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I. INTRODUCTION

Youth violence in Chicago gained national attention in September 2009 after a sixteen-year-old honors student, Derrion Albert, was beaten to death in a fight involving a group of teenagers.[1] A bystander captured the attack on a cellphone video, which news stations later obtained and widely broadcasted.[2] Unfortunately, Derrion's death was but one of many incidents of violent victimization of Chicago youth, with more than 530 Chicago youth under the age of twenty-one killed between January 2008 and January 2012.[3]

In the United States, homicide is the third-leading cause of death for young people between the ages of ten and twenty-four.[4] In 2010, 4828 young people—an average of thirteen each day—were killed nationwide.[5] Among these young homicide victims, 82.8% were killed with a firearm.[6] A 2011 national survey examining health-risk behaviors among youth and young adults found that one in six high school students reported carrying a gun or other type of weapon (e.g., knife or club) at least once in the thirty days prior to the survey.[7] Data reveals significant gender and racial disparities with males and racial/ethnic minorities experiencing the greatest burden. Homicide rates are more than six times higher for young males than females and nearly fourteen times higher for non-Hispanic African-American male youth relative to non-Hispanic Caucasian male youth.[8] Homicide is the leading cause of death among African-American youth between the ages of ten and twenty-four.[9] In addition to the large number of young people killed, significant numbers of young people, an average of 1700 each day, "are treated in emergency departments for assault-related injuries."[10] Each year, youth homicide and nonfatal violence result in an estimated sixteen billion dollars in combined medical and lost productivity costs.[11]

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[1] Azmat Khan, *Derrion Albert: The Death that Riled the Nation*, FRONTLINE (Feb. 14, 2012), http://www.pbs.org/wgbh/pages/frontline/social-issues/interrupters/derrion-albert-the-death-that-riled-the-nation/.

[2] *Beating Death of Derrion Albert, 16, Caught on Video*, HUFFINGTON POST (Nov. 27, 2009), http://www.huffingtonpost.com/2009/09/27/beating-death-of-derrien_n_301319.html.

[3] Kari Lydersen & Carlos Javier Ortiz, *More Young People Are Killed in Chicago than Any Other American City*, CHI. REP. (Jan. 25, 2012), https://www.chicagoreporter.com/more-young-people-are-killed-chicago-any-other-american-city#.Uulg2vtsJh0.

[4] NAT'L CTR. FOR INJURY PREVENTION & CONTROL, CTRS. FOR DISEASE CONTROL & PREVENTION, 10 LEADING CAUSES OF DEATH BY AGE GROUP, UNITED STATES - 2010, *available at* http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf. Homicide is the fourth-leading cause of death for youth between the ages of ten and fourteen, and the second-leading cause of death for youth ages fifteen to twenty-four. *Id.*

[5] DIV. OF VIOLENCE PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION, YOUTH VIOLENCE: FACTS AT A GLANCE 1 (2012) [hereinafter YOUTH VIOLENCE: FACTS AT A GLANCE], *available at* http://www.cdc.gov/violenceprevention/pdf/yv_datasheet_2012-a.pdf. This number accounts for young people between the ages of ten and twenty-four. *Id.*

[6] *Id.*

[7] DANICE K. EATON ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, YOUTH RISK BEHAVIOR SURVEILLANCE - UNITED STATES, 2011 6 (2012), *available at* http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf; YOUTH VIOLENCE: FACTS AT A GLANCE, *supra* note 5.

[8] In 2010, the homicide rate for males ages ten to twenty-four was 12.7 deaths per 100,000 population and the homicide rate for females ages ten to twenty-four was 2.1 deaths per 100,000. *Youth Violence: National Statistics*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/violenceprevention/youthviolence/stats_at-a_glance/hr_age-race.html (last updated Dec. 27, 2013). For non-Hispanic African-American males ages ten to twenty-four the homicide rate was 51.5 per 100,000 population and for non-Hispanic Caucasian males of the same ages, the rate was 2.9 deaths per 100,000. *Id.*

[9] YOUTH VIOLENCE: FACTS AT A GLANCE, *supra* note 5.

[10] Ashley Heinonen, *CDC Webinar Underscores Need for Multi-Agency Approach to Combating Youth Violence*, CURE VIOLENCE (Feb. 26, 2014), http://cureviolence.org/news/cdc-webinar-underscores-need-for-multi-agency-approach-to-combating-youth-violence/.

[11] YOUTH VIOLENCE: FACTS AT A GLANCE, *supra* note 5.

In the United States, young people are exposed to violence at alarming rates and "are more likely to be exposed to violence and crime than are adults."[12] Nationwide, more than 60% of young people under age seventeen have been exposed either directly or indirectly to at least one form of violence in the past year,[13] 86.6% of whom are at "ongoing risk of violent victimization."[14] The 2008 National Survey of Children's Exposure to Violence ("NatSCEV") found that nearly half of the youth surveyed reported that they were physically assaulted within the past year; 24.6% were victims of robbery, vandalism, or theft; 25.3% were witnesses to a violent act; 10.2% were suffering from maltreatment; and 6.1% were sexually victimized.[15] A recent study examining exposure to violence among Chicago youth found that eighty-two percent of children between the ages of five and eight years old had been exposed to some type of violence, with significant numbers reporting exposure to serious forms of violence.[16] Fifty-five percent reported that they hid someplace due to gun violence; nineteen percent witnessed somebody shot in their neighborhood; and fifty-nine percent reported having been afraid to go outside and play because of violence in the neighborhood.[17] Among adolescents between fifteen and seventeen years old, eighty-seven percent reported they had been exposed to some form of violence within their lifetime, with thirty-six percent reporting a family member having been assaulted or robbed, thirty-two percent having a close friend or family member murdered, and eighteen percent witnessing someone shot or killed.[18] These incidence and prevalence rates suggest that children are exposed to a wide spectrum of violence, and exposure is common across all ages of youth.

The consequences of violence exposure go far beyond the immediate physical threat of harm. Violence adversely affects youth regardless of whether they are victims, perpetrators, or witnesses. The aggregated consequences of multiple exposures put youth at an elevated risk for a host of mental, emotional, behavioral, physiological, and developmental problems.[19] For example, research has linked exposure to violence during childhood and adolescence to anxiety, depression, posttraumatic stress disorder ("PTSD"), aggression and delinquency, alcohol and drug abuse, suicide, poor academic achievement, risky sexual behavior, HIV, eating disorders, obesity, and asthma.[20] One mechanism through which exposure to violence affects children is by

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[12] DAVID FINKELHOR ET AL., U.S. DEP'T OF JUSTICE, CHILDREN'S EXPOSURE TO VIOLENCE: A COMPREHENSIVE NATIONAL SURVEY 2 (2009), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf.

