

# Mental Health and Violence in Children and Adolescents



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## KEYWORDS

• Mental health • Violence • Pediatrics • Perpetration • Victimization

## KEY POINTS

- Children with mental illness are at increased risk for violence victimization, and, although most children with mental illness are nonviolent, there are specific types of mental illness that may be associated with the development of violent behavior.
- Children exposed to violence have an increased risk of developing mental health symptoms thereafter regardless of whether violence exposure is direct (eg, assault, adolescent relationship aggression, or abuse) or indirect (eg, intimate partner violence or community violence).
- Pediatric clinicians can use validated screening tools to assess for violence exposure and mental health symptoms among children, and, for those children who screen positive, clinicians should provide referrals to trauma-informed, culturally competent, and evidence-based therapies.

The relationship between mental health and violence in children is complex. It is known that some children with mental health conditions may be at higher risk for violence victimization or violence perpetration. Alternatively, violence exposure and victimization may themselves precipitate adverse mental health outcomes.

Mental health conditions are common among US children. Approximately 1 in 6 children in the United States has a mental health disorder.<sup>1,2</sup> Suicide is the second leading cause of death among children ages 10 to 14 and the third leading cause of death for adolescents and young adults ages 15 to 24.<sup>3</sup> During the coronavirus disease 2019 (COVID-19) pandemic, leading pediatric professional organizations declared a national emergency in youth mental health.<sup>4</sup> During this time, firearm sales reached

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the highest level ever recorded in US history,<sup>5</sup> and firearm-related pediatric hospital encounters increased significantly.<sup>6</sup> The pandemic also brought with it a higher burden of family violence<sup>7</sup> and increased severity of child abuse-related injuries.<sup>8</sup> With rising rates of mental health disorders and violence in children, examination of the relationship between the two is timely.

Moreover, the authors acknowledge that similar upstream risk factors and environmental circumstances may increase the risk for violence involvement and the risk of adverse mental health outcomes<sup>9</sup> as seen in children who have experienced adverse childhood experiences (ACEs) and children from communities with a history of structural marginalization.<sup>10</sup> It is critically important for pediatric clinicians to recognize how various individual and community-level factors may place a child at risk for adverse mental health outcomes, in addition to violence victimization and/or perpetration. Thus, in this article, the authors aim to examine the complex interplay between mental health and violence in children.

## **MENTAL HEALTH AS A RISK FACTOR FOR VIOLENCE VICTIMIZATION AND PERPETRATION**

### ***Mental Health and Violence Victimization***

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Most people with mental illness are more likely to be victims of violence than perpetrators.<sup>11,12</sup> Adults with serious mental illness experience an 11-fold higher rate of violence victimization than the general population, even after adjusting for demographic differences.<sup>13</sup> Among children and adolescents, mental health problems also increase the risk of violence victimization. For example, 1 study conducted using a national probability sample of 1467 children ages 2 to 17 found that children with high levels of co-occurring internalizing and externalizing symptoms have increased exposure to several forms of violence victimization, including peer victimization, maltreatment, and sexual victimization. This increased risk of victimization persists after controlling for earlier victimization and adversity.<sup>14</sup> Among children with mental health symptoms, the type of victimization varies by age, with elementary school-age children experiencing more peer victimization and adolescents experiencing higher rates of sexual victimization.<sup>14</sup>

### ***Mental Health and Violence Perpetration***

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Most people with mental illnesses are nonviolent. Although higher rates of violence perpetration have been identified among people with serious mental illness, the rate of violent behavior only increases from 2% for the general public to 5% for adults with serious mental illness.<sup>15</sup> In adjusted models, severe mental illness alone did not predict future violence, although co-occurring severe mental illness with substance use and past history of violence are independently associated with future violence.<sup>16</sup> Notably, only a small proportion of all violent acts are committed by people with mental illness. For instance, a study of violent incidents in the United States over a 1-year period found that only 3% of violent offenders had schizophrenia.<sup>17</sup> Similarly, an analysis of violent incidents in England and Wales from 2015 to 2016 estimated that 5.3% were committed by individuals with severe mental illness.<sup>18</sup> Clearly, most violent acts are carried out by people without mental illnesses.

Most children with mental health conditions are not violent, but some types of mental illness have been associated with some forms of aggressive behavior. Child oppositional defiant and antisocial behaviors have been associated with violence and aggression, but many studies on this relationship have been limited to specific high-risk populations (such as justice-involved youth) or do not adequately account

for shared family and community factors.<sup>19</sup> In 1 study, half of justice-involved youth were found to have substance use disorders; over 40% met criteria for disruptive behavior disorders, and more than 20% of girls met criteria for a major depressive episode.<sup>20</sup> In a longitudinal community-based study in Chicago, oppositional defiant problems were the only mental health condition that significantly predicted future violence, after adjusting for individual-, peer-, family-, and neighborhood-level variables.<sup>21</sup> In considering these results, it is important to recognize that clinician and systemic biases contribute to the overdiagnosis of oppositional defiant disorder among children of color, whereas these behaviors may actually be related to trauma exposures or alternative mental health diagnoses.<sup>22,23</sup>

One approach to understanding the complex relationship between mental health conditions and violence involves studying sibling pairs, who share similar genetics and environments. In a large population-based sample of US youth, ACEs were significantly associated with childhood antisocial behavior, adolescent delinquency, and young adult violent victimization in bivariate analyses.<sup>24</sup> However, after using sibling comparisons to adjust for unmeasured common genetic and shared environmental confounders, siblings exposed to more ACEs did not demonstrate higher levels of antisocial behavior, delinquent behavior, or risk for future victimization. This suggests that shared familial and environmental factors may underpin child outcomes.

