaison Committee on Medical Education broadly states that the ". . .curriculum must prepare students for their role in addressing the medical consequences of common societal problems, for example, providing instruction in the diagnosis, prevention, appropriate reporting and treatment of violence and abuse." This position is laudable, but articulated from a 50,000-foot level without an attached tactical roadmap to effect systematic implementation.

The reality is that at the medical undergraduate level, academic deans are bombarded constantly with curricular demands to address the exponentially expanding volume of information that they are accountable for shoehorning into a typical 4-year curriculum. Competition for the addition of new course material is stiff, particularly during the basic science years, which is when students typically receive a cursory introduction to preventive medicine concepts. Even if medical students have the opportunity at an undergraduate level to receive more extensive didactic public health education, i.e., a joint MD-MPH degree program, Browne et al.[13] point out in their review that required training in injury prevention is minimal in accredited schools of public health as documented by an Association of Schools of Public Health survey. Even when present, unintentional injury is typically the dominant focus, and most public health professionals never receive formal training on violence or its prevention. The landscape is even more dismal as students enter specialty and subspecialty training. The same dizzying didactic demands exist for residency training program directors as they prepare trainees for board eligibility in their chosen field. Certification criteria are heavily skewed toward acute and chronic disease management steeped in traditional medical model approaches with little attention to primary prevention and biopsychosocial determinants of health. Further, the Accreditation Council on Graduate Medical Education, which evaluates and accredits residency-training programs through its Residency Review Committees, is silent on the specific inclusion of youth violence prevention as an expected competency. Hence, short of self-directed interest, initiative, or mentorship, physicians-in-training in this country, even those entering primary care specialties, are unlikely to encounter formal exposure to youth violence prevention training during medical school or residency.

Practice

Practicing healthcare professionals are well positioned to fully grasp the depth of their need for a clinical skill set that addresses violence, its recognition, treatment, and prevention. Several of the articles in this supplement, authored by seminal experts in their specific areas of youth violence prevention, are focused on developing, incorporating, and translating competency into practice in such circumstances or settings as gang-involved youth, schools, and the primary care office. The article by Sege et al.[9] describes the development of the American Academy of Pediatrics' new youth violence prevention tool for use in the primary care setting. The product is entitled "Connected Kids: Safe, Strong, Secure." The well-conceived approach is predicated on closing the gap through employment of an incorporative strategy, a strategy designed to optimize acceptance by the targeted end-user clinicians.

First, there was recognition and acknowledgment that there are significant inherent challenges and barriers to doing effective violence prevention in the context of primary care delivery. Time is the most critical factor inextricably tied to the need for efficiency in a busy practice setting. Second, a major overriding issue is engendering provider confidence that the tool is efficacious and likely to be of benefit if used according to training instruction. After all, no health professional likes to open a Pandora's box without the capacity to deal with it. Although field evaluation of "Connected Kids" will be ongoing over the next several years, we know that the asset-oriented, strength-based model that forms the theoretical foundation for the program is a time-tested approach that has shown protective promise in growing resilient children and families.[27,28] Sege et al.[9] have meticulously taken advantage of those baseline behaviors that professionals who care for children inherently do well to achieve "buy-in" and acceptance. Addressing primary prevention during the course of ongoing anticipatory guidance is bread-and-butter pediatrics. The ready availability of resource materials addressing violence prevention to the practitioner, the family and, in selected modules, the adolescent, as an integral aspect of the practitioner–patient/family relationship is a model worth following closely.

It may be tempting to characterize continuing education and lifelong learning for seasoned healthcare professionals as relatively futile, i.e., the "horse is already out of the barn" syndrome. Clearly a significant part of the challenge in bringing priority closer to

practice will be in continuing to address the formal preparation of healthcare professionals around issues of youth violence in a committed and accountable manner. A hopeful take-home message emerging from the outstanding collection of work represented by this supplement is that, given proper delivery and proven tools, clinicians can help move themselves toward closing the gap between their own motivations to do something about youth violence and the, as yet, broad availability of early training opportunities through our nations' health professions institutions.

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