[13] *Id.* at 1. Direct exposure to violence involves direct victimization, such as being physically assaulted, sexually abused, bullied, or maltreated. *Id.* at 4, 6–7. Indirect exposure involves indirect victimization, such as having a family member or friend who was the victim of a violent act, and witnessing family or community violence. *Id.*

[14] *Id.* at 2.

[15] *Id.* at 1.

[16] Deborah Gorman-Smith, U. Chi. Sch. Soc. Serv. Admin., Violence Prevention Across the Lifespan: Building the Science (July 25, 2013), http://www.apa.org/science/about/psa/2013/07-08/violence-prevention.pdf.

[17] *Id.*

[18] *Id.*

[19] *See, e.g.*, DAVID FINKELHOR ET AL., U.S. DEP'T OF JUSTICE, POLYVICTIMIZATION: CHILDREN'S EXPOSURE TO MULTIPLE TYPES OF VIOLENCE, CRIME, AND ABUSE 1 (2011), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/235504.pdf.

[20] *See* Deborah Gorman-Smith & Patrick Tolan, *The Role of Exposure to Community Violence and Developmental Problems Among Inner-City Youth*, 10 DEV. & PSYCHOPATHOLOGY 101, 102, 109 (1998); Thomas Billitteri, *Youth Violence: Are "Get Tough" Policies the Best Approach?* 20 CONG. Q. RESEARCHER 193, 196 (2010); Heather A. Turner et al., *Recent Victimization Exposure and Suicidal Ideation in Adolescents*, 166 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1149, 1152 (2012); Natasha K. Bowen & Gary L. Bowen, *Effects of Crime and Violence in Neighborhoods and Schools on the School Behavior and Performance of Adolescents*, 14 J. ADOLESCENT RES. 319, 335–36 (1999); Dexter R. Voisin et al., *Testing Pathways Linking Exposure to Community Violence and Sexual Behaviors Among African American Youth*, J. YOUTH & ADOLESCENCE, Dec. 11, 2013, at 2–3, http://link.springer.com/article/10.1007/s10964-013-0068-5; Sylvie Mrug et al., *Violence Exposure Across Multiple Contexts: Individual and Joint Effects on Adjustment*, 78 AM. J. ORTHOPSYCHIATRY 70, 75–79 (2008); SCOTT MENARD, U.S. DEP'T OF JUSTICE, SHORT- AND LONG-TERM CONSEQUENCES OF ADOLESCENT VICTIMIZATION 8–13 (2002), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/191210.pdf; A.J. Midei & K.A. Matthews, *Interpersonal Violence in Childhood as a Risk Factor for Obesity: A Systematic Review of the Literature and Proposed Pathways*, 12 OBESITY REV. e159, e167–68 (2011); Greg

disrupting the architecture of the developing brain.[21] Excessive, repeated stress impairs cell growth and inhibits the formation of healthy neural circuits, damages the brain's stress-response system, and contributes to health problems later on in life.[22] Importantly, the way in which violent exposure impacts a child depends on the child's developmental stage and the frequency and context of exposure.[23] These data clearly highlight violence as an issue of national concern. With the growing awareness of violence as a significant social problem has come the emergence of a field of practice and research on violence *prevention*.

This Article provides a framework for understanding youth violence from a public health perspective, one that focuses on preventing violence before it starts. Similar to the public health approach to all other injuries and problems, a public health approach to violence prevention begins with identifying the populations and locations of greatest risk, identifying risk and protective factors for involvement in youth violence, and developing, testing, and then implementing evidence-based strategies and programs to prevent involvement in violence.

II. A PUBLIC HEALTH APPROACH TO ADDRESSING YOUTH VIOLENCE

Until recently, violence has been framed as a public safety problem and addressed primarily within the criminal justice system.[24] The criminal justice perspective classifies violence as a "crime" and attributes the cause of violence to the personal characteristics of the offender.[25] This framing of violence focuses on acts of individual perpetrators, resulting in a punitive and reactive response by the criminal justice community.[26] The public health approach focuses on the safety and well-being of entire populations.[27] A public health approach uses research to identify "risk factors," characteristics of the individual, family, community, or society that increase the probability that an individual will be involved in violence either as a victim or perpetrator.[28] By identifying these risk factors and implementing interventions to impede risk trajectories for violence, the public health approach emphasizes prevention of violence before it occurs.[29] The next sections provide an overview of the difference between criminal justice and public health approaches to the issue of youth violence. The scientific approach to understanding the extent and nature of youth violence, the development and testing of preventive interventions and dissemination, and implementation of evidence-based interventions is outlined. Finally, a prevention approach focused on families is described.[30]

A. Incapacitation and Deterrence: An Overview of a Criminal Justice Approach to Reducing Youth Violence

Historically, the problem of youth violence has been addressed after-the-fact and primarily within the juvenile and adult criminal justice systems.[31] Rather than focus on the

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Johnson, *A Link Between Asthma and Violence?*, PENN CURRENT (Sept. 30, 2010), http://www.upenn.edu/pennnews/current/node/4074.

[21] Nat'l Scientific Council on the Developing Child, *Excessive Stress Disrupts the Architecture of the Developing Brain* 1, 4 (Harvard Univ. Ctr. on the Developing Child, Working Paper No. 3, 2014), *available at* http://developingchild.harvard.edu/resources/reports_and_working_papers/working_papers/wp3/.

[22] *Id.* at 3, 8 n.6.

[23] *See* Joy D. Osofsky, *The Impact of Violence on Children*, DOMESTIC VIOLENCE & CHILD., 1999, at 33, 36, 38.

[24] Mark H. Moore, *Public Health and Criminal Justice Approaches to Prevention*, 19 CRIME & JUST. 237, 237, 243 (1995).

[25] *See id.* at 239, 243.

[26] *Id.* at 243–44.

[27] *Id.* at 239–40, 242–44.

[28] *Id.* at 244.

[29] *Id.* at 247.

[30] *Id.* at 238.