Autism spectrum disorder (ASD) can in some situations be associated with aggression; it is important to note that this aggression most often impacts within-family functioning and well-being.<sup>25</sup> In a sample of 1584 children and adolescents with ASD enrolled in the Autism Treatment Network, 53% were reported to have aggressive behaviors.<sup>26</sup> In inpatient medical units, episodes of acute agitation occur during as many as 12% of hospitalizations by children with ASD.<sup>27</sup> Specific therapeutic strategies such as functional behavioral assessment, reinforcement strategies, and functional communication training may reduce the frequency and intensity of aggressive behaviors among children with ASD.<sup>28</sup> Pharmacologic treatments, particularly second-generation antipsychotic agents, may also be of some benefit in reducing aggression among children with ASD.<sup>28</sup>

### ***Assessment of Violence Risk and Prevention***

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To prevent violence perpetration among children with mental health disorders, tools are needed to identify risk. To this end, some tools have been developed to predict violence within health care settings and schools. Among children admitted to inpatient psychiatric units, the Brief Rating of Aggression by Children and Adolescents (BRACHA) accurately and reliably predicts the risk of violence during hospitalization.<sup>29,30</sup> It consists of 14 items (12 historical and behavioral items and 2 clinical observations) scored by emergency department staff before admission. Efforts have also been made to predict risks of school violence. For instance, an analysis of structured interviews with students using natural language processing and machine learning demonstrated capacity to predict risks of school violence.<sup>31</sup> Such risk assessment tools are not yet widely used.

Once a child has been identified as at risk for violence perpetration, effective preventive interventions are needed to mitigate risk. Improved access to mental health services is likely to be important, as half of children with mental health disorders in the United States do not receive needed treatment or counseling from mental health professionals.<sup>2</sup> Additionally, evidence-based violence prevention interventions have been developed for families, schools, and communities.<sup>32</sup> Examples include programs to enhance parent-child bonding and to promote community-based mentorship.<sup>32</sup>

Multiple interventions targeted to various developmental stages and levels (both individual- and population-based) may be needed to prevent violence.<sup>33</sup>

## MENTAL HEALTH FOLLOWING EXPOSURE TO VIOLENCE

Adverse mental health outcomes following exposure to violence are common in youth.<sup>34,35</sup> It is important to consider the nuanced ways in which direct and indirect exposures to violence affect youth. Direct violence exposures are defined as personal experiences of violence victimization through threat or injury.<sup>36</sup> Examples of direct violence exposures in children include assault, adolescent relationship aggression, and child abuse. Indirect violence exposures are defined as witnessing violence, hearing violence (eg, gunshots heard in the neighborhood), or losing a family member or peer as a victim of violence.<sup>36</sup> Examples of indirect violence exposures in children include intimate partner violence and community violence. All violence exposures, whether direct or indirect, may lead to mental health sequelae in youth, although effects may differ based on the type of exposure.<sup>36,37</sup>

### *Firearm Violence*

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Firearm injuries are associated with short- and long-term mental health sequelae among youth.<sup>34</sup> In 1 retrospective cohort study, over a quarter of youth with a firearm injury were diagnosed with a new mental health condition in the year after injury.<sup>38</sup> Compared with youth who sustain other types of traumatic injuries (ie, motor vehicle collisions), youth with firearm injuries have 1.5 times higher odds of developing new mental health diagnoses in the year after injury.<sup>39</sup> The most common mental health disorders that arise among youth after firearm injuries are substance-related and addictive disorders and trauma- or stressor-related disorders.<sup>38,40</sup> In particular, firearm-related injuries are strongly correlated with subsequent development of post-traumatic stress disorder (PTSD) in youth.<sup>34,41</sup> Youth with nonfatal firearm injuries also experience significant increases in mental health service utilization and expenditures following injury.<sup>42,43</sup>

Childhood exposure to firearm violence has been associated with the development of externalizing symptoms,<sup>44</sup> such as aggressive and disruptive behaviors, as well as internalizing symptoms,<sup>45,46</sup> such as anxiety and depression. Studies have suggested that younger children exposed to firearm violence may exhibit more internalizing symptoms, whereas older children may exhibit more externalizing symptoms.<sup>36</sup> The effects of exposure to firearm violence may differ based on age and developmental stage. One study found that younger children (ages 2–9 years) developed PTSD symptoms from indirect exposures (eg, hearing gun shots), while older children (ages 10–17 years) did not develop significant PTSD symptoms unless they were direct victims of gun violence.<sup>41</sup>