[31] *Id.* at 237–38.

prevention of violent crime, the juvenile justice system moved from its original purpose of rehabilitation to a more reactive and punitive response to youth violence.[32] The rise of juvenile violent crime rates between the mid-1980s and early 1990s moved retribution to the forefront, generating a series of policy proposals advocating for harsher and more frequent punishment of juvenile offenders.[33] The adoption of "get tough" policies and practices dramatically increased the incarceration rate among juveniles and has disproportionately impacted minority youth populations.[34] Large numbers of youth have been incarcerated, despite research that finds that this approach is not effective in reducing recidivism or curbing youth violence, and in some instances, may actually increase a youth's risk for involvement in violence.[35]

For example, the Community Preventive Services Task Force examined the effect on violence of juvenile transfer laws and policies across states.[36] The Task Force found strong evidence that transfer to the adult criminal justice system increases the propensity for violence among juvenile offenders, and recommended against such laws.[37] Furthermore, transferred juveniles had a thirty-four percent increase in felony rearrests compared with youth retained in the juvenile justice system.[38] Transferred youth may also experience violent outcomes, such as elevated levels of pretrial violence, victimization during incarceration, and suicide.[39] Unfortunately, laws allowing for the transfer of juveniles into the adult criminal justice system have increased dramatically over the past few decades.[40] An estimated 250,000 youth every year are prosecuted, sentenced, or incarcerated as adults.[41] In the face of countervailing evidence demonstrating that such laws are ineffective in curbing violence and future delinquency, it is

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[32] Billitteri, *supra* note 20, at 202–04.

[33] *See, e.g.*, John J. Dilulio Jr., *Moral Poverty: The Coming of the Super-Predators Should Scare Us into Wanting to Get to the Root Causes of Crime a Lot Faster*, CHI. TRIB. (Dec. 15, 1995), http://articles.chicagotribune.com/1995-12-15/news/9512150046_1_crime-talking-bomb. "[W]e will probably need to incarcerate at least 150,000 juvenile criminals in the years just ahead. In deference to public safety, we will have little choice but to pursue genuine get-tough law-enforcement strategies against the superpredators." *Id.* at 5. Superpredator is a term used to describe morally-impoverished juveniles who are prone to violence and crime. *Id.* at 3. Predictions of a large-scale youth crime wave in conjunction with the media's selective attention of to a small number of particularly violent crimes, which included school shootings, exasperated public fear of a youth violence epidemic. Emily A. Polachek, *Juvenile Transfer: From "Get Better" to "Get Tough" and Where We Go from Here*, 35 WM. MITCHELL L. REV. 1162, 1169 (2009).

[34] Billitteri, *supra* note 20, at 199 (discussing disproportionate minority impact); *see also* ANNIE E. CASEY FOUND., REDUCING YOUTH INCARCERATION IN THE UNITED STATES 2 (2013), *available at* http://www.aecf.org/m/resourcedoc/AECF-DataSnapshotYouthIncarceration-2013.pdf (discussing trends in juvenile incarceration and identifying the disparity in incarceration rates experienced by minority youth).

[35] RICHARD A. MENDEL, ANNIE E. CASEY FOUND., NO PLACE FOR KIDS: THE CASE FOR REDUCING JUVENILE INCARCERATION 11-12 (2011), *available at* http://www.aecf.org/OurWork/JuvenileJustice/~/media/Pubs/Topics/Juvenile%20Justice/Detention%20Reform/NoPlaceForKids/JJ_NoPlaceForKids_Full.pdf. Research shows that seventy to eighty percent of incarcerated youth recidivate within the first two to three years of release. *Id.* at 10. Seventy-four percent of incarcerated youth are non-violent offenders. *Id.* at 10. Confined youth are exposed to high levels of violence, abuse (a 2010 Bureau of Justice Statistics study reported an epidemic of sexual abuse in juvenile corrections facilities) and maltreatment, which are all risk factors for violence perpetration. *Id.* at 6–9. States that have significantly reduced their juvenile confinement rates have not experienced a subsequent increase in youth violence. *Id.* at 26–27; Angela McGowan et al., *Effects on Violence of Laws and Policies Facilitating the Transfer of Juveniles from the Juvenile Justice System to the Adult Justice System: A Systematic Review*, 32 AM. J. PREVENTIVE MED. S7, S13 (2007) (discussing the effects of juvenile transfer policies on violence among incarcerated youth).

[36] McGowan et al., *supra* note 35, at S7.

[37] *Id.* at S7, S13–15.

[38] *Id.* at S14.

[39] *Id.* at S17–18. Victimization rates of youth offenders during incarceration have been reported to be forty-six percent for those confined to adult facilities and thirty-seven percent for juvenile facilities. *Id.* at S17. The suicide rate for youth detained in adult correctional facilities is estimated to be 2041 youth per 100,000 and 57 per 100,000 for those in juvenile facilities. *Id.* at S17–18.

[40] RICHARD E. REDDING, U.S. DEP'T OF JUSTICE, JUVENILE TRANSFER LAWS: AN EFFECTIVE DETERRENT TO DELINQUENCY? 1 (2010), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/220595.pdf. For example, in 1979, fourteen states had automatic transfer laws compared to thirty-one states in 2003. *Id.*

[41] NEELUM ARYA, CAMPAIGN FOR YOUTH JUSTICE, STATE TRENDS: LEGISLATIVE VICTORIES FROM 2005 TO 2010 REMOVING YOUTH FROM THE ADULT CRIMINAL JUSTICE SYSTEM 7 (2011), *available at* http://www.campaignforyouthjustice.org/documents/CFYJ_State_Trends_Report.pdf.

alarming that these policies still exist today in many states.[42] Such discrepancies between research and practice constitute a major barrier to reducing and preventing youth violence.