### *Child Abuse*

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ACEs, including childhood physical, sexual, and emotional abuse, are strongly correlated with adverse mental health outcomes during childhood and into adulthood. One systematic review and meta-analysis found that adults who experienced multiple ACEs were more likely to have depression, anxiety, suicide attempts, problematic alcohol use, and problematic drug use.<sup>10</sup> The cumulative effect of maltreatment among children has also been demonstrated, with increased mental health symptom severity as children experience more types of maltreatment.<sup>47</sup> Children who experience abuse have a high prevalence of PTSD, with reported incidence rates of up to 50% to 90%.<sup>48</sup> These children are also more likely to exhibit both internalizing and

externalizing symptoms.<sup>48,49</sup> For example, a meta-analysis found that sexual and physical abuse are strongly associated with development of major depressive disorder (MDD) before age 18.<sup>35</sup> Experiences with childhood maltreatment throughout the life course appear to have independent and additive effects on children's mental health.

### ***Adolescent Relationship Aggression***

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Adolescent relationship aggression (ARA) is highly prevalent among adolescents, with rates of 9% to 20% reported in nationally representative samples, and it is associated with subsequent mental health risks.<sup>50–52</sup> In particular, both boys and girls who experience ARA have increased risk of suicide attempts, while girls are also 2 times as likely to have severe depressive symptoms following ARA.<sup>50,52</sup> One study found that girls with depression and a history of ARA victimization were 61% more likely to attempt suicide than nonvictimized girls with depression.<sup>53</sup> Additionally, adolescents who experience more distinct forms of ARA (eg, sexual, physical, or psychological) are more likely to have adverse mental health outcomes, including depressive symptoms, suicide attempts, and substance abuse.<sup>54,55</sup> Given the prevalence of ARA among adolescents, pediatric clinicians may consider screening for ARA exposure to increase recognition of at-risk youth.<sup>56</sup>

### ***Intimate Partner Violence***

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The negative impact of intimate partner (domestic) violence (IPV) on youth mental health outcomes is well described. In a meta-analysis of psychosocial outcomes, 63% of children exposed to IPV had worse emotional health outcomes compared with nonexposed children.<sup>57</sup> Youth who witness severe IPV are almost 3 times more likely to develop conduct disorder,<sup>58</sup> twice as likely to develop MDD,<sup>35</sup> and over 4 times more likely to have symptoms of anxiety.<sup>59</sup> Exposure to domestic violence provides a key example of how indirect violence exposure can be associated with pediatric mental health outcomes.

### ***Community Violence***

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The isolated influence of community violence exposure on youth mental health is difficult to measure, given significant overlap with other family and neighborhood characteristics.<sup>36</sup> Studies have demonstrated that closer geographic proximity to violent events is associated with increased mental health symptoms and greater mental health service utilization after an event.<sup>60,61</sup> Youth who are chronically exposed to community violence may become desensitized and develop externalizing behaviors.<sup>62</sup> Among Black, urban adolescents, community violence exposure has also been associated with subsequent suicidal thoughts and behaviors.<sup>63</sup> Notably, community violence, and, in particular, firearm violence, disproportionately impacts communities of color as a result of historic trauma, systemic racism, and selective disinvestment in these communities.<sup>64</sup> With acute and chronic sequelae, the mental health consequences of community violence among youth are longitudinal and multifaceted.

## **MENTAL HEALTH SERVICE UTILIZATION**

Many children who are exposed to violence face barriers to accessing mental health services. One national study identified that 20% of adolescents have experienced personal victimization, yet only half of those adolescents accessed mental health services within a year of trauma.<sup>65</sup> Another nationally representative study showed that 16% of children have experienced high ACE scores (defined as 5 or more ACEs for ages 2–9

**Table 1**  
**Screening and diagnostic tools for post-traumatic stress disorder**

Screening or Diagnostic Tool	Purpose	Symptom Domains	Completed By	Target Age	Number of Items	Average Time to Complete
Child Behavior Checklist (CBCL) <sup>90</sup>	Screening	Social functioning, anxiety, mood, externalizing symptoms	Parent/caretaker	6–18	120	15 min
Child Trauma Screen (CTS) <sup>91</sup>	Screening	Trauma exposure, traumatic stress	Self	6–17	10	10 min
UCLA PTSD Reaction Index (UCLA PTSD RI) <sup>92</sup>	Screening/preliminary diagnosis	Traumatic stress, neglect	Self	6–18	48	10 min
Child PTSD Symptoms Scale – Self-Report Version for DSM-5 (CPSS-5-SR) <sup>93</sup>	Diagnostic	PTSD, daily functioning	Self	8–18	24	10 min

*Abbreviation:* PTSD, Post-traumatic stress disorder.