B. The Emergence of Youth Violence as a Public Health Concern: A Historical Perspective

At the turn of the twentieth century, "[t]uberculosis and pneumonia were the two leading causes of death."[43] During the first half of the twentieth century, however, advancements in public health and medicine, such as immunizations and environmental sanitation measures, led to significant reductions in infectious diseases.[44] Because of these advancements, the ability to contend with infectious diseases changed the primary causes of death for the general population.[45] As lifestyle disease replaced infectious disease as the leading cause of death, the public health field began to realize the benefit of behavioral interventions in preventing disease.[46]

Similar to infectious diseases, the issue of youth violence can be seen as a public health issue. Since 1965, homicide and suicide have ranked among the leading causes of death in the United States.[47] Additionally, during the 1980s and 1990s, youth homicide and suicide rates increased dramatically.[48] This development garnered national attention to the issue of youth violence and legitimized it as a public health concern, providing a window of opportunity for the public health community to respond to violence.[49]

C. The Four-Step Public Health Model to Prevent Youth Violence

The public health approach to youth violence prevention emphasizes interdisciplinary collaboration and draws from a variety of academic disciplines, including psychology, social work, sociology, criminal justice, medicine, economics, and education.[50] The public health approach to prevention employs a method of scientific inquiry and involves four-steps. These steps include the following: 1) defining and monitoring the problem; 2) identifying risk and protective factors; 3) developing and testing prevention strategies; and 4) assuring widespread adoption of effective strategies.[51] The incidence and prevalence rates across the general youth population and within specific groups of youth (e.g., males, African-Americans) presented earlier in this Article represent the first step in the public health model, defining and monitoring the problem. Data collected nationally and over time aid in understanding the extent, nature, and geographic concentration of the problem. This information helps direct prevention strategies to the most appropriate contexts and settings. The following sections will explore the three remaining steps of the public health approach to violence prevention, beginning with identifying the factors that place youth at risk for, as well as protect youth from, involvement in violence.

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[42] *Id.* at 3–4. As of 2010, however, fifteen states have modified their transfer laws to reduce the number of youth transferred to the adult criminal justice system. *Id.*

[43] Linda L. Dahlberg & James A. Mercy, *History of Violence as a Public Health Issue*, 11 AM. MED. ASS'N J. ETHICS 167, 167 (2009), *available at* http://virtualmentor.ama-assn.org/2009/02/pdf/mhst1-0902.pdf.

[44] *Id.*

[45] *Id.*

[46] *See id.*

[47] *Id.*

[48] *Id.* Between 1985 and 1993, the homicide rate among persons aged ten to twenty-four years increased eighty-three percent from a rate of 8.7 homicides per 100,000 persons to 15.9 homicides. Corinne David-Ferdon et al., Ctrs. for Disease Control & Prevention, *Homicide Rates Among Persons Aged 10-24 Years – United States, 1981–2010*, 62 MORBIDITY & MORTALITY WEEKLY REP. 545, 545 *available at* http://www.cdc.gov/mmwr/pdf/wk/mm6227.pdf. The overall rate declined between 1994 and 1999. *Id.*

[49] *See* Dahlberg & Mercy, *supra* note 43, at 167–68 (noting the growing recognition of framing violence as a public health issue).

[50] *Id.* at 3.

[51] *Id.* at 4.

1. Multiple Levels of Influence: Risk and Protective Factors for Youth Violence Prevention

Risk and protective factors exist at all levels of the "social ecology"—the individual level, the relationship level, the community level, and the societal level.[52] No single factor causes a child to become violent. Rather, it is the interaction of multiple risk and protective factors at certain developmental stages that drives violent behavior.[53]

Based on this model, the key risk factors associated with youth violence are generally divided into these four broad domains: individual, family, peer, and community or neighborhood.[54] Indirect and direct risk and protective factors relate to each level of intervention and interact to increase or decrease risk for youth involvement in violence across different stages of development.[55] Individual risk factors for the perpetration of youth violence include a history of violent victimization, hyperactivity, learning problems, early antisocial attitudes, beliefs and behaviors, poor cognitive development, substance abuse, high emotional distress, poor behavioral control, and exposure to violence and family conflict.[56] Risk factors at the family level are associated with authoritarian childrearing practices, poor and inconsistent discipline, low parental involvement, poor parental monitoring, parental failure to emotionally connect with a child, parental antisocial behavior, and parental substance abuse.[57] At the peer- and school-level, association with deviant peers, gang involvement, poor academic achievement, inability to adjust in school, and peer rejection contribute to heightened risk.[58] In addition to individual, family, peer, and school factors, community characteristics may also influence the propensity for violent offending among youth.[59] Neighborhood disadvantage and social disorganization have been identified as risk factors at the community level.[60]

Conversely, protective factors moderate or buffer the adverse effects of the aforementioned risks and are equally important to address when developing preventive interventions.[61] Positive and supportive parent-child relationships, effective family communication, consistent discipline, appropriate levels of parental monitoring, pro-social peer groups, and the presence of functioning social organization within the community have been shown to have a protective effect in the development of youth violence.[62] Risk and protective factors are important to understanding youth violence and provide specific targets to inform preventive interventions.

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[52] *Id.* at 12–13. Social ecology is the complex interplay between individual and contextual factors that leads to a particular behavior, disease, or problem. *Id.* at 12. Individual-level factors consider personal characteristics of the youth, such as biology, personality, and personal attitudes and beliefs. *Id.* at 12–13. The second level addresses proximal social relationships, such as relationships with family members, peers, and other adults in the school and community. *Id.* at 13. Community-level factors include school and neighborhood characteristics (e.g., access to resources, school climate, and social disorganization). *Id.* At the societal level, characteristics of social norms and policies are addressed. *Id.*

[53] *Id.* at 12.

[54] *See* J. DAVID HAWKINS ET AL., U.S. DEP'T OF JUSTICE, PREDICTORS OF YOUTH VIOLENCE 2 (2000), *available at* http://www.safecommunitiestaskforce.org/uploads/6/8/4/6/6846151/predictors_of_youth_violence.pdf (identifying school factors as a fifth factor); David B. Henry et al., *Risk and Direct Protective Factors for Youth Violence Prevention: Results from the Centers for Disease Control and Prevention's Multistate Violence Prevention Project*, 43 AM. J. PREVENTIVE MED. S67, S69–71 (2012) (discussing individual predictors, family factors, school factors, and peer factors); Todd I. Herrenkohl et al., *Developmental Risk Factors for Youth Violence*, 26 J. ADOLESCENT HEALTH 176, 177–78 (2000) (identifying school factors as a fifth factor).

[55] HAWKINS ET AL., *supra* note 54, at 2–5.

[56] *Youth Violence: Risk and Protective Factors*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/violenceprevention/youthviolence/riskprotectivefactors.html (last updated Dec. 27, 2013).

[57] *Id.*

[58] *Id.*

[59] *Id.*

[60] *Id.*

[61] *Id.*; Jeffrey E. Hall et al., *Centers for Disease Control and Prevention's Expert Panel on Protective Factors for Youth Violence Perpetration: Background and Overview*, 43 AM. J. PREVENTIVE MED. S1, S3 (2012).

[62] *Youth Violence: Risk and Protective Factors*, *supra* note 56.

2. Effective Prevention Strategies

Research on risk and protective factors has been used to inform the development and testing of interventions to prevent youth violence. Traditionally, three levels of prevention—primary, secondary, and tertiary—have characterized public health interventions, with an emphasis on primary prevention (i.e., before the disease or problem occurs).[63] However, violence prevention researchers have adopted a modified version of this model of prevention to better align with the complexity of the problem of youth violence. This new model considers prevention in terms of population and risk categorized by three levels of intervention: universal, selected, and indicated.[64] Universal interventions targeting youth violence are delivered to entire groups or populations (i.e. all levels of risk).[65] For example, school-based programs delivered to all students in a school to prevent violent and aggressive behavior would be considered a universal intervention. Selective interventions target subsets of youth considered at-risk for violence, such as group therapy for children exposed to intimate partner violence.[66] Indicated interventions target youth who already exhibit individual markers for interpersonal violence, such as a rehabilitation program for violent juvenile offenders.[67]

Decades of research have resulted in the development and identification of a growing number of evidence-based approaches that have been found to result in significant reductions in violence as well as reductions in other risk behaviors.[68] These programs are provided in different contexts and are designed to address the individual, family, peer, and community or neighborhood risk and protective factors described earlier.[69] For example, programs delivered within schools, with families, and targeting neighborhood and community risk have been found, through randomized, controlled trials, to result in reductions in crime and violence among youth participating in the programs when compared with similar youth who did not participate in the program.[70]

Universal school-based violence prevention programs are a commonly-utilized approach to prevention.[71] A systematic review of these programs by the Task Force on Community Preventive Services found that these programs, on average, result in a fifteen percent relative reduction in youths' violent behavior.[72] For example, Life Skills Training ("LST") teaches youth

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[63] WORLD HEALTH ORG., WORLD REPORT ON VIOLENCE AND HEALTH 15 (Etienne G. Krug et al. eds., 2002), *available at* http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf?ua=1. Secondary prevention seeks to reduce prevalence, intervening when early manifestations of a disease develop. *Id.* Tertiary prevention occurs after total manifestation of a disease or condition and attempts to reduce the sequelae arising from it. *Id.*

[64] *Id.*

[65] *Id.*

[66] *Id.*

[67] *Id.*

[68] *See, e.g.*, *Positive Action, Model Program*, BLUEPRINTS FOR HEALTHY YOUTH DEV., http://www.blueprintsprograms.com/factSheet.php?pid=58f0744907ea8bd8e0f51e568f1536289ceb40a5 (discussing Positive Action, a universal school-based program designed to reduce violence and other problem behaviors, such as school dropout, school misconduct, and substance abuse by targeting risk and protective factors at the individual, peer, and school levels).

[69] *Youth Violence: Prevention Strategies*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/violenceprevention/youthviolence/prevention.html (last updated Aug. 30, 2011) (providing resources to several evidence-based youth violence prevention programs targeting all types of risk and protective factors within multiple contexts, including peer, family, school, and community).

[70] WORLD HEALTH ORG., *supra* note 63, at 16. Rigorous evaluation refers to "a strictly scientific assessment of interventions in different settings." *Id.*; *see also* ROBERT HAHN ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, THE EFFECTIVENESS OF UNIVERSAL SCHOOL-BASED PROGRAMS FOR THE PREVENTION OF VIOLENT AND AGGRESSIVE BEHAVIOR: A REPORT ON RECOMMENDATIONS OF THE TASK FORCE ON COMMUNITY PREVENTIVE SERVICES 6–8 (2007); John MacDonald et al., *The Effect of Business Improvement Districts on the Incidence of Violent Crimes*, 16 INJ. PREVENTION 327, 327, 331 (2010) (examining the impact of a community-level intervention called business improvement districts on youth violence, which aims to decrease neighborhood disorder and disadvantage).

[71] *See* HAHN ET AL., *supra* note 70.

[72] *Id.* at 6.

about anger management and conflict resolution and has been shown in several trials to decrease the incidence of fighting and delinquency in youth by almost forty percent.[73]

Community-wide reductions in youth violence "attempt to modify the environments in which young people interact with each other" and can only come from comprehensive strategies that address broader risks.[74] One promising strategy is the use of Business Improvement Districts, which are public-private partnerships that invest resources in local services and activities, such as street cleaning, security, and adding green spaces, to increase the appeal and use of the area.[75] An evaluation of this approach in Los Angeles, California found a twelve percent drop in robberies and an eight percent drop in overall violent crime.[76]

These are just a few examples of evidence-based prevention strategies that have been identified through rigorous research. There is also a growing number of school, family, and community-based prevention strategies.[77] Blueprints for Healthy Youth Development, a research program within the Center for the Study and Prevention of Violence at the University of Colorado Boulder, works to identify evidence-based prevention programs that are effective in reducing violence.[78] Over fifty model or promising programs that reduce violence or key risk factors for violence, such as delinquency and substance abuse, have been identified by the Blueprints project.[79] Given strong evidence linking stressful family environments to the development of aggression and violent behavior, family-based interventions show particular promise in preventing youth violence.[80]

III. STRENGTHENING FAMILIES TO PREVENT YOUTH VIOLENCE

Family is generally considered the most important socializing influence on a child's life.[81] Extensive testing of family-focused programs[82] provides strong evidence that strengthening the family "not only [reduces and] prevent[s] negative behaviors, but in fact increase[s] the

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[73] Gilbert J. Botvin et al., *Preventing Youth Violence and Delinquency Through a Universal School-Based Prevention Approach*, 7 PREVENTION SCI. 403, 404, 406 (2006). LST addresses individual, peer, and school risk linked to the developmental context of early adolescence such as favorable attitudes toward drug use and violence, association with antisocial peers, and pro-violence school norms. *Id.* at 404.

[74] *See* WORLD HEALTH ORG., *supra* note 63, at 43–45.

[75] MacDonald et al., *supra* note 70, at 327.

[76] *Id.* at 329.

[77] *See, e.g.*, *Youth Violence: Prevention Strategies*, *supra* note 69.

[78] Blueprints for Healthy Youth Development, CTR. FOR STUDY & PREVENTION VIOLENCE, INST. BEHAV. SCI., U. COLO. BOULDER, http://www.colorado.edu/cspv/blueprints/ (last visited May 4, 2014).

[79] Blueprints for Healthy Youth Development Search Results, CTR. FOR STUDY & PREVENTION VIOLENCE, INST. BEHAV. SCI., U. COLO. BOULDER, http://www.blueprintsprograms.com/programResults.php (last visited August 25, 2014).