**Table 2**  
Selected examples of treatment approaches for children exposed to violence

Treatment Approach	Overview	Target Age	Trauma Sub-type	Goals/Outcomes	Evidence Rating <sup>a</sup>
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) <sup>89</sup>	An evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers  A components-based treatment model that incorporates trauma-sensitive interventions with cognitive-behavioral, family, and humanistic principles and techniques	3–21	Sexual abuse, domestic violence, traumatic grief, disaster, terrorism, multiple or complex traumas	<ul style="list-style-type: none"> <li>• Reduction in depressive, anxiety, post-traumatic stress symptoms</li> <li>• Reduction in parental distress</li> </ul>	1
Child Parent Psychotherapy (CPP) <sup>94</sup>	CPP is based in attachment theory whose goal is to support and strengthen the child-caregiver relationship to restore the child's cognitive, behavioral, and social functioning	0–6	Loss or separation, community violence, medical conditions	<ul style="list-style-type: none"> <li>• Reduction in behavioral problems</li> <li>• Improvement in depressive and PTSD symptoms</li> <li>• Improving change in attachment classification</li> </ul>	2
Collaborative Models <sup>72</sup>	A practice team of primary care and behavioral health clinicians work in concert to provide a systematic, cost-effective, and patient- and family-centered approach	0+	All types	<ul style="list-style-type: none"> <li>• Improvement in clinical outcomes</li> <li>• Early identification of symptoms</li> </ul>	NR

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**Table 2**  
(continued)

Treatment Approach	Overview	Target Age	Trauma Sub-type	Goals/Outcomes	Evidence Rating <sup>a</sup>
	Model types are: consultation (formal and informal); colocation; and collaborative/integrative (comanagement of cases)				
Hospital-based Violence Intervention Programs (HVIPs) <sup>70</sup>	Aim to reduce violent injury recidivism by providing intensive case management services to high-risk patients who were violently injured. Holistically address risk factors for violent injury including mental health.	Varies by program	Penetrating trauma, sexual trauma	<ul style="list-style-type: none"> <li>• Reduce repeat injury</li> <li>• Access to longitudinal mental health services</li> <li>• Reduction in post-traumatic stress symptoms</li> </ul>	NR
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) <sup>95</sup>	Manually-guided and empirically supported group treatment, primarily based on cognitive-behavioral principles. Teaches skills to improve resilience.	12–21	Complex trauma, chronic traumas, chronic medical conditions	<ul style="list-style-type: none"> <li>• Remaining in treatment</li> <li>• Improvement in post-traumatic stress symptoms</li> </ul>	NR

*Abbreviation:* PTSD, post-traumatic stress disorder.

<sup>a</sup> California Evidence-Based Clearinghouse (CEBC) rating<sup>96</sup>: 1. Well-supported by research evidence. 2. Supported by research evidence. 3. Promising research evidence. 4. Evidence fails to demonstrate effect. 5. Concerning practice. NR. not able to be rated.



and 7 or more ACEs for ages 10–17), yet fewer than 50% had accessed mental health services within the last year.<sup>66</sup> Discrepancies in parent-child report of traumatic exposures may be 1 factor impeding identification of needs and referral for services.<sup>67–69</sup> At times, violent injury can serve as the point of access to mental health services, as is the case with Hospital-Based Violence Intervention Programs (HVIPs),<sup>70,71</sup> collaborative models,<sup>72</sup> and school-based interventions.<sup>73</sup>

### ***Inequities in Access to Mental Health Services***

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Significant differences exist by race and ethnicity in the utilization of mental health services, with lower utilization among non-Hispanic Black and Hispanic children compared with non-Hispanic White children.<sup>74–76</sup> Specifically among children who have experienced ACEs such as violence exposure, fewer Black children receive mental health services compared with White children.<sup>66</sup> Proposed mechanisms underlying these inequities include differences in insurance coverage,<sup>77</sup> institutional mistrust,<sup>78</sup> stigma,<sup>79</sup> cultural misalignment between providers and clients,<sup>80</sup> lack of awareness of available services,<sup>81</sup> and differences in physician referrals.<sup>82</sup>

Multilayered efforts are needed to improve equity in access to mental health services among children exposed to violence. At an individual level, clinicians should select therapies to address trauma symptoms that are aligned with each child's individual, social, and cultural needs.<sup>83,84</sup> At a structural level, critical steps will include addressing structural determinants of health such as poverty, eliminating discriminatory practices, and increasing insurance access.<sup>85</sup>

### ***Screening for Trauma Exposure and Interventions***

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The role of primary care pediatric clinicians in identifying and addressing potentially traumatic events and PTSD symptoms cannot be overemphasized.<sup>86</sup> For trauma-exposed youth, relational health and resilience can be improved through delivery of trauma-informed care, defined by the National Child Traumatic Stress Network as medical care in which all parties assess, recognize, and respond to the effects of traumatic stress on children, caregivers, and health care providers.<sup>87</sup> The framework of healing-centered engagement expands on this with a holistic strengths-based approach to healing that is focused on sustaining well-being.<sup>88</sup> Using trauma-informed care with a healing-centered approach, pediatric clinicians can learn about their patient's trauma exposure, assess for sequelae, and refer to mental health services when indicated. Several validated questionnaires have been developed to guide efforts to assess the impact of trauma (**Table 1**). Alternatively, pediatric clinicians can simply ask, "Has anything scary or concerning happened to you or your child since the last visit?"<sup>87</sup> If screening suggests exposure to a potentially traumatic event or PTSD symptoms, a referral to trauma-focused cognitive-behavioral therapy<sup>89</sup> or other evidence-based therapies may be indicated (**Table 2**). Pediatric clinicians can also provide contained relaxation tools such as deep breathing, mindfulness exercises, and reassurance.<sup>87</sup>

### **SUMMARY**

In summary, the relationships between mental health and violence in youth are complex. Although some mental health conditions are associated with violence perpetration, most children with mental illness are nonviolent. In contrast, mental health conditions are a strong risk factor for violence victimization. In turn, children with a history of violence victimization are at higher risk for having mental health sequelae. Although the type of exposure to violence and age of exposure may influence symptom development, many children will develop internalizing and/or externalizing symptoms following

direct exposures to violence. Importantly, indirect exposures to violence, such as intimate partner violence and community violence, can also lead to adverse mental health outcomes in children. Despite high rates of exposure to violence and mental health conditions among children, evidence-based mental health treatments for trauma- and stressor-related conditions remain underutilized, with notable inequities among Black and Hispanic children. It is critical that pediatric clinicians regularly screen youth for exposure to and risk for violence, as well as mental health symptoms, to ensure youth receive evidence-based, culturally competent, trauma-informed, and healing-centered mental health care.

### CLINICS CARE POINTS

- Children with mental illness are much more likely to be victims of violence than perpetrators.
- Specific mental health conditions have been associated with violence and/or aggressive behaviors, although most children with these diagnoses are nonviolent.
- Children exposed to violence are at risk of developing mental health symptoms thereafter, regardless of whether exposure is direct or indirect.
- Younger children may have more internalizing symptoms following violence exposure, while adolescents may have more externalizing symptoms.
- Pediatric clinicians should practice trauma-informed care by learning about their patients' trauma exposure and associated mental health symptoms at each visit using validated tools when possible.
- For children who screen positive for mental health symptoms, pediatric clinicians should provide reassurance, simple interventions (ie, breathing exercises), and appropriate referrals to treatment.

### CONFLICTS OF INTEREST DISCLOSURES

The authors have no conflicts of interest relevant to this article to disclose.

### REFERENCES

1. Bitsko RH, Claussen AH, Lichstein J, et al. Mental health surveillance among children — United States, 2013–2019. *MMWR Suppl* 2022;71(2):1–42.
2. Whitney DG, Peterson MD. US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *JAMA Pediatr* 2019;173(4):389–91.
3. Centers for Disease Control and Prevention: National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). 2020. Available at: <https://www.cdc.gov/injury/wisqars/index.html>. Accessed August 9, 2021.
4. AAP-AACAP-CHA Declaration of a national emergency in child and adolescent mental health. Available at: <https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/>. Accessed December 12, 2021.
5. Mannix R, Lee LK, Fleegler EW. Coronavirus disease 2019 (COVID-19) and firearms in the United States: will an epidemic of suicide follow? *Ann Intern Med* 2020;173(3):228–9.

6. Gastineau KAB, Williams DJ, Hall M, et al. Pediatric firearm-related hospital encounters during the SARS-CoV-2 Pandemic. *Pediatrics* 2021;148(2). <https://doi.org/10.1542/peds.2021-050223>.
7. Cappa C, Jijon I. COVID-19 and violence against children: a review of early studies. *Child Abuse Negl* 2021;116:105053.
8. De Boer C, Ghomrawi HM, Bouchard ME, et al. Effect of the COVID-19 pandemic on presentation and severity of traumatic injury due to physical child abuse across US children's hospitals. *J Pediatr Surg* 2022;57(4):726–31.
9. Varshney M, Mahapatra A, Krishnan V, et al. Violence and mental illness: what is the true story? *J Epidemiol Community Heal* 2016;70(3):223–5.
10. Hughes K, Bellis MA, Hardcastle KA, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Heal* 2017;2(8):e356–66.
11. Maniglio R. Severe mental illness and criminal victimization: a systematic review. *Acta Psychiatr Scand* 2009;119(3):180–91.
12. Monahan J, Vesselinov R, Robbins PC, et al. Violence to others, violent self-victimization, and violent victimization by others among persons with a mental illness. *Psychiatr Serv* 2017;68(5):516–9.
13. Teplin LA, McClelland GM, Abram KM, et al. Crime victimization in adults with severe mental illness: comparison with the National Crime Victimization Survey. *Arch Gen Psychiatry* 2005;62(8):911–21.
14. Turner HA, Finkelhor D, Ormrod R. Child mental health problems as risk factors for victimization. *Child Maltreat* 2009;15(2):132–43.
15. Whiting D, Lichtenstein P, Fazel S. Violence and mental disorders: a structured review of associations by individual diagnoses, risk factors, and risk assessment. *Lancet Psychiatr* 2021;8(2):150–61.
16. Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch Gen Psychiatry* 2009;66(2):152–61.
17. Walsh E, Buchanan A, Fahy T. Violence and schizophrenia: examining the evidence. *Br J Psychiatry* 2002;180:490–5.
18. Senior M, Fazel S, Tsiachristas A. The economic impact of violence perpetration in severe mental illness: a retrospective, prevalence-based analysis in England and Wales. *Lancet Public Heal* 2020;5(2):e99–106.
19. Connor DF. *Aggression and antisocial behavior in children and adolescents: research and treatment*. Guilford Press; 2002.
20. Teplin LA, Abram KM, McClelland GM, et al. Psychiatric Disorders in Youth in Juvenile Detention. *Arch Gen Psychiatry* 2002;59(12):1133.
21. Boots DP, Wareham J. *Mental health and violent offending in Chicago youth: a multilevel approach*. Office of Justice Programs; 2019. Available at: <https://www.ojp.gov/ncjrs/virtual-library/abstracts/mental-health-and-violent-offending-chicago-youth-multilevel>. Accessed August 26, 2022.
22. Fadus MC, Ginsburg KR, Sobowale K, et al. Unconscious bias and the diagnosis of disruptive behavior disorders and ADHD in African American and Hispanic youth. *Acad Psychiatry* 2020;44(1):95.
23. Simon KM. Them and me — the care and treatment of Black boys in America. *N Engl J Med* 2020;383(20):1904–5.
24. Connolly EJ. Further evaluating the relationship between adverse childhood experiences, antisocial behavior, and violent victimization: a sibling-comparison analysis. *Youth Violence Juv Justice* 2020;18(1):3–23.