[80] Nancy Rappaport & Christopher Thomas, *Recent Research Findings on Aggressive and Violent Behavior in Youth: Implications for Clinical Assessment and Intervention*, 35 J. ADOLESCENT HEALTH 260, 264 (2004).

[81] *See, e.g.*, Laurence Steinberg, *Youth Violence: Do Parents and Families Make a Difference?*, NAT'L INST. JUST. J., April 2000, at 30, 33. "I doubt that there is an influence on the development of antisocial behavior among young people that is stronger than that of the family." *Id.*; *see* Deborah Gorman-Smith et al., *Schools and Families Educating Children: A Preventive Intervention for Early Elementary School Children*, *in* PREVENTING YOUTH SUBSTANCE ABUSE: SCIENCE-BASED PROGRAMS FOR CHILDREN AND ADOLESCENTS 113, 117 (Patrick Tolan et al. eds. 2007).

[82] *See, e.g.*, John E. Lochman, *Parent and Family Skills Training in Target Prevention Programs for At-Risk Youth*, 21 J. PRIMARY PREVENTION 253, 256–57 (2000); David Olds et al., *Long-term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior: 15-Year Follow-Up of a Randomized Controlled Trial*, 280 JAMA 1238, 1241 (1998); Gorman-Smith, *supra* note 16; Blueprints for Healthy Youth Development, *Multisystemic Therapy (MST)*, CTR. FOR STUDY & PREVENTION VIOLENCE, INST. BEHAV. SCI., U. COLO. BOULDER, http://www.blueprintsprograms.com/evaluationAbstracts.php?pid=cb4e5208b4cd87268b208e49452ed6e89a68e0b8 (last visited August 25, 2014); Richard Spoth et al., *Increasing School Success through Partnership-Based Family Competency Training: Experimental Study of Long-Term Outcomes*, 23 SCH. PSYCHOL. Q. 70, 81–82.

likelihood of the kinds of positive outcomes that lead to a successful and productive future."[83] The earlier prevention programs are put into place in a child's development, the higher the likelihood of positive youth development.[84] The child is not only more likely to avoid violence, but is also more likely to succeed across areas of behavioral, social, and emotional development.[85] The evidence reveals the importance of intervening before problem behaviors begin and to help parents and families raise their children to become healthy and productive adults.[86]

As children grow, their needs and the demands of their environment change over time and the nature and extent of exposure to developmental settings shift.[87] For example, family is the most influential system during early childhood, but as children enter school and spend more time with peers, their behavior becomes increasingly influenced by school and peer contexts.[88] Thus, as children develop, the family must manage both the child's individual behavior and the influences of other social settings.[89] This is why effective parenting and a strong connection to family is so important to decrease the likelihood of a child's involvement with delinquent peers, which can, in turn, decrease the risk of involvement in violence.[90]

Understanding the particular developmental and "ecological" (or setting) influences on the youth and family is important to understanding risk. As stated earlier, a child's development is influenced by the social settings in which the child lives or participates, and the extent and nature of the interaction between these settings.[91] Looking specifically at the family setting, however, neighborhood context matters.[92] The same level of family functioning (including parenting practices) may have different effects on risk for youth violence, depending on the neighborhood in which the family lives.[93] For example, the same level of monitoring that a parent provides when living in a relatively crime-free neighborhood may not be sufficient when living in a high-crime urban neighborhood.[94]

The key implication for family-focused violence prevention is that the impact of preventive interventions likely depends on the social ecology in which development occurs and the context within which the intervention is being delivered.[95] Just as the social-ecological model to understanding risk and development emphasizes the influence of the ongoing qualities of the

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[83] Deborah Gorman-Smith et al., *What Should Be Done in the Family to Prevent Gang Membership?*, *in* CHANGING COURSE: PREVENTING GANG MEMBERSHIP 75, 76 (Simon et al. eds. 2013) [hereinafter *Prevent Gang Membership*], *available at* https://ncjrs.gov/pdffiles1/nij/239234.pdf.

[84] *Id.*

[85] LYNN A. KAROLY ET AL., PROVEN BENEFITS OF EARLY CHILDHOOD INTERVENTIONS 1–2 (2005), *available at* http://www.rand.org/content/dam/rand/pubs/research_briefs/2005/RAND_RB9145.pdf.

[86] *Prevent Gang Membership*, *supra* note 83, at 76.

[87] *Id.* at 77.

[88] *Id.*

[89] *Id.*

[90] *Id.*

[91] Deborah Gorman-Smith, *Urban Neighborhoods, Families, and Juvenile Delinquency*, PREVENTION RESEARCHER, Feb. 2008, at 17. "Settings" refer to social systems that influence child development, including "family functioning, peer relationships, schools, communities, and larger societal influences" such as public policies and the media. *Id.*

[92] *Id.*

[93] Deborah Gorman-Smith et al., *A Developmental-Ecological Model of the Relation of Family Functioning to Patterns of Delinquency*, 16 J. QUANTITATIVE CRIMINOLOGY 169, 188–89, 193 (2000) [hereinafter *Relation of Family Functioning*]; Robin L. Jarrett, *African American Children, Families, and Neighborhoods: Qualitative Contributions to Understanding Developmental Pathways*, 2 APPLIED DEV. SCI. 2, 9 (1998).

[94] Deborah Gorman-Smith et al., *The Relation of Community and Family to Risk Among Urban-Poor Adolescents*, *in* HISTORICAL AND GEOGRAPHICAL INFLUENCES OF PSYCHOPATHOLOGY 317, 349 (Cohen et al. eds., 1998).

[95] *Prevent Gang Membership*, *supra* note 83, at 77–79.

social settings in which the child lives, the developmental-ecological model contends that prevention efforts must address setting-related issues beyond the family in order to be effective.[96]

IV. CONTEXTUAL-CONSIDERED FAMILY-FOCUSED PREVENTIVE INTERVENTION

Too often, programs are developed and implemented without considering elements of the context within which the intervention is being delivered.[97] As a result, resources are wasted and clients' needs remain unmet.[98] In order to overcome this issue, the lead author, Dr. Gorman-Smith, and her colleague applied a developmental-ecological approach to designing two family-focused preventive interventions—Schools and Families Educating Children ("SAFE Children") and Guiding Responsibility and Expectations in Adolescents Today and Tomorrow ("GREAT")—targeting first- and sixth-graders considered to be at high-risk for violence involvement.