25. Hodgetts S, Nicholas D, Zwaigenbaum L. Home sweet home? families' experiences with aggression in children with autism spectrum disorders. *Focus Autism Other Dev Disabil* 2013;28(3):166–74. <https://doi.org/10.1177/1088357612472932>.
26. Mazurek MO, Kanne SM, Wodka EL. Physical aggression in children and adolescents with autism spectrum disorders. *Res Autism Spectr Disord* 2013;7(3):455–65.
27. Hazen EP, Ravichandran C, Hureau AR, et al. Agitation in patients with autism spectrum disorder admitted to inpatient pediatric medical units. *Pediatrics* 2020;145(Suppl 1):108–16.
28. Fitzpatrick SE, Srivorakiat L, Wink LK, et al. Aggression in autism spectrum disorder: presentation and treatment options. *Neuropsychiatr Dis Treat* 2016;12:1525–38.
29. Barzman DH, Brackenbury L, Sonnier L, et al. Brief rating of aggression by children and adolescents (BRACHA): development of a tool for assessing risk of inpatients' aggressive behavior. *J Am Acad Psychiatry Law* 2011;39(2):170–9.
30. Barzman D, Mossman D, Sonnier L, et al. Brief rating of aggression by children and adolescents (BRACHA): a reliability study. *J Am Acad Psychiatry Law* 2012;40(3):374–82.
31. Ni Y, Barzman D, Bachtel A, et al. Finding warning markers: leveraging natural language processing and machine learning technologies to detect risk of school violence. *Int J Med Inform* 2020;139:104137.
32. Robinson J, Bailey E, Witt K, et al. What works in youth suicide prevention? A systematic review and meta-analysis. *EClinicalMedicine* 2018;4-5:52–91.
33. Hammond WR, Whitaker DJ, Lutzker JR, et al. Setting a violence prevention agenda at the centers for disease control and prevention. *Aggress Violent Behav* 2006;11(2):112–9.
34. Ranney M, Karb R, Ehrlich P, et al. What are the long-term consequences of youth exposure to firearm injury, and how do we prevent them? A scoping review. *J Behav Med* 2019;42(4):724–40.
35. LeMoult J, Humphreys KL, Tracy A, et al. Meta-analysis: exposure to early life stress and risk for depression in childhood and adolescence. *J Am Acad Child Adolesc Psychiatry* 2020;59(7):842–55.
36. Bancalari P, Sommer M, Rajan S. Youth exposure to endemic community gun violence: a systematic review. *Adolesc Res Rev* 2022;7(3):383–417.
37. Mitchell KJ, Jones LM, Turner HA, et al. Understanding the impact of seeing gun violence and hearing gunshots in public places: findings from the Youth Firearm Risk and Safety Study. *J Interpers Violence* 2021;36(17–18):8835–51.
38. Oddo ER, Maldonado L, Hink AB, et al. Increase in mental health diagnoses among youth with nonfatal firearm injuries. *Acad Pediatr* 2021;21(7):1203–8.
39. Ehrlich PF, Pulcini CD, De Souza HG, et al. Mental health care following firearm and motor vehicle-related injuries. *Ann Surg* 2022;276(3):463–71.
40. Zima BT, Pulcini CD, Hoffmann JA, et al. 116 Newly detected psychiatric diagnoses among medicaid-enrolled children following firearm injury. *J Am Acad Child Adolesc Psychiatry* 2022;61(10):S221.
41. Turner HA, Mitchell KJ, Jones LM, et al. Gun violence exposure and posttraumatic symptoms among children and youth. *J Trauma Stress* 2019;32(6):881–9.
42. Oddo ER, Simpson AN, Maldonado L, et al. Mental health care utilization among children and adolescents with a firearm injury. *JAMA Surg* 2022. <https://doi.org/10.1001/jamasurg.2022.5299>.