A. Schools and Families Educating Children (SAFE Children)

SAFE Children is a family-focused intervention that focuses on enhancing parent and child orientation to school, providing academic tutoring, promoting self-control and social competence in the child, reducing aggression, and improving parenting and family functioning.[99] The program is "intended to benefit generally as well as protect those" considered to be at an elevated risk for violence.[100] The program helps families enhance their ability to manage development within the inner-city community and to help children succeed socially and at school.[101]

The SAFE Children intervention targets high-risk students and consists of the following elements: 1) enhancing parent and child orientation to and involvement with school; 2) reading tutoring; 3) promoting self-control in the child; 4) promoting the child's social competence; 5) reducing aggression; and 6) improving parenting and family functioning.[102] In a randomized controlled efficacy trial, the SAFE Children intervention had significant effects on these risk markers, including academic achievement and parental involvement in school.[103] For high-risk families, child aggression, child concentration problems, child social competence, and parental monitoring were significantly affected.[104] High-risk children also had significant reductions in aggression and hyperactivity and increases in social competence and parent involvement in school.[105]

B. GREAT Families Program

Similar in design to SAFE Children, the GREAT families program was developed for middle school (sixth grade) youth and their families to decrease aggression by promoting children's academic and social competence and improve parental skills, support, and involvement

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[96] *Id.* at 78.
[97] *Id.* at 79.
[98] *Id.*
[99] Patrick Tolan et al., *Supporting Families in a High-Risk Setting: Proximal Effects of the SAFEChildren Preventive Interventions*, 72 J. CONSULTING & CLINICAL PSYCHOL. 855, 857 (2004).
[100] *Id.* Characteristics such as higher-child aggression and poorer-parenting practices would put youth at a heightened risk for violence. *Id.*
[101] *Id.*
[102] *Id.* at 857.
[103] *Id.* at 860, 863.
[104] *Id.* at 863.
[105] *Id.*

with the schools.[106] The program is structured to be delivered over fifteen weeks through multiple family groups, and activities are integrated through social-cognitive strategies, parenting skills, family management, developmental education, and inter-family support among participants.[107] These elements serve a protective function for children with risk-related characteristics who are identified by school staff as aggressive and influential among their peers and referred to the program.[108] The GREAT families program was evaluated as part of a multi-site trial funded by the Centers for Disease Control and Prevention.[109] The intervention had positive effects not only for participating youth and families, but there was also a decrease in aggression at the school-level.[110] Decreasing aggressive behavior among youth participating in the program impacted the behavior of other students in the same grade.[111]

Both the SAFE[112] and GREAT family interventions are delivered in a multiple-family group format with four to eight families per group.[113] Multiple family groups provide opportunities to develop informal networks of social support within the community.[114] Previous research using this format has found that parents begin to use one another to answer questions regarding school and community resources, as well as provide support around parenting of children of similar age and within the context of urban neighborhoods.[115]

C. Engaging Families in Preventive Interventions

While research documents the positive effects of a number of family-focused preventive interventions, recruiting and retaining family participants is a major barrier to effective implementation.[116] Participation rates of twenty to twenty-five percent are not uncommon, and researchers and practitioners have encountered "problematically low recruitment and retention rates" among families,[117] suggesting that higher-risk individuals and families are frequently underrepresented.[118]

Complicating the picture is the fact that engagement, or the recruitment and retention of participants, cannot be adequately measured as consent/refusal and attendance/nonattendance.[119] When examining engagement, it is important to consider a range of variables, including parental beliefs and attitudes toward the program, parental beliefs concerning child problem behaviors, family preferences, and sociodemographic factors, all of which predict program acceptance and responsiveness to intervention efforts.[120] Given the multiple variables at play, families display

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[106] The Multisite Violence Prevention Project, *The Ecological Effects of Universal and Selective Violence Prevention Programs for Middle School Students: A Randomized Trial*, 77 J. CONSULTING & CLINICAL PSYCHOL. 526, 528–30 (2009) [hereinafter *Ecological Effects*].
[107] *Id.* at 530–31.
[108] *Id.* at 530.
[109] The Multisite Violence Prevention Project, *The Multisite Violence Prevention Project: Background and Overview*, 26 AM. J. PREVENTIVE MED. 3, 8 (Supp. 2004).
[110] *Ecological Effects*, *supra* note 106, at 538–40.
[111] *Id.*
[112] Deborah Gorman-Smith et al., *Predictors of Participation in a Family-Focused Preventive Intervention for Substance Use*, 16 PSYCHOL. ADDICTIVE BEHAVS. S55, S57 (2002) [hereinafter *Predictors of Participation*].
[113] *Ecological Effects*, *supra* note 106, at 531.
[114] *See Ecological Effects*, *supra* note 106, at 530.
[115] Mary McKernan Mckay et al., *A Collaboratively Designed Child Mental Health Service Model: Multiple Family Groups for Urban Children with Conduct Difficulties*, 21 RES. ON SOC. WORK PRAC. 664, 666 (2011).
[116] Richard L. Spoth et al., *Translating Family-Focused Prevention Science into Public Health Impact: Illustrations from Partnership-Based Research*, 34 ALCOHOL RES. & HEALTH 188, 197 (2011).
[117] Richard Spoth & Cleve Redmond, *Research on Family Engagement in Preventive Interventions: Toward Improved Use of Scientific Findings in Primary Prevention Practice*, 21 J. PRIMARY PREVENTION 267, 268–69 (2000).
[118] *Id.* at 269.
[119] *Id.* at 270–71.
[120] *Id.* at 270–75.

varying levels of engagement.[121] Some families participate fully from beginning to end while others demonstrate increasing levels of engagement over time. Still other families may fail to enroll, attend sporadically, or drop out of the intervention.[122]

Research on family engagement has uncovered a number of characteristics influencing patterns of participation in family-focused prevention programs.[123] These studies have identified perceived anticipated benefits from the program (e.g., behavior problems of the child, struggles with parenting), logistical barriers (e.g., transportation, time, child care, cost), and past use of resources (e.g., inclination to seek out help) as key determinants of participation.[124] Research suggests that program support with logistics and participation incentives can boost participation rates.[125]

Engaging families and keeping them in intervention programs is one of the most serious challenges in prevention program delivery.[126] This may be particularly true for universal or early interventions when parents and families may not be perceived as having serious problems or be in need of immediate intervention.[127] Family engagement will therefore likely require intensive and extensive outreach efforts.[128]

V. OBSTACLES TO IMPLEMENTATION OF EVIDENCE-BASED INTERVENTIONS

While there is a growing list of approaches that significantly decrease youth violence, there are a number of obstacles that impede the realization of that goal. Evidence-based strategies are underutilized.[129] In the absence of rigorous evaluation, violence prevention efforts may be ineffective at best or harmful at worse.[130] As is true across other fields of study, many interventions and practices that are not effective continue to be used.[131] They are used because those in the field are not aware of the evidence, but also because it is hard for people and organizations to change or readjust their practices even in the face of strong research indicating

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[121] Richard Spoth et al., *supra* note 115 at 197.