43. Pulcini CD, Goyal MK, Hall M, et al. Nonfatal firearm injuries: utilization and expenditures for children pre- and postinjury. *Acad Emerg Med* 2021;28(8):840–7.
44. Fleckman JM, Drury SS, Taylor CA, et al. Role of direct and indirect violence exposure on externalizing behavior in children. *J Urban Heal* 2016;93(3):479–92.
45. Borg BA, Rabinak CA, Marusak HA. Violence exposure and mental health consequences among urban youth. *Curr Psychol* 2021. <https://doi.org/10.1007/s12144-021-02141-4>.
46. Fowler PJ, Tompsett CJ, Braciszewski JM, et al. Community violence: a meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. *Dev Psychopathol* 2009;21(1):227–59.
47. Cecil CAM, Viding E, Fearon P, et al. Disentangling the mental health impact of childhood abuse and neglect. *Child Abus Negl* 2017;63:106–19.
48. Leeb RT, Lewis T, Zolotor AJ. A review of physical and mental health consequences of child abuse and neglect and implications for practice. *Am J Lifestyle Med* 2011;5(5):454–68.
49. Strathearn L, Giannotti M, Mills R, et al. Long-term cognitive, psychological, and health outcomes associated with child abuse and neglect. *Pediatrics* 2020; 146(4). <https://doi.org/10.1542/peds.2020-0438>.
50. Ackard DM, Eisenberg ME, Neumark-Sztainer D. Long-term impact of adolescent dating violence on the behavioral and psychological health of male and female youth. *J Pediatr* 2007;151(5):476–81.
51. Wincentak K, Connolly J, Card N. Teen dating violence: a meta-analytic review of prevalence rates. *Psychol Violence* 2017;7(2):224–41.
52. Exner-Cortens D, Eckenrode J, Rothman E. Longitudinal associations between teen dating violence victimization and adverse health outcomes. *Pediatrics* 2013;131(1):71–8.
53. Olshen E, McVeigh KH, Wunsch-Hitzig RA, et al. Dating violence, sexual assault, and suicide attempts among urban teenagers. *Arch Pediatr Adolesc Med* 2007; 161(6):539–45.
54. Vagi KJ, O'Malley Olsen E, Basile KC, et al. Teen dating violence (physical and sexual) among US high school students. *JAMA Pediatr* 2015;169(5):474.
55. Choi HJ, Weston R, Temple JR. A three-step latent class analysis to identify how different patterns of teen dating violence and psychosocial factors influence mental health. *J Youth Adolesc* 2017;46(4):854–66.
56. Cutter-Wilson E, Richmond T. Understanding teen dating violence. *Curr Opin Pediatr* 2011;23(4):379–83.
57. Kitzmann KM, Gaylord NK, Holt AR, et al. Child witnesses to domestic violence: a meta-analytic review. *J Consult Clin Psychol* 2003;71(2):339–52.
58. Meltzer H, Doos L, Vostanis P, et al. The mental health of children who witness domestic violence. *Child Fam Soc Work* 2009;14(4):491–501.
59. Johnsona RM, Kotch JB, Catellier DJ, et al. Adverse behavioral and emotional outcomes from child abuse and witnessed violence. *Child Maltreat* 2002;7(3): 179–86.
60. Leibbrand C, Hill H, Rowhani-Rahbar A, et al. Invisible wounds: community exposure to gun homicides and adolescents' mental health and behavioral outcomes. *SSM - Popul Heal* 2020;12:100689.
61. Vasan A, Mitchell HK, Fein JA, et al. Association of neighborhood gun violence with mental health-related pediatric emergency department utilization. *JAMA Pediatr* 2021;175(12):1244–51.