[122] *See, e.g.*, *Predictors of Participation, supra* note 112, at S56.

[123] *See, e.g.*, *id.* (examining patterns of family participation in a family-focused preventive intervention and family sociodemographic characteristics specific to engagement); Alan E. Kazdin, *Parent Management Training: Evidence, Outcomes, and Issues*, 36 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1349, 1353 (1997); Richard Spoth & Cleve Redmond, *Parent Motivation to Enroll in Parenting Skills Programs: A Model of Family Context and Health Belief Predictors*, 9 J. FAM. PSYCHOL. 294, 295 (1995) (looking at family context variables and health beliefs as predictors of participation in family prevention programs); Richard Spoth et al., *A Prospective Validation Study of Inclination, Belief, and Context Predictors of Family-Focused Prevention Involvement*, 36 FAM. PROCESS 403, 403 (1997) (examining family sociodemographic factors, beliefs, attitudes, and inclination to participate in family-focused preventive interventions).

[124] *Predictors of Participation*, *supra* note 112, at S56.

[125] *Id.*

[126] Spoth & Redmond, *supra* note 116, at 268.

[127] *Id.* at 258.

[128] Richard Spoth, *Translating Family-Focused Prevention Science into Effective Practice: Toward a Translational Impact Paradigm*, 17 CURRENT DIRECTIONS PSYCH. SCI. 415, 419 (2008).

[129] SIOBHAN M. COONEY ET AL., EVIDENCE-BASED PROGRAMS: AN OVERVIEW 5 (2007), *available at* http://whatworks.uwex.edu/attachment/whatworks_06.pdf.

[130] *See* OFFICE OF THE SURGEON GENERAL, YOUTH VIOLENCE: A REPORT OF THE SURGEON GENERAL 126–135 (2001), *available at* http://files.eric.ed.gov/fulltext/ED451422.pdf. For example, several high-quality evaluations of a popular drug prevention program, Drug Abuse Resistance Education ("DARE"), have found a lack of effect in reducing drug and alcohol abuse. *Id.* at 126–27. Rigorous evaluations of Scared Strait found that youth who participated in the program had higher recidivism rates compared to their control group peers. *Id.* at 135.

[131] Blueprints for Healthy Youth Development, CTR. FOR STUDY & PREVENTION VIOLENCE, INST. BEHAV. SCI., U. COLO. BOULDER, http://www.colorado.edu/cspv/blueprints/.

inefficacy.[132] In addition, most research attention, and thus the most success, has been found for programs that focus on individual behavior, while few prevention strategies address community and societal risk.[133] While these programs are absolutely one part of the strategy to be used, changing individual behavior alone is not likely to lead to population-level change. [134]

The process of implementation and dissemination must also be considered. Widespread dissemination and high-quality implementation of these effective programs and policies has not been achieved.[135] As a result, there has been a call for greater attention to research to better understand how evidence-based interventions can be implemented at scale and translated to widespread practice in communities.[136] Translating effective programs into community settings is a complicated, long-term process but one of immense practical importance.[137] Achieving sustainable interventions requires careful attention to the implementation process.[138] Thus, understanding the necessary factors that support or impede high-quality implementation is an existing gap in research that needs to be filled.[139]

Despite the impressive progress made, considerably more work is required to advance both the science and practice of prevention. Research is needed to test new approaches, identify mediating mechanisms of intervention effects, understand factors associated with poor implementation fidelity and how to surmount them, and determine whether adaptation is necessary to make prevention programs suitable to different populations.[140] In addition, future research should focus on identifying optimal combination(s) of youth violence prevention strategies that address multiple risk and protective factors at multiple levels of intervention (i.e., individual, relational, community, and societal).[141] Such efforts are critical in creating effective comprehensive prevention strategies that will produce population-level violence reduction.[142]

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[132] *See* Janet Houser, *Evidence-Based Practice in Health Care*, in EVIDENCE-BASED PRACTICE: AN IMPLEMENTATION GUIDE FOR HEALTHCARE ORGANIZATIONS 1, 11–12 (Janet Houser & Kathleen S. Oman eds., 2011), *available at* http://sgh.org.sa/Portals/0/Articles/Evidence-based%20Practice%20-%20An%20Implementation%20Guide%20for%20Healthcare%20Organizations.pdf (discussing barriers to using evidence-based practices in healthcare settings); IOWA PRACTICE IMPROVEMENT COLLABORATIVE, EVIDENCE-BASED PRACTICES: AN IMPLEMENTATION GUIDE FOR COMMUNITY BASED SUBSTANCE ABUSE TREATMENT AGENCIES 15–16 (2003), *available at* http://www.uiowa.edu/~iowapic/files/EBP%20Guide%20-%20Revised%205-03.pdf (discussing individual and organizational demands that impede adoption and implementation of evidence-based programs and practices in community agencies).

[133] World Health Org., *supra* note 63, at 43–45.

[134] *Id.* at 47–48.

[135] Delbert S. Elliott & Sharon Mihalic, *Issues in Disseminating and Replicating Effective Prevention Programs*, 5 PREVENTION SCI. 47, 47 (2004).

[136] *Id.*

[137] *Id.* at 48.

[138] *See id.* at 47–50.

[139] *Id.* at 48.

[140] *Id*. at 47–48. There has been an ongoing debate about whether or not evidence-based programs should be implemented as intended by the program developer or modified to align with the local context of the implementing site. *Id.* at 50. Although there is an increasing demand for local adaptations of evidence-based prevention programs, there is a lack of rigorous research examining the impact of such modifications on program effectiveness. *Id.* at 51; *see also Ecological Effects*, *supra* note 106, at 540 (need explanatory parenthetical for see also cite).

[141] WORLD HEALTH ORG., *supra* note 63, at 46–47.

[142] *Id.*