62. Quimby D, Dusing CR, Deane K, et al. Gun exposure among Black American youth residing in low-income urban environments. *J Black Psychol* 2018;44(4):322–46.
63. Lambert SF, Copeland-Linder N, Ialongo NS. Longitudinal associations between community violence exposure and suicidality. *J Adolesc Heal* 2008;43(4):380–6.
64. Martin R, Rajan S, Shareef F, et al. Racial disparities in child exposure to firearm violence before and during COVID-19. *Am J Prev Med* 2022;63(2):204–12.
65. Guterman NB, Hahm HC, Cameron M. Adolescent victimization and subsequent use of mental health counseling services. *J Adolesc Heal* 2002;30(5):336–45.
66. Finkelhor D, Turner H, LaSelva D. Receipt of behavioral health services among US children and youth with adverse childhood experiences or mental health symptoms. *JAMA Netw Open* 2021;4(3):e211435.
67. Schreier H, Ladakakos C, Morabito D, et al. Post-traumatic stress symptoms in children after mild to moderate pediatric trauma: a longitudinal examination of symptom prevalence, correlates, and parent-child symptom reporting. *J Trauma Inj Infect Crit Care* 2005;58(2):353–63.
68. Dyb G, Holen A, Brænne K, et al. Parent-child discrepancy in reporting children's post-traumatic stress reactions after a traffic accident. *Nord J Psychiatry* 2003;57(5):339–44.
69. Skar A-MS, Jensen TK, Harpviken AN. Who reports what? A comparison of child and caregivers' reports of child trauma exposure and associations to post-traumatic stress symptoms and functional impairment in child and adolescent mental health clinics. *Res Child Adolesc Psychopathol* 2021;49(7):919–34.
70. Juillard C, Cooperman L, Allen I, et al. A decade of hospital-based violence intervention. *J Trauma Acute Care Surg* 2016;81(6):1156–61.
71. Myers RK, Vega L, Culyba AJ, et al. The psychosocial needs of adolescent males following interpersonal assault. *J Adolesc Heal* 2017;61(2):262–5.
72. Burkhart K, Asogwa K, Muzaffar N, et al. Pediatric integrated care models: a systematic review. *Clin Pediatr (Phila)* 2020;59(2):148–53.
73. Bagneris JR, Noël LT, Harris R, et al. School-based interventions for post-traumatic stress among children (ages 5–11): systematic review and meta-analysis. *School Ment Health* 2021;13(4):832–44.
74. Cummings JR, Druss BG. Racial/ethnic differences in mental health service use among adolescents with major depression. *J Am Acad Child Adolesc Psychiatry* 2011;50(2):160–70.
75. BURNS BJ, PHILLIPS SD, WAGNER HR, et al. Mental health need and access to mental health services by youths involved with child welfare: a national survey. *J Am Acad Child Adolesc Psychiatry* 2004;43(8):960–70.
76. Coker TR, Elliott MN, Kataoka S, et al. Racial/ethnic disparities in the mental health care utilization of fifth grade children. *Acad Pediatr* 2009;9(2):89–96.
77. Gudiño OG, Lau AS, Hough RL. Immigrant status, mental health need, and mental health service utilization among high-risk hispanic and Asian Pacific Islander youth. *Child Youth Care Forum* 2008;37(3):139–52.
78. Liebschutz J, Schwartz S, Hoyte J, et al. A chasm between injury and care: experiences of black male victims of violence. *J Trauma* 2010;69(6):1372.
79. Zimmerman FJ. Social and economic determinants of disparities in professional help-seeking for child mental health problems: evidence from a national sample. *Health Serv Res* 2005;40(5p1):1514–33.
80. Muñoz RF, Mendelson T. Toward evidence-based interventions for diverse populations: the San Francisco General Hospital prevention and treatment manuals. *J Consult Clin Psychol* 2005;73(5):790–9.

81. Richardson LA. Seeking and obtaining mental health services: what do parents expect? *Arch Psychiatr Nurs* 2001;15(5):223–31.
82. Wong EC, Schell TL, Marshall GN, et al. Mental health service utilization after physical trauma. *Med Care* 2009;47(10):1077–83.
83. Pina AA, Polo AJ, Huey SJ. Evidence-based psychosocial interventions for ethnic minority youth: the 10-year update. *J Clin Child Adolesc Psychol* 2019;48(2):179–202.
84. Metzger IW, Anderson RE, Are F, et al. Healing interpersonal and racial trauma: integrating racial socialization into trauma-focused cognitive behavioral therapy for African American youth. *Child Maltreat* 2021;26(1):17–27.
85. Hoffmann JA, Alegria M, Alvarez K, et al. Disparities in pediatric mental and behavioral health conditions. *Pediatrics* 2022;150(4).
86. Lipschitz DS, Rasmussen AM, Anyan W, et al. Clinical and functional correlates of post-traumatic stress disorder in urban adolescent girls at a primary care clinic. *J Am Acad Child Adolesc Psychiatry* 2000;39(9):1104–11.
87. Duffee J, Szilagyi M, Forkey H, et al. Trauma-informed care in child health systems. *Pediatrics* 2021;148(2). <https://doi.org/10.1542/PEDS.2021-052579/179781>.
88. Corburn J, Boggan D, Muttaqi K, et al. A healing-centered approach to preventing urban gun violence: the Advance Peace Model. *Humanit Soc Sci Commun* 2021;8(1):142.
89. de Arellano MAR, Lyman DR, Jobe-Shields L, et al. Trauma-focused cognitive-behavioral therapy for children and adolescents: assessing the evidence. *Psychiatr Serv* 2014;65(5):591–602.
90. Achenbach TM, Ruffle TM. The child behavior checklist and related forms for assessing behavioral/emotional problems and competencies. *Pediatr Rev* 2000;21(8):265–71.
91. Lang JM, Connell CM. Development and validation of a brief trauma screening measure for children: the Child Trauma Screen. *Psychol Trauma Theory, Res Pract Policy* 2017;9(3):390–8.
92. Kaplow JB, Rolon-Arroyo B, Layne CM, et al. Validation of the UCLA PTSD Reaction Index for DSM-5: a developmentally informed assessment tool for youth. *J Am Acad Child Adolesc Psychiatry* 2020;59(1):186–94.
93. Foa EB, Asnaani A, Zang Y, et al. Psychometrics of the Child PTSD Symptom Scale for DSM-5 for trauma-exposed children and adolescents. *J Clin Child Adolesc Psychol* 2018;47(1):38–46.
94. Lieberman AF, Ghosh Ippen C, Van Horn P. Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *J Am Acad Child Adolesc Psychiatry* 2006;45(8):913–8.
95. Weiner DA, Schneider A, Lyons JS. Evidence-based treatments for trauma among culturally diverse foster care youth: treatment retention and outcomes. *Child Youth Serv Rev* 2009;31(11):1199–205.
96. California Evidence-Based Clearinghouse for Child Welfare. Available at: [www.cebc4cw.org](http://www.cebc4cw.org). Accessed March 19, 2023.